CHAPLIN-PEREZ CENTER
SCHOOL AGE PROGAM
Location:
37 Center Street
Woonsocket, RI 02895

(Part of Hope Street Early Learning Center)

Connecting for Children and Families
46 Hope Street
Woonsocket, RI 02895
Phone: 401-766-3384
Fax: 401-762-2324

Please submit the following with your application:

- $15.00 Membership Fee
- Birth Certificate
- Meal Form (included in packet)

Date _____

Connecting for Children and Families
Hope Street Early Learning Center/School Age
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: _____DOB_____ School: _____

Name: _____ Age: _____DOB_____ School: _____

Name: _____ Age: _____DOB _____School: _____

Name: _____ Age: _____DOB_____ School: _____

Membership fee of $15.00 yearly must be paid **before** child starts the program. Please make checks payable to Connecting for Children & Families.

<u>**Early Learning Center/School Age**</u>
<u>**Parent Authorization For Emergency Treatment**</u>

In consideration of admittance, I hereby authorize

Hope Street Early Learning Center/School Age at Connecting for Children and Families

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

____

(Name of child)

Should an emergency arise at the center on a field trip. It is understood that a conscientious effort will be made by the center to contact me at the emergency 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 ambulance

______________________	______________	______________
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: __________

Enrollment Date:_____

Connecting for Children and Families
Hope Street Early Learning Center/School Age

Child's Name: _____ Social Security #: ___ /___ /___

Birthdate: ___ /___ /___ Ethnicity: _____ Male / Female

Home Address: _____

Home phone #: _____

School: _____

Attended a Child Care Previously _____ Yes _____ No

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 _____

Home Language _____

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_____
_____

May we use photos/videos, social media/internet 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:_____ Date: _____

FOR OFFICE USE ONLY

DATE CHILD REGISTERED FOR PROGRAM: _____

Membership Fee 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 _____