Springs of Life Children's Center

ENROLLMENT PACKET

2019

Dear Parent,

Thank you for considering Springs of Life Children's Center (SLCC) for your childcare needs! We are committed to providing quality care in a loving environment. Our staff is trained to encourage each child to reach his or her potential in areas of physical, emotional, social, intellectual and spiritual growth.

Please take the time to read through our Parent Handbook to make sure that SLCC is a good fit for you and your child(ren). ***All of the information requested in the enrollment packet is required by state fY[i`Uh]cb, and must be submitted prior to your child(ren) starting.*** Please make sure that all of the information is filled out correctly. If you have any questions or concerns, one of our staff members would be happy to help you. You are also welcome to visit the center and to meet with a staff person prior to filling out any paperwork. Our desire is that you, as a parent, feel comfortable with SLCC prior to your child's enrollment.

After you've completed the Enrollment Packet, please turn it in to a staff member along with the Enrollment Fee ($20 for one child and $10 for each additional child - CCAP pays this for families with CCAP assistance).

We look forward to serving your family! May God Bless you on your journey in Parenting!

Dan Finnegan
Board President
Springs of Life Children's Center

SPRINGS OF LIFE CHILDREN'S CENTER FAMILY INFORMATION REGISTRATION FORM

FAMILY INFORMATION

Child's First, M.I. and Last Name	Name Called By	Gender	Age	Date of Birth	Desired Start Date

Guardian #1

First, M.I. and Last	Relationship	Date of Birth	E-Mail Address	
Home Address		City/ State	Zip Code	Phone Number
Place of Employment		Work Phone #	Business Address	

Guardian #2

First, M.I. and Last	Relationship	Date of Birth	E-Mail Address	
Home Address		City/ State	Zip Code	Phone Number
Place of Employment		Work Phone #	Business Address	

Guardian #3

First, M.I. and Last	Relationship	Date of Birth	E-Mail Address	
Home Address		City/ State	Zip Code	Phone Number
Place of Employment		Work Phone #	Business Address	

Emergency Contact	Relationship	Primary Phone #	Address (including zip code)
*			
*			

At least two emergency contacts with valid phone numbers and address are* ***required by state regulations*

Persons ***NOT*** allowed to pick-up my child(ren)	Reason**

If any reason listed involves a divorce/incident that resulted in sole custody and/or restraining order, a copy of the court order ***must be on file* at all times.

SPRINGS OF LIFE CHILDREN'S CENTER

MEDICAL CONSENT FORM ALL FIELDS ARE REQUIRED (do not leave blank - write "n/a")

Child #1 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

Child #2 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

Child #3 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

Child #4 Name	Special Diet*	
Allergies*	Medical Conditions**	Medication**

* Any food allergies that require a change in menu need to be documented and signed by a licensed medical practitioner using the *Special Diet Statement* form.

Any, and all, special needs and/or medical conditions need to be reviewed by the SLCC board to evaluate whether specialized care can be accommodated. SLCC follows all State Rules & Regulations regarding anti-discriminatory laws

** All medical conditions need to be documented and signed by a licensed medical practitioner using the *Specialized Child Care Plan* form.

Please read and sign the following statement:

I hereby certify that all the information provided on this page is accurate and complete. I further state that my child has no other medical issues, special diet accomodations, allergies, or mental disorders, aside from the ones listed above.

Parent's Signature: ____**Date**: ________________

Name of Professional	Emergency Phone Number	Business Address
Doctor:		
Dentist:		
Hospital:		
Insurance:		

State regulations require that you list a doctor, dentist, and hospital, all with a phone number and address

Consent for Medical Care & Treatment

Please read carefully and **initial each of the following statements**.

I hereby give my permission for SLCC staff & medical personnel to care for my child(ren) in the event of an emergency. _____ I give my permission for my child(ren) to be transported by ambulance, helicopter or aide care in the event that I am not present and unable to be reached. _____ I waive my right of informed consent and authorize hospital care, treatment & procedures to be performed on my child(ren) at the advice of a licensed physician, healthcare provider, hospital, and/or emergency personnel in order to safeguard my child(ren)'s life(s). _____ I understand that I am responsible for any and all costs for care that may accrue due to emergency care.

Guardian's Printed Name: ____ **Dated:** ____________

Guardian's Signature : ____

Springs of Life Children's Center
Child Care Financial Contract

	Full Name	Social Security # (required)
Primary Payer:		-- --
Secondary Payer:		-- --

Tuition Worksheet

Classroom	Age Range	Tuition	Child Name(s)	Scholarship* / CCAP	Total Adjusted Tuition (write "copay" if CCAP)
Infants (Full-time only)	6wks-12m	$ 280.00			
Toddler (Full-time only)	12m-2.5y	$ 255.00			
PS1 (Full-time only)	2.5y-3.0y	$ 245.00			
PS2 (Full-time only)	3.0y-4.0y	$ 210.00			
PK (Full-time only)	4.0y-5.0y	$ 210.00			
**SAP FT (>5 hours per day)	5.0y - 16.0y	$ 200.00			
**SAP PT (<5 hours per day)	5.0y-16.0y	$ 110.00			
**SAP FT Drop-in (>5 hrs)	5.0y - 16.0y	$ 55.00			
**SAP PT Drop-in (<5 hrs)	5.0y-16.0y	$ 35.00			
			Total tuition (write copay if CCAP) =		

*Any family is welcome to apply for a scholarship provided by Springs of Life Church. Please speak with the Enrollment Specialist if you are interested in applying.

**All School-age program rates include transportation: the weekly transportation rate is $20 for both FT and PT programs. The daily transportation rate is $5 per day.
**Full-time days (child attends >5 hours on school closure days for holidays/weather) are a $30 per day upcharge on top of part-time tuition.

Fee Schedule (in addition to weekly tuition and monthly co-pays)

Fee	Amount
Enrollment Fee	$20 for 1st child, $10 for each additional child
Check Resubmission Fee	$10/incident
Returned Check Fee	$25/incident
Late Payment Charge	$10/incident
Late Pick-up Charge	see late pick-up form for details
Over 10 hours daily care	TBD by director/Finance Department on case-by-case basis

Signed Payment Agreement

I, ________________________________, understand that upon signing this form I enter into a binding contract with Springs of Life Children's Center. I agree to pay the charge of _________________ every _________________, in addition to any other charges or fees I incur on my account. I agree to give SLCC two-weeks written and paid notice if I decide to end my contract with SLCC for any reason, whether I decide to have my child(ren) in the center for those two weeks or not.

Primary Payer Signature: ____________________________ Date: ________________________

Secondary Payer Signature: __________________________ Date: ________________________

SPRINGS OF LIFE CHILDREN'S CENTER
CHILD BEHAVIOR HISTORY FORM

SLCC believes each child is capable of making positive behavior choices and changes when necessary. As stated in the Discipline section of our Parent Handbook, SLCC takes a team approach in the child behavior modification process, calling on the help of both SLCC Staff and the child's Parents to curb unwanted behavior.

Please take this time to inform us of all previous/current discipline or behavior issues your child has. By completing this form, you will equip us to better serve both you and your child.

Place an "X" in any corresponding behaviors to the child listed.	Children's Names				
	Child 1:	Child 2:	Child 3:	Child 4:	Child 5:
No Behavior Issues					
Blatant Disobedience					
Excessive Crying or Whining					
Biting					
Excessive Tantrum-throwing or Fits					
Hitting or Punching					
Inappripriate Touching or Exposure					
Kicking					
Pulling Hair					
Mocking or Teasing Other Children					
Name-Calling					
Swearing					
Talking Back to Someone in Authority					
Other:					

Has your child(ren) ever been asked to leave a previous school or child care center (if yes, please explain):

____

____

Please read carefully and inital next to each of the following statements:

_______ I understand all children are subject to a two week probation period, in which time, the Springs of Life Director will ensure our center is a good fit for your child.

_______ I understand all listed behavior must be cleared through the Springs of LIfe School Age Director and/or Preschool Director prior to enrollment.

_______ I understand upon any unexcused behavior, all children are subject to a suspension period of any number of days, per the Springs of Life Children's Director.

_______ I understand non-disclosure of such behavior concerns would be ground for immediate termination of care with Springs of LIfe Children's Center.

_______ I certify the information provided on this page is accurate and complete. I further acknowledge that my child has no other major behavioral issues, other than those listed.

Parent's Signature: ________________________________ Date: ______________

Director's Signature: ________________________________ Date: ______________

Table 1. MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION

Vaccine [a]	Level of School/Age of Student											
	Child Care 2 to 3 mos	**Child Care 4 to 5 mos**	**Child Care 6 to 7 mos**	**Child Care 8 to 11 mos**	**Child Care 12 to 14 mos**	**Child Care 15 to 17 mos**	**Child Care 18 to 23 mos**	**Preschool 2 to 4 yrs**	**K Entry 4 to 6 yrs**	**Grades K to 5 5 to 10 yrs**	**Grades 6 to 12 11 to 18 yrs**	**College**
Pertussis/Tetanus/ Diphtheria	1	2	3	3	3	4	4	4	5/4 [b]	5/4 [b c]	6 [c d]	
Polio [e]	1	2	3	3	3	3	3	3	4/3 [f]	4/3 [f]	4/3 [f]	
Measles/Mumps/ Rubella [g]					1	1	1	1	2 [h]	2 [h]	2 [h]	2 [h i]
Haemophilus influenzae type b (Hib) [j]	1	2	2	3/2	3/2	3/2/1	3/2/1	3/2/1				
Pneumococcal Conjugate [k]	1	2	3/2	3/2	4/3/2	4/3/2	4/3/2					
Hepatitis B [l]	1	2	2	2	3	3	3	3	3	3	3	
Varicella [m]					1	1	1	1	2 [n]	2/1 [n]	2/1 [n o]	
Meningococcal												[p]

a: Vaccine doses administered ≤ 4 days before the minimum interval or age are to be counted as valid.

b: Five doses of pertussis, tetanus, and diphtheria vaccines are required at school entry in Colorado unless the 4th dose was given at ≥ 48 months (i.e., on or after the 4th birthday) in which case only 4 doses are required.

c: For students ≥ 7 years who have not had the required number of pertussis doses, no new or additional doses are required. Any student ≥ 7 years at school entry in Colorado who has not completed a primary series of 3 appropriately spaced doses of tetanus and diphtheria vaccine may be certified after the 3rd dose of tetanus and diphtheria vaccine (or tetanus, diphtheria, and pertussis vaccine if 10 or 11 years) if it is given > 6 months after the 2nd dose.

d: The student must meet the minimum prior requirement for the 4th or 5th doses of diphtheria, tetanus, and pertussis vaccine and have 1 tetanus, diphtheria, and pertussis vaccine dose.

e: For polio, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

f: Four doses of polio vaccine are required at school entry in Colorado unless the 3rd dose was given ≥ 48 months (i.e., on or after the 4th birthday) in which case only 3 doses are required. Four valid doses are a complete series regardless of age at completion.

g: For measles, mumps, and rubella, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable for the specific disease tested. The 1st dose of measles, mumps, and rubella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

h: The 2nd dose of measles vaccine or measles, mumps, and rubella vaccine must have been administered at least 28 calendar days after the 1st dose.

i: Measles, mumps, and rubella vaccine is not required for college students born before January 1, 1957.

j: The number of Hib vaccine doses required depends on the student's current age and the age when the vaccine was administered. If any dose was given ≥ 15 months, the Hib vaccine requirement is met. For students who began the series < 12 months, 3 doses are required of which at least 1 dose must have been administered at ≥ 12 months (i.e., on or after the 1st birthday). If the 1st dose was given at 12 to 14 months, 2 doses are required. If the current age is ≥ 5 years, no new or additional doses are required.

k: The number of pneumococcal conjugate vaccine doses depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered at: (i) ≤ 6 months, 3 doses are required at 6 to 14 months and 4 doses are required at 15 to 23 months with 1 dose administered on or after the 1st birthday; (ii) 7 to 11 months, 2 doses are required at 6 to 14 months and 3 doses are required at 15 to 23 months with 1 dose on or after the 1st birthday; (iii) 12 to 23 months, 2 doses are required. If the current age is ≥ 2 years, no new or additional doses are required.

l: For hepatitis B, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable. The second dose should be administered at least 4 weeks after the first dose, and the third dose should be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose is to be administered at 24 weeks of age (6 months of age) and is not to be administered prior to that age.

m: For varicella, written evidence of a laboratory test showing immunity or a documented disease history from a health care provider is acceptable. The 1st dose of varicella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

n: If the second dose of varicella vaccine was administered to a child <13 years, the minimum interval between dose 1 and dose 2 is 3 months, however, if the second dose is administered at least 28 days following the first dose, the second dose does not need to be repeated. For a child who is ≥13 years, the second dose of varicella vaccine must have been administered at least 28 calendar days after the 1st dose. See Table 2 for the school years/grade levels that the 1st and 2nd doses of varicella will be required.

o: If the 1st dose of varicella vaccine was administered at ≥ 13 years, 2 doses are required, separated by a minimum of 4 to 8 weeks.

p: Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new student or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed.

Table 2. TIMETABLE FOR IMPLEMENTATION OF REQUIREMENTS FOR SELECTED IMMUNIZATIONS FOR GRADES K TO 12

Refer to Table 1 for the minimum number of doses required for a particular grade level. Table 2 shows the year of implementation for a requirement from Table 1 and is restricted to varicella vaccine dose 1 (Var1) and dose 2 (Var2) and tetanus, diphtheria, and pertussis vaccine (Tdap). Requirements and effective dates for other vaccines are listed in Table 1. In this table, after a vaccine is required for grades K to 12, it is no longer shown, but the requirements listed in Table 1 continue to apply.

School Year	Grade Level												
	K	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
2007–08	Var2	Var1	Var1	Var1	Var1	Var1	Tdap Var1	Var1			Tdap		
2008–09	Var2	Var2	Var1	Var1	Var1	Var1	Tdap Var1	Tdap Var1	Var1		Tdap	Tdap	
2009–10	Var2	Var2	Var2	Var1	Var1	Var1	Tdap Var1	Tdap Var1	Tdap Var1	Var1	Tdap	Tdap	Tdap
2010–11	Var2	Var2	Var2	Var2	Var1	Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap	Tdap
2011–12	Var2	Var2	Var2	Var2	Var2	Var1	Var1	Var1	Var1	Var1	Var1	Var1	
2012–13 (Var1 required for grades K to 12)	Var2	Var2	Var2	Var2	Var2	Var2	Var1	Var1	Var1	Var1	Var1	Var1	Var1
2013–14	Var2	Var2	Var2	Var2	Var2	Var2	Var2						
2014–15	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2					
2015–16	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2				
2016–17	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2			
2017–18	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2		
2018–19	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	
2019–20 (Var2 required for grades K to 12)	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2

Colorado CACFP
Child and Adult Care Food Program

Dear Parent or Guardian,

Congratulations! You have chosen a childcare provider that participates in the Child and Adult Care Food Program (CACFP). Participating in the CACFP means that the provider cares about good nutrition for children, will introduce and serve a variety of nutritious foods for your child to eat, and will serve foods appropriate for your child's nutritional needs. The provider you have chosen cannot charge a separate fee for meals, nor ask you to provide food for your child for meals claimed for reimbursement from the CACFP, except in some special cases. Depending upon the hours in care, your provider will be serving your child breakfast, morning snack, lunch, afternoon snack, supper and/or late snack.

Please complete, sign and return this **Income Eligibility Form (IEF)** to the center as soon as possible. This information is required for the center to receive CACFP reimbursement for the meals served to your child. The Colorado Department of Public Health and Environment assures that **this form is confidential** and the information you provide will not be used elsewhere.

If no person in your household receives benefits from Temporary Assistance For Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), also known as Food Stamps, or the Food Distribution Program on Indian Reservations (FDPIR), or is not the beneficiary of the Other Source Categorical Eligibility programs, please list your household's total gross income from the current month, the amount projected for the first month the application is made for, or the month prior to the application. The U.S. Department of Agriculture, which funds the CACFP, defines a household as a group of related or unrelated individuals who are living as one economic unit and who share housing and all significant income and expenses.

If no person in your household receives benefits from Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), you must provide the last four digits of your Social Security Number according to regulations. The disclosure of the Social Security Number is voluntary; however, the last four digits of the Social Security Number, or an indication of "none," is required for the approval of this form.

If any of the children living in the household are beneficiaries of the Other Source Categorically Eligible programs (Foster, Head Start/Early Head Start or Even Start Program, Homeless, Migrant or Runaway), the children are eligible for free meals and there is no need to complete an application - just mark the box next to the program that applies. The institution collecting the form will need to verify the child's participation in the program by requesting documentation from the placement office if the child is a foster child, from the Even Start or Head Start official if the child or the pregnant mother is enrolled Head Start or Early Head Start or the child is an Event Start participant, and from the Migrant, Homeless or Runaway program officials, if the child is a migrant, homeless or runaway child. For Even Start, documentation from the Even Start official confirming that the child has not yet entered Kindergarten.

If any person in your household receives benefits from the Temporary Assistance For Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), income reporting in Part 3 and the disclosure of the last four digits of the Social Security Number (SSN) in Part 4 are not required.

Household Income Chart

If your household's income is less than or the same as the amounts indicated for your household's size on the chart below, the center will receive more meal reimbursement from the Child and Adult Care Food Program (CACFP) to help provide the best meals possible for the children in care.

Household Size	1	2	3	4	5	6	7	8	For each additional person add:
Yearly	22,459	30,451	38,443	46,435	54,427	62,419	70,411	78,403	+ 7,992
Monthly	1,872	2,538	3,204	3,870	4,536	5,202	5,868	6,534	+ 666
Weekly	432	586	740	893	1,047	1,201	1,355	1,508	+154

This chart is not to be used for determining eligibility by center staff, but is a guide for families completing the form.

Colorado CACFP

Child and Adult Care Food Program

2018-2019 Income Eligibility Form Letter For Child Care

Child Meal Patterns

Child & Adult Care Food Program

Breakfast (Select all three components for a reimbursable meal)				
Food Components and Food Items	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18 (At-risk afterschool programs and emergency shelters)
Fluid Milk	4 ounces	6 ounces	8 ounces	8 ounces
Vegetables, fruits, or portions of both	¼ cup	½ cup	½ cup	½ cup
Grains*				
Whole grain-rich or enriched bread	½ slice	½ slice	1 slice	1 slice
Whole grain-rich or enriched bread product, such as biscuit, roll or muffin	½ serving	½ serving	1 serving	1 serving
Whole grain-rich, enriched or fortified cooked breakfast cereal, cereal grain and/or pasta	¼ cup	¼ cup	½ cup	½ cup
Whole grain-rich, enriched or fortified ready-to-eat breakfast cereal (dry, cold)				
Flakes or rounds	½ cup	½ cup	1 cup	1 cup
Puffed cereal	¾ cup	¾ cup	1 ¼ cup	1 ¼ cup
Granola	⅛ cup	⅛ cup	¼ cup	¼ cup
Grains substituted with a meat/meat alternate* (May be used to meet the entire grain requirement a maximum of three times per week.	½ ounce	½ ounce	1 ounce	1 ounce

Lunch and Supper (Select all five components for a reimbursable meal)				
Food Components and Food Items	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18
Fluid Milk	4 ounces	6 ounces	8 ounces	8 ounces
Meat/meat alternates				
Lean meat, poultry, or fish	1 ounce	1 ½ ounce	2 ounces	2 ounces
Tofu, soy product, or alternate protein products	1 ounce	1 ½ ounce	2 ounces	2 ounces
Cheese	1 ounce	1 ½ ounce	2 ounces	2 ounces
Large egg	½	¾	1	1
Cooked dry beans or peas	¼ cup	⅜ cup	½ cup	½ cup
Peanut/soy/nut or seed butters	2 TBSP	3 TBSP	4TBSP	4 TBSP
Yogurt, plain or flavored unsweetened or sweetened	4 ounces/ ½ cup	6 ounces/ ¾ cup	8 ounces/ 1 cup	8 ounces/ 1 cup

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Here are the next steps now that you have turned in an enrollment packet (these must be done before your first day):

1. Turn in any missing/incomplete paperwork:
   a. ______________________________
   b. ______________________________
   c. ______________________________
   d. ______________________________
2. Get CCAP authorization on our CCAP provider ID # (if applicable)
3. Schedule and complete an orientation
4. Set a start date with the Enrollment Team
5. Arrive on your scheduled start date with your first day supplies

Thank you for enrolling your child at Springs of Life! We are blessed to have the opportunity to serve you and your family.