AKWESASNE CHILD CARE PROGRAM

APPLICATION FOR ENROLLMENT

Please make sure the following documents are completed and signed before handing in your application:

- ☐ **Application & Profile of the Child**
- ☐ **Signed Consent Form (Pink)**
- ☐ **Signed Dr's Note (Orange)**
- ☐ **Copy of Immunization Record**
- ☐ **No outstanding bills with ACCP**

All items must be complete and submitted prior to consideration for entry into the Akwesasne Child Care Program (ACCP). Once application is complete, the Supervisor will let you know approximately how long the wait list is, or when you can anticipate your child to be enrolled. Incomplete applications will not be considered, and it is the parent's responsibility to submit all documents.

ACCP will accept faxed or PDF copies from your pediatrician.

Please call back frequently to check your status, 613-938-5067.

Niawen Kowa for considering the Akwesasne Child Care Program

Date of Submission: _____

AKWESASNE CHILD CARE PROGRAM

APPLICATION FOR ENROLLMENT

Child's Information:

Name: _____
Last First Middle Mohawk

Date of Birth: _____(M/D/Y) ☐ Male ☐ Female

Child's Physical Address: _____

Primary Hours of Care: From: _____ To: _____

First Choice Center: ☐ Kawehnoke ☐ Kanatakon ☐ TsiSnaihne ☐ Private Home

****

Family Information:

	Mother or Guardian	Father
Name		
Home #		
Cell #		
Street Address Zip		☐Same as Mom
Employer		
Work #		
Work Address Zip		
Email		
Child lives with?		
Main payer?		

*Listing the father's name automatically gives him permission to pick up his child.

Siblings Enrolled? _____ Names: _____

****

Medical Contact Information

Child's Health Insurance: OHIP/QHIP_____ Exp. Date _____

Doctor: _____ Address: _____ Phone: _____
Hospital Preference: ____Cornwall Community ___Massena Memorial Hospital
Please list all allergies, special medical or dietary needs, or other areas of concern & Plan:
_____

Health History:

Has your child had any contagious childhood diseases: Yes☐ No ☐
(If yes, please list – e.g. Chicken Pox) _____

Any behavior or special considerations: ☐Yes ☐ No If yes, please explain: _____

Emergency Contacts:

Child will be released only to the custodial parent or legal guardian and the person's listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason, the custodial parent or legal guardian cannot be reached:

Name	Relation	Home Phone	Cellular Phone

Child Guidelines:

Are there any circumstances regarding your child's physical, emotional development or social status that you would like us to be aware of? _____

_____

Do you have any recommendations for us in order to make your child's day more comfortable?

_____

Fee Schedule:

Flat rates: Infant: $100, Toddler: $100, Preschool: $80 Afterschool Care: $40 Private Home is by the hour. Student Rate? __Yes or __No Sponsored Seat? ___ACFS__ AFVP__ CSP__

I agree to pay for child care at set rate as required bi-weekly & everything listed within application is true to the best of my knowledge.

Parent(s) Signature: _____ Date: _____

_____ Date: _____

Program guidelines

The Akwesasne Child Care Program reserves the right to discontinue services if at any time it is determined that our program is not able to meet your needs or your child's needs.

For Office Use Only:

Name of center child will be enrolled: _____ Date of Enrollment: _____

Private Home ☐ Name of Provider: _____ Phone # _____

Supervisor's Signature: _____ Date: _____

Transferred:

Center _____ Private Home ☐ Provider Name: _____

As of _____ day of _____, _____.

Supervisor's Signature: _____ Date: _____

Service Discharge Date/Termination:

Date: _____ Center: _____ Reason: _____

Balance of Account: $_____ Supervisor: _____

PROFILE OF CHILD

Please complete your child's age section in order to ease with transition into the center and for teacher's insight to better teach your child. Applications are confidential.

Language spoken at home: Mohawk: ☐English ☐Other: _____

List other family members besides parents living at home, ages and relationship to child:

Name	Age	Relationship

Band Number: _____ Enrolled to which band: _____ Clan: _____

Mohawk Name: _____ Is your child read to & how often? _____

What types of cultural experiences has your child been exposed to? _____

Is your child use to having a baby-sitter? Yes ☐ No ☐ Is the sitter a family member? _____

Personality:

Is your child usually: loud ☐ happy ☐ shy ☐ energetic ☐ calm ☐ quiet ☐ Other _____

Infant Section 3m-18m

Eating Pattern	Breast Fed:	X's per day:	Familiar w/Bottle:
	Formula:	X's per day:	Brand:
	Good Eater:	Fair Eater:	Poor Eater:
Foods Introdcd?		Tried eggs, pnuts, milk,tom?	
Feed self?		Use fingers?fork?	
Eat in Highchair?		Time eat brkft & lunch?	
Sleep Patterns	Crib:	Parents bed:	Toddler Bed:
Nap x's:	Length of nap:	Wakes in am?	Time to bed?
Preference:	Rocked:	Bundled:	Puts self to sleep?
Diapering	Size:	Normal BM#:	Wet#:
Physical	Norm Body Temp?	Teething?	Sit up?
Crawl?	Toddle?	Walk?	Run?

Toddler Section 18m-30m

Eating Pattern	Good Eater:	Fair Eater:	Poor Eater:
Feed self?	Use fingers?fork?	Table/High Chr?	Biter?
Sleep Patterns	Crib?:	Parents bed?:	Toddler Bed?:
Nap x's:	Length of nap:	Wakes in am?	Time to bed?
Diapering	Potty Trained?	Normal BM#:	Wet#:
	Potty Chair/Toilet?	Special Words to diaper?	
Language	List Words/Songs:		
	Easy to understand?		
	Fears?(dogs, dark?)		

Preschool 30m & up to 6 yrs Section

Eating Pattern	Feed self?	Follow routine?	Been to school?
Sleep Patterns	Naps? X'sday?	Bed/Crib?	Bed Time?
Language	Easy to understand?	Sings?	Dress self?
Behavior	Shares well?	Cleans up?	Tried p-nut, egg, tom, stung by bee?

AKWESASNE CHILD CARE PROGRAM
MEDICAL ASSESSMENT & IMMUNIZATION
PEDIATRICIAN/PHYSICIANS SIGN OFF

Child's Name: _____ Date of Birth: ___/___/_____
D M Y

Address: _____

_____

Health Insurance Number: _____ OHIP / QHIP
Exp. Date: _____

PHYSICIAN MUST COMPLETE THIS SECTION:

1. Does this child have any physical or emotional limitations that would preclude him/her from participating in all program activities? ___ No ___ Yes (If yes, please explain)

_____

_____

2. Does this child have any difficulties with the following?:

Speech: ___Yes ____No
Hearing: ___Yes ____No
Vision: ___ Yes ____No

3. Does this child require any special motor devices (wheelchair, braces, etc.)?: ___Yes ___No
If yes, please explain: _____

4.Does this child have any known allergies? : ___Yes ____No If yes, please provide treatment plan. Food: _____ **Medicine:** _____ **Other:** _____

5. Do you feel there is there any special care required in the eight hour child care program?
___Yes ____No (Special Needs assistance will be coordinated if needed) **If yes, please explain**

_____

6. Does this child have asthma? ___Yes ___No If yes, please provide more info & plan.

7. What is the child's Weight: _____ **Height:** _____

8. Is this child's immunization up to date? ___Yes ____No

_____ _____
Pediatrician/Physician's Signature **Date**

_____**Print Name**

AKWESASNE CHILD CARE PROGRAM
CONSENT FORMS

Child's Name:_____ DOB: _____ Center:_____

EMERGENCY TREATMENT

In the event of an emergency, I hereby consent to authorize the administration of any medical procedures deemed necessary by my child's doctor, or if unavailable, another physician or hospital selected by the Mohawk Council of Akwesasne, Child Care Program Representative.

Parent's Signature: _____ Date:_____

Print Name: _____ OHIP/QHIP #:_____

Witness: _____ Date:_____

FIELD TRIP PERMISSION FORM

I give my permission for my child to participate in walking field trips from the Kawehnoke/Kanatakon/TsiSniahne/PHDC Centers.
Larger field trips will require individual permission slips and will be presented prior to the trip. .

Parent's Signature: _____

MEDIA RELEASE FORMS

I give my permission for my child to be photographed while attending the Akwesasne Child Care Program, pictures are posted within the classrooms, on their cubby's, occasionally the newspaper, or facebook.

Parent's Signature: _____

INFORMATION RELEASE FORM

I hereby consent to allow the release of my child's information to the Community Health Program to obtain immunization information and authorization.

Parent's Signature: _____

IMMUNIZATION SCHEDULE

I have regularly taken my child to immunized and can assure the Akwesasne Child Care Program that their immunizations are up to date as per the Public Health Agency of Canada Immunization Standards. Copy of Record attached? __Yes __No

Parent's Signature: _____

.....

APPROVAL of RECORD: Record up to date? __Yes __No If no, please attach appointment cards.
Community Health Nurse Signature or stamp:_____ Date:_____
And/Or Center Supervisor Signature:_____ Date:_____
*Physician may sign off on immunizations as well on their form.