



Easterseals Children’s Academy Contractual Agreement

Care is provided Monday through Friday

Start Date:_____

The Meriden Campus is open 7:00 AM until 5:00 PM

Weekly Rate:_____

The Waterbury Campuses are open 7:30 AM until 5:30 PM

Door Code:_____

I hereby declare my intention to enroll my child _____ in the Easterseals Children’s Academy program at _____ starting _____.

I understand that: (please read carefully)

1. There is a per-child LATE FEE of \$10.00 for every 15 minutes or part thereof that a parent is late picking up the child. If a parent is consistently late, the fee is doubled.
2. Your child must be signed IN AND OUT daily on the sheets in his/her classroom.
3. Fees are due ONE WEEK IN ADVANCE. Parents may choose to pay weekly, bi-weekly, or monthly, but IN ADVANCE. If tuition balance is one week past due, parents will be contacted to remind them that their tuition payment is overdue and the ramifications of non-payment. If payment is not received by the end of that second week, your child will not be allowed to return to the program until all balances are paid in full. If your child is absent due to illness, vacation, etc., payment is still due in full.

Center is closed for the following days:

- New Year’s Day
- President’s Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day (Thursday & Friday)
- Christmas Day (two days)
- Staff Professional Development Days

4. If you wish to withdraw your child from the program, a withdrawal letter is necessary. If a withdrawal letter is not submitted to the Center two (2) weeks in advance, then you will be responsible for those last two weeks of tuition.
5. **If a child has not attended for one week and no phone call has been received from the parent indicating the reason for the child’s absence, the child’s enrollment will be automatically terminated.**
6. You must provide a small blanket and a complete set of extra clothes for your child. All items must be clearly marked with the child’s name, if not done; we reserve the right to mark your child’s name on these items.
7. School Readiness Children ONLY – The child must attend 5 days per week, at least 6 hours per day to remain eligible for the School Readiness Program.

I have read the Easterseals Children’s Academy Parent Handbook, and I further agree to abide by the policies and guidelines of the program, which I have received.

Parent/Guardian Signature_____

Date _____

Easterseals Children’s Academy

22 Tompkins Street • Waterbury, CT 06708 • 203.757.7012
128 Avenue of Industry • Waterbury, CT 06508 • 203.591.1814
125 Broad Street • Meriden, CT 06450 • 203.686.1438



CHILD'S NAME: _____ DATE ENTERED: _____ HOURS/ DAY: _____

DATE OF BIRTH: _____ M: F:

INSURANCE: Husky #: _____ Private Insurance _____ Medicaid #: _____

RACE: Caucasian African American Hispanic Asian Other

Child's Parents Are: Married Separated Divorced Single Widowed

MOTHER/GUARDIAN NAME: _____ EMAIL: _____

ADDRESS: _____ City: _____, CT Zip: _____

TELEPHONE NUMBERS Home: (____) _____ Work: (____) _____

OCCUPATION: _____ HEALTH INSURANCE _____

FATHER/GUARDIAN NAME: _____ EMAIL: _____

ADDRESS: _____ City: _____, CT Zip: _____

TELEPHONE NUMBERS Home: (____) _____ Work: (____) _____

OCCUPATION: _____ HEALTH INSURANCE _____

Does the child live with his/hers parent(s)? Yes If so, with whom: Both Mother Father

No If not, with whom: _____

Names and Birth Date of Brothers & Sisters:

List other persons now living in child's home and relationship to child:

AS APPROVED FOR IN FEDERAL LAW, I HEREBY REQUEST THAT EASTER SEAL REHABILITATION CENTER OF GREATER WATERBURY, INC MAKE A WRITTEN DETERMINATION OF MY ELIGIBILITY FOR THE SCHOOL READINESS PROGRAM. I UNDERSTAND THAT THE INFORMATION I SUBMIT CONCERNING MY INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION BY EASTER SEAL REHABILITATION CENTER OF GREATER WATERBURY, INC.

FAMILY SIZE: TOTAL _____ PARENTS _____ GIRLS _____ BOYS _____ OTHER DEPENDANTS _____

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INCOME: GROSS EARNINGS FROM SALARIES, WAGES, TIPS, INCLUDING COMMISSIONS, OVERTIME, AND BONUSES

MOTHER/GUARDIAN: WEEKLY \$_____ OR MONTHLY \$_____

FATHER/GUARDIAN: WEEKLY \$_____ OR MONTHLY \$_____

OTHER INCOME: Includes but not limited to: pensions, annuities, dividends interest (more than \$10.00 a month), rental income, income from boarders, estate or trust income, royalties, social security or supplemental security income, veterans' benefits, unemployment compensation, workers' compensation, alimony, foster care payments, cash gifts from friends and relatives, lottery winnings and cash assistance from federal, state, and municipally funded assistance programs.

MOTHER/GUARDIAN: WEEKLY \$_____ OR MONTHLY \$_____

FATHER/GUARDIAN: WEEKLY \$_____ OR MONTHLY \$_____

PROOF OF INCOME IS REQUIRED.

A copy of your latest income tax form and/or 3 check stubs are needed for determination of family share.

HEALTH:

Child's Physician: _____ Telephone: _____

Child's Dentist: _____ Telephone: _____

Does your child have: Severe Asthma Diabetes Allergies Seizures/Convulsions

Did mother have any complications during pregnancy? Yes No If yes, please describe _____

What was child's weight at birth? _____

Were there any complications at birth? Yes No If yes, please describe _____

Do you think your child began:

Walking on time? Yes No If no, explain _____

Talking on time? Yes No If no, explain _____

Has this child ever been hospitalized? Yes No

Due to: _____

Has this child suffered from a serious/illness/injury? Yes No

If yes, please describe _____

Has this child suffered from any allergies? Yes No

If yes, please describe _____

What are symptoms of the reaction? _____

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Is this child taking any medications? Yes No

If yes, please describe _____

Please describe any other health concerns that you have about this child and about which you would like to inform staff.

Are you currently pregnant? Yes No Due Date: _____

Are you receiving prenatal services? Yes No

NUTRITION:

Does your child eat breakfast? Yes No

What does he/she typically eat for breakfast? _____

Does your child eat lunch? Yes No

What does he/she typically eat for lunch? _____

Does your child eat dinner? Yes No

What does he/she typically eat for dinner? _____

Do you have any concerns about your child's diet? Yes No

If yes, please describe _____

Is your child potty trained? Yes For how long? _____

No Child wears: Diapers Pull-ups All day Only while sleeping

Does your child nap? Yes No For how long? _____

Is your child in any other programs at this time? If so, what? _____

Has your child ever attended another preschool program? Yes No

If yes, please indicate the name of the program _____ For how long? _____

Does your child have playmates his/hers own age? Yes No

What types of play does your child enjoy? _____

What kind of discipline do you use at home? _____

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How does your child respond? _____

Do you have any special concerns about your child? Yes No

If yes, what are they? _____

Does your child have any behavior patterns that you would like to call to our attention? Yes No

If yes, please describe. _____

Has your child ever received a PPT? Yes No

Does your child have an IEP? Yes No

Does your child have any special needs/concerns/identified services? Yes No

Do you feel as though you have enough time in your schedule to accomplish activities? Yes No

Do you read to your children? Yes No

Do your children see you reading? Yes No

Parent/Guardian Signature

Date

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Easterseals Children’s Academy Release Form

The following is a list of people authorized to remove my child, _____, from the program. (Persons on this list **MUST** be over 18 years of age.)

****Please note: When a parent is not allowed to pick up a child, proper paper work (restraining order, custody papers, etc.) must be on file with the center. Parents must add themselves to the list****

Name	Relationship to Child	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please be sure the first and last names on the above list match the names on the person’s photo ID.

In case of emergency or other unusual circumstance, your child will be released to a person whose name is not on this list only with a written note from a parent and verification by phone of this by an Easterseals Children’s Academy staff member.



VISION AND HEARING SCREENINGS

The first five years of life are very important to your child because this time sets the stage for success in school and later life. It is important to ensure that each child's health and development are proceeding without problems or concerns. Vision & Hearing screenings are provided to assess age appropriate response.

These simple screenings help to detect possible concerns regarding how a child sees and hears the world around him/her. Early identification of vision and hearing difficulties can make a big difference in children. Early screening and identification lead to earlier diagnosis and treatment. The earlier treatment begins, the better the prospects are for the child.

You will receive in writing the results of the screenings upon completion.

VISION AND HEARING SCREENING PERMISSION

Child's Name: _____ Date of Birth: _____

___ Yes ___ No Has your child ever had EAR TUBES placed in his/her ears by a surgeon/ENT doctor?

___ Yes, please screen my child for VISION AND HEARING

___ Please screen my child for VISION ONLY, my child has had a professional hearing evaluation in the past.

___ Please screen my child for HEARING ONLY, my child has had a professional vision evaluation in the past.

___ No, PLEASE DO NOT SCREEN BY CHILD FOR VISION OR HEARING

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

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Easterseals Children’s Academy Permission Release Form

Name of Child:_____ Date of Birth:_____

Emergency Transportation:

I, _____ the parent/guardian give my permission to Easterseals Children’s Academy to transport my child via ambulance to the nearest hospital for treatment for emergency care. My preferred hospital is:_____.

Parent/Guardian Initials _____ Date_____

Emergency Medical Treatment:

I, _____ the parent/guardian give my permission to Easterseals Children’s Academy staff to give emergency medical treatment to my child if needed.

Parent/Guardian Initials _____ Date_____

Special Activities:

I give permission for my child to attend field trips organized by Easterseals Children’s Academy. I understand that these trips may include walks away from the premise (such as walks around the building or to other parts of the building that may not be on the license).

Parent/Guardian Initials _____ Date_____

Photo Release:

I give permission to have my child’s picture taken by the Easterseals Children’s Academy staff for use within the center.

Parent/Guardian Initials _____ Date_____

Parent/Guardian Full Signature_____ Date_____

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