Thames Valley Council
for Community Action, Inc.
Partnering for Prosperous Communities Since 1965

TVCCA EDUCATION SOLUTIONS CHILD DEVELOPMENT PROGRAM

Parent/Child Schedule Agreement

Schedule Agreement for: _____

Child's Name

_____

Child's Name

Children's hours at the Child Development Center are determined by need. Your child may attend during regular scheduled hours. When parents are not working, children will be scheduled for seven hours. No child may attend for more than ten hours per day.

_____ Provide Work/Training Schedule to classroom as necessary

	Arrival Time	Pick-Up Time
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

Parent Responsibilities:

1. Arrival and pick up of child according to above schedule.
2. Report absences to center **one hour before child's scheduled time.**
3. Request **in advance** to change hours and complete a new Childcare Schedule Agreement.
4. Extra hours may be provided upon request, providing licensing and staff requirements allow it.

By signing, I agree to the above terms.

_____ _____

Parent/Guardian Signature Date

_____ _____

Child Development Center Staff Signature Date

TVCCA EDUCATION SOLUTIONS CHILD DEVELOPMENT PROGRAM

Family Authorization/Enrollment Registration Form

Child's Full Name: _____ DOB: _____ Date of Enrollment: _____

Center Enrolling in: _____ Classroom: _____

Home Address: _____ # of bedrooms _____

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1) **Parent/Guardian Name: _____Cell phone #: _____**

Email Address: _____ Opt. In to receive texts from program? Yes ☐ No ☐

Employment Name: _____ Employment phone _____

Employment Address: _____

Workdays & Hours: _____ Authorized to Pick-Up: Yes ☐ No ☐

2) **Parent/Guardian Name: _____ Cell phone #: _____**

Home Address (if different than above): _____

Email Address: _____ Opt. In to receive texts from program? Yes ☐ No ☐

Employment Name: _____ Employment phone _____

Employment Address: _____

Workdays & Hours: _____ Authorized to Pick-Up: Yes ☐ No ☐

Medical Coverage Name: _____ Policy #: _____

Physician: _____ Office phone #: _____Office Fax#: _____

Address: _____

Dentist: _____ Office phone #: _____ Office Fax #: _____

Address: _____

Known Allergies: _____ Known Medical Conditions: _____

Medications Currently Taking: _____

****I understand that by enrolling my child in the program, I MUST give at least one (1) Adult Emergency Contact(s) who have my permission to take my child from the center. The center staff will verify the emergency contacts. Adult Emergency Contacts must provide a picture I.D. I also understand that when emergency contacts are called to pick up my child they are permitted to receive and sign information from center staff regarding the reason for pick-up.**

Program Agreement

- I agree that my child may participate in spontaneous field trips (i.e.: grocery store, etc.) and/or scheduled field trips. Prior notice will be given for scheduled field trips. *Emergency policies will be followed while on field trips.* ☐ **N/A** ☐ **Yes** ☐ **No**
- I agree that photographs or videos of my child and their name may be used in newspapers, social media, displays, bulletin boards, or educational publications for publicity. Check those where we can display. ☐**Classroom** ☐**Center Hallway** ☐**Social Media** ☐ **None**
- I agree to allow TVCCA EDUCATION SOLUTIONS staff to put my child on the bus for transportation to public school services ☐**N/A** ☐**Yes**☐ **No**
- All copies of custody decrees and/or guardianship documents are attached ☐ **N/A** ☐ **Yes**
- All copies of court paperwork (i.e. restraining/protective orders) are attached ☐ **N/A** ☐ **Yes**
- I understand that in the event of a medical emergency, my child will receive emergency medical treatment as needed.
- I understand that by enrolling my child in this program, I must give a ***minimum*** **of <u>one (1) Adult Emergency Contact</u> who has my permission to take my child from the center**. I also understand that when emergency contacts are called to pick up my child they are permitted to receive and/or sign information from center staff regarding the reason for pick-up.

* ***<u>I hereby acknowledge the information on this form is correct. I understand that if any of this information changes, I am obligated to notify the program immediately.</u>*** *

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ **Date:** _____

If any changes, please complete a new form*

TVCCA EDUCATION SOLUTIONS CHILD DEVELOPMENT PROGRAM

PERMISSION FORM

HEALTH SCREENINGS:

Per State of CT requirements, health screenings are required to be done on enrolled children during the program year. If these screenings are not done by your own health care provider or dentist, TVCCA EDUCATION SOLUTIONS staff can conduct the screenings or will arrange to have them done by a local trained screener or health care provider. Parent/Guardian will be notified of screening results. Results may be shared with child's health provider, TVCCA EDUCATION SOLUTIONS Child Development staff or other TVCCA EDUCATION SOLUTIONS programs, such as WIC, as needed.

Yes **No** (Please Check One)

☐ **Y** ☐ **N** **Hearing Evaluation**: Listening to different tones by using headphones, or with OAE screening tool.

☐ **Y** ☐ **N** **Vision**: Acuity, Stereopsis, SureSight or SPOT: to screen for possible eye concerns.

☐ **Y** ☐ **N** **Blood Pressure**: Using an arm cuff (sphygmomanometer) beginning at age 3.

☐ **Y** ☐ **N** **Dental Screening or Exam**: Dental screening or exam is performed by a dentist or dental hygienist to check the child's mouth for noticeable oral health problems.

☐ **Y** ☐ **N** **Growth Assessment**: Taking height & weight; sharing Nutrition Questionnaire & growth assessments with the Registered Dietician for evaluation.

BEHAVIORAL/DEVELOPMENTAL/EDUCATIONAL SCREENINGS:

During the program year, **behavioral/developmental/educational screenings** are required to be done on enrolled children. The behavioral screening may include the E-Deca2 or ASQSE The developmental tools may include any of the following: Sparkler, Smart Teach, Ages & Stages system, Speech & Language, MCHAT.

☐ **Y** ☐ **N** I give permission for all behavioral, developmental & educational screenings and assessments to be completed on my child.

☐ **Y** ☐ **N** I give permission for the TVCCA EDUCATION SOLUTIONS Behavioral Health Consultant to observe my child in the classroom/PAC time throughout the year. I understand feedback will be shared with staff and/or parent/guardian in the form of meetings such as Family Reviews, Case Reviews, or parent/staff meetings.

PERMISSION TO CHANGE:

☐**Y** ☐**N** *For Infant/Toddler/Preschool Classrooms*: I give permission for TVCCA EDUCATION SOLUTIONS staff to assist in the changing of my child's diapers/pull-up and/or clothing in the event he /she wets and/or soils his/her clothing. I understand I will be contacted to come to the center immediately if a spare set of clothes, diapers/wipes are not available or to change my child if he/she refuses to change himself/herself.

I hereby understand that:

- **Food Allergies/Restrictions** information about my child will be posted in the site's kitchen and classroom.
- All TVCCA EDUCATION SOLUTIONS Staff and Consultants are considered **Mandated Reporters** and required by law to file a report with the Department of Children and Families in cases where child abuse and/or neglect is suspected.
- Any **information needed** pertaining to my child/family **as required by funding sources** such as Department of Social Services, Office of Early Childhood, State Department of Education, Head Start, and local Boards of Education will be obtained/shared as needed. My child/family's information can also be shared with other TVCCA EDUCATION SOLUTIONS programs.

Child's Full Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Rev: 8/26

TVCCA EDUCATION SOLUTIONS CHILD DEVELOPMENT PROGRAM

Release of Information

HEALTH AND FAMILY SERVICES

Child's Name: _____ **DOB:** _____

Parent/Guardian's Name: _____

My signature on this Release of Information authorizes the release of the identified information specified below to the agency noted on this form. I, the parent/guardian, agree that a photocopy of the requested information may be used in lieu of the original.

- **FAMILY SERVICES:** ***I authorize the exchange of oral and/or written information to the specified agency below:***
  Information (i.e. treatment plans, pre-existing family plans, oral communication with worker, etc.)

_____

_____

- **HEALTH:** ***I authorize the release of the identified information specified below:***

_____ Physical Exam and Date:

_____ Immunizations

_____ TB: Test Result and Date OR Risk Assessment: Date_____ Not at Risk ____ At Risk ____

_____ Blood Lead Level: Test Result and Date _____ OR Risk Assessment: Date_____ Not at Risk ___ At Risk __

_____ Hemoglobin/Hematocrit: Test Result and Date_____ OR No Record_____

_____ Blood Pressure: Result and Date: _____ OR No Record_____

_____ TVCCA EDUCATION SOLUTIONS Dental Form and Date: _____ OR No Record_____

_____ Health Management Plan: _____ OR No Plan Needed_____

_____ Food Allergy/Restriction: _____

_____ Medication Authorization: _____

Other**:** _____

- **FILE REQUEST**: ***I, the parent/guardian of the child noted above, request a copy of the following information from my child's file:***

_____Health/Nutrition Information: _____

_____ Education Information: _____

_____ Family Services Information: _____

_____Disability/Mental Health Services Information: _____

This information is requested from the following agency/provider: _____
Agency/Provider Telephone Number: _____
Agency/Provider Fax Number: _____
ATTN: _____
Please keep a copy of this form for your records and return a copy with the requested information to the following address:

_____

_____

_____

ATTN: _____

_____

DATE

_____

PARENT/GUARDIAN SIGNATURE

_____ _____ _____ _____

STAFF SIGNATURE **TELEPHONE NUMBER** **FAX NUMBER** **DATE**

TVCCA EDUCATION SOLUTIONS CHILD DEVELOPMENT PROGRAM

The **Safe Sleep Policy** will be reviewed annually at pre-service with all staff and upon enrollment with families in TVCCA EDUCATION SOLUTIONS Child Development Center to familiarize them with the program's sleep policies for infants and to provide them with current recommendations. Safe sleep and napping practices reduce the risk of sudden infant death syndrome (SIDS) and the spread of contagious diseases. SIDS is the unexpected death of a seemingly healthy infant under one year of age for whom no cause of death can be determined. It is the leading cause of death from one to twelve months of age. The chance of SIDS occurring is highest when an infant first starts childcare. In order to maintain safe sleep practices, these policies and procedures will be followed:

Infant Sleep Practices and Environment:

- All childcare staff who work, or may potentially work, in an infant classroom will receive training on the infant Safe Sleep Policy at Classroom Orientation before working in the infant classroom.
- Infants up to twelve months of age will always be placed on their backs to sleep, unless there is a signed sleep position medical waiver on file. In that case, a waiver notice will be posted on the infant's crib and the waiver filed in the infant's health file.
- Infants shall be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting port-a-crib size sheet in a [CPSC] safety–approved crib. If the correct sized sheet is not brought in by the family, staff will provide one that has been laundered with our center laundry detergent
- Swaddling infants is prohibited unless written documentation from a practitioner is on file.
- No monitors or positioning devices should be used, and no other items should be in a crib occupied by an infant except for a pacifier.
- Pacifier use has been shown to decrease the risk of SIDS. Infants may be offered a pacifier when they are in the crib if parents offer a pacifier at home. Pacifiers will not be attached by a string or to infant's clothing. Pacifiers will not be reinserted if they fall out after the infant is asleep.
- When an infant can easily turn over from back to front and front to back, the infant will be put to sleep on their back but will be allowed to assume their preferred sleep position.
- If an infant falls asleep in any place that is not a safe sleep environment, staff should move the infant when possible and place them on their back in their crib.
- Only one infant will be in a crib at a time, unless infants are being evacuated for an emergency.
- Overheating is one of the risk factors for SIDS; to avoid overheating: keep the room at a temperature that is comfortable for lightly clothed adults, and do not overdress infants when they sleep.
- The infant's head will remain uncovered when they sleep.
- Bibs and garments with ties or hoods shall be removed from infants before they are placed to sleep.
- No child under the age of 3 years shall have access to teething necklaces, teething bracelets or other jewelry that could present a choking or strangulation hazard (i.e.: necklaces, bracelets).
- Infants under 12 months shall be physically observed at least every 15 minutes to assess the infant's breathing, color, temperature and comfort.
- The childcare program is a smoke-free environment. Infants exposed to smoke have an increased risk of SIDS.
- Awake infants will have supervised "Tummy Time" to allow for the development of strong back and neck muscles and prevent the development of flat areas on the head.
- The amount of time infants spend in a car seat, swing, or bouncy chair will be limited as this can delay motor development and may also cause the infant to develop a flat area on the back of their head.
- Children under twelve months of age will not have blankets. If the infant requires additional warmth, a blanket sleeper will be used (provided by parent/guardian), if available.

I, the undersigned parent or guardian of _____, do hereby state that I have read and
(child's full name)
received a copy of the facility's Infant Safe Sleep Policy and that the Family Liaison (or other designated staff member) has discussed the facility's Infant Safe Sleep Policy with me.

Date of Child's Enrollment: _____

Signature of Parent or Guardian: _____ Date:_____

Distribution: one signed copy to parent/guardian; signed copy in child's health file.

TVCCA EDUCATION SOLUTIONS CHILD DEVELOPMENT PROGRAM

MEDICATION POLICIES

TVCCA EDUCATION SOLUTIONS Child Development staff can administer medication to children when a medication plan has been put in place and approved. Because giving medication requires additional staff attention and storing medication on site can present safety concerns, we ask that parents/guardians check with their child's physician about whether the dosing schedule can be adjusted to take place outside of our program hours. If dosing cannot be adjusted around center hours, TVCCA EDUCATION SOLUTIONS Child Development staff will provide routine administration of oral and topical medications. Other types of medication (such as eye ointments/drops, ear drops, or nasal drops) may be considered on a case-by-case basis. Injectable medications are limited to pre-measured epinephrine auto-injectors. Please note that inhalation medications are addressed under a separate policy.

It is the parent/guardian's responsibility to ensure that the required authorization form clearly states it is for use in a childcare center. Please note that your child may not be able to attend the program if the proper medication authorization form is not completed.

The following policies apply to all medications to be administered at a TVCCA EDUCATION SOLUTIONS center:

1. All **prescription** medications **REQUIRE** a completed "AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL, CHILD CARE, and YOUTH CAMP PERSONNEL" form. The form **MUST** include:
    - Child's name, address & birthdate; list of allergies, if any, and any negative interactions with food or drugs
    - Medication name, dose & method of administration; including specific instructions for giving medication
    - Time of administration, dates to start & stop medication. Authorization dates may not exceed 1 year. Any date changes **REQUIRE** written change or new authorization form.
    - Possible side effects, and prescriber's plan for management
    - Whether medication is a controlled drug
    - Physician signature, address and telephone number
    - Parental permission to administer drug, address and telephone number.
2. All non-prescription topical medications require a completed **"Parent/Guardian Authorization for the Administration of Non-Prescription Topical Medications by TVCCA EDUCATION SOLUTIONS Child Development Personnel"** form. The form must be signed by a parent or guardian and include clear instructions. Authorization applies only to the following topical medications, and none may be in aerosol spray cans:
    - Non-prescription diaper changing ointments that are free of antibiotic or steroidal components.
    - Non-prescription medicated powders.
    - Non-prescription insect repellents.
    - Non-prescription teething medications
    - Non-prescription sunscreen protectants that are free of amino benzoic acid (PABA) or its derivatives, with a minimum of SPF 15.
    - Non-prescription lotions free of antibiotic, antifungal, or steroidal components.

    All other over the counter medications such as Tylenol or Ibuprofen **REQUIRE** a physician to complete an "AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL, CHILD CARE, and YOUTH CAMP PERSONNEL" form and will need to meet the requirements for prescription medications.
3. If medication is ordered "AS NEEDED" (i.e. inhalers, allergy medications, etc.) the doctor **MUST** be specific about what it is

needed for, when it is indicated, and how often it can be repeated. Ill children will still be excluded from the center.

EXAMPLES: * as needed every 4 hours for wheezing due to asthma
* as needed every 6 hours for insect sting allergy

4. Parents or guardians are required to bring medications to the center and demonstrate to staff how to administer them properly. Medications must not be sent to the center with the child.
With the exception of emergency medications such as an EpiPen, the first dose of any new medication must be given at home to monitor for possible side effects.
5. ALL necessary items (measuring spoons, etc.) to dispense medication(s) must be provided by the parent or guardian.

6. A Medication Log will be used to document the administration of each medication during center hours.
The Med. Log **MUST** include:

- The child's name, address, DOB, and food & medication allergies
- Name of the prescriber
- Name of medication, dosage, time & method of administration
- Whether medication is a controlled drug, & drug count if medication is a controlled drug
- Name of pharmacy, phone number & prescription number
- Date, time & dose that is administered
- Comments as needed, including child's level of cooperation
- Medication errors, if applicable
- Signature of staff administering medication

7. LABELS and PACKAGING:
PRESCRIPTION ITEMS: **MUST** be labeled by pharmacy with child's and doctor's names, prescription date, medication name, directions, and be in the original child-proof prescription bottle. Prescription label and authorization form **MUST** match exactly.

AUTHORIZED OVER-THE-COUNTER ITEMS: **MUST** be in the original store package and labeled with child's name and directions for administration.

8. MEDICATION STORAGE: All prescription medications except for Epinephrine auto-injector syringes and as needed inhalant medications to treat asthma, will be stored in a locked box out of reach of children.

Medications requiring refrigeration will be secured in a designated locked box in the refrigerator.

- All controlled medication will be stored in a locked box in a locked area (double locked).
- Epinephrine auto-injector syringes and as needed inhalant medications to treat asthma, will be stored in a safe manner, inaccessible to children, to allow for quick access in an emergency.
- All authorized non-prescription topical medication will be stored in a safe manner, inaccessible to children.

9. UNUSED MEDICATION(S) **MUST** be returned to parent/guardian **OR** destroyed within one (1) week of the termination of the medication order. Medication will be disposed of in the garbage in the presence of at least one (1) witness. Both parties will sign a Disposal of Medication form to document the disposal.

10. All medications require at least an **ANNUAL RENEWAL** from physician.

11. Staff must have current certification to administer a prescription medication to a child. Staff without current certification will not administer any prescription medications. Parents will be notified—either verbally or in writing—whenever a prescription medication is administered.

I understand and agree to the medication policies.

Name of enrolled child: _____

Parent/Guardian Signature _____ Date _____

FOOD ALLERGY/RESTRICTION FORM FOR ENROLLED CHILDREN

Section A:

To Be Completed by Childcare Center and Parent/Guardian

Date: _____

Name of child: _____ Date of Birth _____

Name of Parent/Guardian: _____ Telephone Number: _____

Childcare center: _____ Classroom: _____

Family Liaison: _____

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____

name of child's recognized medical authority

to release such protected health information of my child as is necessary for the specific purpose of special diet information to TVCCA EDUCATION SOLUTIONS and I consent to allow the recognized medical authority to freely exchange the information listed on this form and in my child's records with the childcare program as necessary.

I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that I may rescind permission to release this information at any time, except when the information has already been released. My permission to release this information will expire on: _____

**Note: The recommended expiration date is for a period of one year so that updates to the medical statement can be made in conjunction with the child's annual physical.*

Signature of parent/guardian: _____ Date: _____

Section B:

Completed by child's recognized medical authority

This section must be completed by the child's physician (MD), physician assistant (PA), doctor of osteopathy (DO), advanced practice registered nurse (APRN / NP), or registered dietitian (RD / RDN).

1. Medical Diagnosis affecting child's diet/nutrition: _____

2. If the medical diagnosis is a food intolerance or allergy, mark the severity level that best describes the child's condition and/or allergic reaction:

○◯ **Low food intolerance**	○◯ **Mild food allergy**	○◯ **Moderate food allergy**	○◯ **Severe- Life Threatening / Anaphylactic**

3. Is Epinephrine needed on-site during program hours? (Check one) ○◯ **YES** ○◯ **NO**

(Please note: Staff cannot administer medication until an Authorization to Administer Medication is completed by Physician.)

4. List food(s) to be **omitted** from the diet, and food(s) to be **substituted** (Diet Plan):

Foods to Omit:	**Substitute with:**

5. Can the omitted food(s) be consumed in processed products (e.g. milk in muffins, eggs in bread), or when prepared in a certain way? (e.g. when cooked) ◯ **YES** ◯ **NO**

*If **YES**, list allowed processing/preparations:

6. Specify any additional information and/or accommodations that need to be made for this child's food allergy/ restriction during mealtimes:

Name of recognized medical authority: _____ Phone: _____

Signature of recognized medical authority: _____ Date: _____

Office Stamp:

After 1 year from original date, if there are no changes to the child's allergy and/or restriction, the child's parent/guardian may initial this form to renew this plan for 1 additional year. At the end of this additional year, a new form must be completed by the child's recognized medical authority: Initials: _____ Date: _____

Milk Substitution Form

Section A:

Completed by Childcare Center

Date: _____

Name of child: _____ Birth Date: _____

Childcare center: _____ Classroom: _____

Family liaison: _____

Section B:

Completed by child's Parent/Guardian:

1. Reason for milk substitution request: _____

2. Requested milk substitute: (Choose only one of the two CACFP-approved options)

◌◯ **Lactaid** ◌◯ **Soy Milk*** *usually not recommended for children under 2 years old

3. Can the child have dairy-based yogurt and cheese?* ◯ **YES** ◯ **NO**

4. Can the child have dairy-based milk in prepared foods? (e.g. milk in muffins/pancakes/breads)* ◯ **YES** ◯ **NO**

*If you answered "**NO**" to questions 3 or 4, you must fill out a "CACFP Food Allergy/Restriction" form and have it completed by your child's recognized medical authority.

If changes to this form need to be made at any time, a new form must be completed.

Parent/Guardian Signature: _____ **Date:** _____

Religious Restriction or Food Preference Form

Section A:

Completed by Childcare Center

Date: _____

Name of child: _____ Date of Birth: _____

Childcare center: _____ Classroom: _____

Family Liaison: _____

Section B:

Completed by child's parent/guardian:

1. Food(s) to omit due to religious reasons or preference: _____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____

RELEASE OF INFORMATION AUTHORIZATION

Student Name: _____ **Date of Birth**: _____

In order to allow TVCCA to properly communicate important information about my child, I hereby authorize **TVCCA, as manager of the MPTN CDC,** to participate in the following actions with **The Mashantucket Pequot Tribal Nation – Education Department (MPTN)**:

- Release information about my child to the MPTN Education Department.

- Participate in two-way communication with the MPTN Education Department.

The shared information will be used for educational planning and programming and will be kept confidential to best serve the needs of your child. The MPTN Education Department may further share information with other relevant MPTN departments and employees, only as needed to best support your child.

Shared information may include: academic records, disciplinary/behavior/counseling records, IEP/504 and related documents, attendance records, biological information (e.g., date of birth, gender, nationality), personally identifiable information, medical or health records and financial information.

This authorization is valid for one academic year at the MPTN Child Development Center (August 1-July 31 of a given calendar year).

I understand that completion of this Release of Information is a condition of my child's enrollment at the MPTN Child Development Center. I understand that I can revoke this Release of Information at any time; however, by doing so my child will no longer be eligible to enroll in the MPTN Child Development Center. I have had the opportunity to review this form and ask the MPTN Department of Education any questions I may have prior to signing.

Parent/Guardian Name _____

Parent/Guardian Signature _____Date: _____

Revised Aug 2026