Hope Street School-Age Program

Connecting for Children and Families
46 Hope Street
Woonsocket, Rhode Island 02895
Phone: 401.766.3384
Fax: 401.762.2324

Please submit the following with your application:

Birth certificate
Physical
Immunization record

Date _____

Connecting for Children and Families
Hope Street Child Care Center
46 Hope Street
Woonsocket RI 02895

Membership application

Parent/Guardian's Name: _____

Address: _____

City/State/Zip: _____

Phone number: _____

Email Address: _____

Names of household members:

Adult(s): _____

Children:

Name: _____ Age: _____ School: _____

Name: _____ Age: _____ School: _____

Name: _____ Age: _____ School: _____

Name: _____ Age: _____ School: _____

Family Membership fee ($15) _____

Membership fee must be paid **before** child starts the program.

Please make checks payable to Connecting for Children & Families.

Hope Street Child Care Center

Parent Authorization For Emergency Treatment

In consideration of admittance, I hereby authorize

Connecting for Children and Families

To arrange for medical examination and/or treatment of my child,

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(Name of child)

Should an emergency arise at the day care center or on a field trip. It is understood that a conscientious effort will be made by the day care center to contact me at the emergence number I have provided below before any medical action is taken.

I would prefer to have my child taken to the following hospital if the need arises:

(Name of Hospital)

I understand that choice of hospital may be limited by service of local rescue squad.

_____ _____ _____

Signature-Mother/Guardian **Home Phone** **Business Phone**

_____ _____ _____

Signature-Father/Guardian **Home Phone** **Business Phone**

Health Insurance Plan: _____

Policy Number: _____

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Relatives or other persons to be contacted in an emergency:

Name: _____ **Address:** _____

Phone number: _____ **Relationship to child**: _____

Name: _____ **Address:** _____

Phone number: _____ **Relationship to child:** _____

Date: _____

Connecting for Children and Families Enrollment Date: _____
Hope Street Childcare Center

Child's Name: _____ Social Security #: ___ /___ /___ Birthdate: ___ /___ /___ Ethnicity: _____ Male / Female
Home Address: _____ Home phone #: _____
School: _____ (for school age children only)

Mother/Guardian Name: _____ Social Security #: ___ /___ /___ Ethnicity: _____
Home Address: _____
Employer/School Name & Address: _____Work/School Hours: _____
Health Coverage/Policy #: _____ Home phone #: _____ Work phone #: _____ Cell phone #: _____
Marital Status: _____

Father/Guardian Name: _____ Social Security #: ___ /___ /___ Ethnicity: _____
Home Address: _____
Employer/School Name & Address: _____Work/School Hours: _____
Health Coverage/Policy #: _____ Home phone #: _____ Work phone #: _____ Cell phone #: _____
Marital Status: _____

Family Annual Income: _____ Family size _____

CHILD RELEASE INFORMATION

(All information is kept confidential)

My child may be released to the following people:

Name: _____ Phone #: _____ Cell #:_____ Relationship to child: _____
Name: _____ Phone #: _____ Cell #:_____ Relationship to child: _____
Name: _____ Phone #: _____ Cell #:_____ Relationship to child: _____
Name: _____ Phone #: _____ Cell #:_____ Relationship to child: _____

Does your child have any allergies? NO/YES If yes, please list _____

Is your child currently taking any medications? NO/YES If yes, please list _____

Does your child have any limitations that staff should be made aware of? NO/YES If yes, please list _____

At your child's school, are they eligible for free lunch? YES/NO Reduced lunch? YES/NO

May we use photos of your child in promotional materials for Connecting for Children & Families? YES/NO

Parent Signature: _____

FIELD TRIPS

I give permission for my child/children to accompany CCF on field trips. I understand that I will be informed as to the location of the trip and the time my child/children will be returning. I give permission for my child/children to accompany CCF on local trips around the areas, such as a walk to Costa Park or a trip to friendly Nursing Home.

In the even that emergency medical care is needed that parent/guardian will be responsible for the fee charged by the emergency service

Parent Signature: _____

FOR OFFICE USE ONLY

DATE CHILD REGISTERED FOR PROGRAM: _____ **(Activity fee must be paid in full no later than one month after registration)**

ACTIVITIES FEES PAID: (if paid in installments, record each payment separately)

DATE: _____ AMT. PD.:_____ INITIALS: _____ | DATE: _____ AMT. PD.:_____ INITIALS: _____ | DATE:_____ AMT. PD.:_____ INITIALS:_____ |

_____Before School _____ After School _____ Toddler Care _____ Preschool Care _____ Summer School Age _____

Child Care Certificate Number _____