Harrison Children's Center, Inc.

300 Harrison Ave.
Harrison, NY 10528
914-835-4271
hccdebbie@gmail.com

June 2, 2020

Dear Parents,

I hope this letter finds everyone and their families well. These clearly have been unprecedented times. Planning has become complicated, if not impossible at times. Not only are we hoping for normalcy in September, but we are planning on it.

Attached (or enclosed if mailed) you will find a registration packet for September. Please fill the registration packet out and return it by Monday July 6, 2020. If your registration packet is received by July 6th the registration fee will be waived *for returning families*. If you choose to register after July 6th then the registration fee is as follows:

June 1st – July 5th – Fee waived for returning families
June 1st – July 5th - $75.00 for families new to After School Programs
July 6th – July 27th - $100.00
After July 27th - $150.00

You can scan and e-mail registration packets back to hccbilling@gmail.com if no registration fee is required. Otherwise mail to: Harrison Children's Center at 300 Harrison Ave. Harrison NY 10528. Registration fees can be paid by check or via Zelle. (Zelle is the preferred method) Zelle payments can be sent to hccbilling@gmail.com Please understand that it is important we have registration packets back in order to appropriately staff.

At this time, I am not sure what our after- school programs will look like, but new protocols will be put into place to keep your children healthy. I am sure it will involve a lot of hand-washing and smaller groups. We will work with the Harrison School District to ensure we create and follow proper protocol in September.

Angela, Gina, and Adrian look forward to getting back to business in September. Please feel free to contact them if you have any questions regarding registration. I am always available, so do not hesitate to contact me with any questions or concerns.

Angela, Gina, Adrian and myself wish everyone a safe, healthy and relaxing summer.

Best Regards,

Debbie Imperia
Executive Director

The Harrison Children's Center After School Program

Registration Packet

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Debbie Imperia
Executive Director
914-835-4271

Angela LaSorsa	Gina D'Amore	Adrian Tascon
Director	Director	Director
Harrison Avenue	Parsons	Preston
(914) 643 – 8754	(914) 484 – 0394	(914) 826 – 6899

Harrison Children's Center After School Program Registration Checklist

Before you hand in the registration packet, please use the checklist to make sure that you have included all necessary information and forms**.**

- Medical Forms (Immunization Records)
- Registration Form is filled out completely (**including email**)
- The registration fee- A check for $75.00 prior to June 30th,
  $100 June30th – July 15th, $150 After July 15th
  payable to The Harrison Children's Center
- Required parent and child information sheet is completed.
- Emergency Information Sheet is filled out completely.
- You and your child sign the Handbook Acknowledgment and Behavior Policy page.
- State Registration – Blue Cards (2 per child)
- Parent and child information survey is completed
- Parent – School Agreement
- If your child has allergies or asthma necessary paperwork required **MUST**
  Be submitted prior to your child starting. (please see Director for necessary paperwork)

_____________________ Signature

_________________ Date

Once all paperwork and deposit has been submitted to the Director,
there is a 48 hour waiting period before your child may attend the program.

Registration Form

Child's Name:___________________________________Birth Date__________

Child's Elementary School: ____

Grade (in Sept) ______Teacher's Name: _________________________________

Parent's Name: ____

Address: ____

Primary Email address for After School Purposes: (*required) __________________

Cell #_______________Home #_____________Work # ______________________

Days your child will be attending the After School Program:

Monday____Tuesday_____Wednesday_____Thursday_____Friday _____

Approximate time frame your child will be picked up: _______________

I understand that I am responsible for paying tuition for days I have contracted. In the event of absences, tuition will not be refunded.

Parent Signature:_________________________________Date: _________

Required Parent & Child Information

Child's Name:______________________________ Birth Date__________________

Nickname:_________________________________ Sex: ____________________

Mother	**Father**
Name: _____________________________	Name: ____________________________
Home Address:_____________________	Home Address:_____________________
___________________________________	___________________________________
Home Phone:______________________	Home Phone:______________________
Employer:__________________________	Employer:__________________________
Business Address:___________________	Business: __________________________
Days at work:_______________________	Days at work:_______________________
Occupation: ________________________	Occupation:_________________________
Business Phone:_____________________	Business Phone: ____________________
Cell Phone:_________________________	Cell Phone:_________________________
Email:_____________________________	Email:_____________________________

Marital Status: _________________

Who is legally responsible for the child? ____

Authorized Emergency Contact/Pickup? (Be sure to include someone who usually knows your whereabouts.)

1. Name:_________________________Phone:__________________________
2. Name:_________________________Phone:__________________________
3. Name:_________________________Phone: __________________________
4. Name:_________________________Phone:___________________________

Persons ***not*** authorized to pick up child:

1. Name:_____________________ 2. Name:________________________

Handbook Acknowledgement

Please read the Harrison Children's Center After School Handbook. Once you have read the handbook please review pertinent information with your child. In order for our program to run smoothly it's important that everyone understands the guiding principles of our After School Program. If you have any questions or suggestions regarding the Handbook please feel free to discuss them with your director.

Cell Phone Policy

While we realize many children bring cell phones to school, due to OCFS Regulations **ALL CELL PHONES MUST** remain in their backpacks. If you need to reach your child please call the After School Director.

Behavior Policy

Our After School Programs are committed to creating an environment in which children can develop the basic values of respect, caring, honesty and responsibility. Our philosophy is to foster positive self-esteem. This enables children to learn how to develop appropriate behavioral limits in a variety of situations.

The Harrison Children's Center offers an environment where all children and staff feel respected, safe and secure. Parents will be notified if a child is disruptive, engages in dangerous behaviors, use of inappropriate language or bullies staff or children. Such behaviors will be discussed with both the student and the parent/guardian. If these behaviors persist, this will result in a suspension and/or removal from the program. The Harrison Children's Center views the safety of our staff and all children a top priority. Please be sure to discuss this policy with your child so everyone involved is aware of what is expected while attending our program.

I have read both the After School Program Handbook and Behavior Policy. I have reviewed them with my child and agree to adhere to the above.

______________________________	__________________
Parent/Guardian Signature	Date
______________________________	__________________
Student's Signature	Date

Parent- School Agreement

1) The following is your child's Monthly fee $_____________

2) The tuition for all programs is due the first ten days of the month.

3) There will be no refund if your child is absent from the HCC.

4) HCC will not pro-rate months due to an alternate activity that you select for your child to attend for part of the month.

5) As stated in the child/parent information sheet:
No person or persons other than those specifically authorized by the child's parents will be allowed to pick up a child unless he/she has a note written and signed by the parent. Proper identification must be provided at pick up. (Picture I.D.)

6) I give my permission to The Center for the following:

a) To allow my child to leave the center to go on field trips neighborhood walking trips, and to use Harrison's public parks.

b) To seek emergency medical treatment for my child in case I am unavailable when such treatment is needed.

c) To allow my child to appear in photographs taken by the center and to allow any pictures of my child to be released for publication in newspapers, brochures and our website.

d) I am responsible for transporting my child to and from the Center and will not hold the Harrison Children's Center responsible for my child during that time.

e) Include my child's name, address, and phone number on a center list for the exclusive use of current center families.

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YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THIS AGREEMENT, AND THAT YOU ARE WILLING TO ABIDE BY THE TERMS THEREOF. THE CENTER WILL NOT BE RESPONSIBLE FOR ANYTHING THAT MAY HAPPEN AS A RESULT OF FALSE INFORMATION GIVEN AT THE TIME OF ENROLLMENT.

I further understand that this agreement will expire on June 30, 20___

Signature of Parent/Guardian:______________________Date: _________________

Hours of Operation: 3:00 – 6:00 p.m.

Registration Fee is $75 by June 30th
or June 30th – July 15th $100
after July 15th $150

Tuition Schedule

5 Days a week	$465.00 month	2 Days a week	$205.00 month
4 Days a week	$380.00 month	1 Day a week	$145.00 month
3 Days a week	$290.00 month	Drop-in	$40.00 per day

Payment is due by the 10th of each month. All half day dismissals are included in the monthly rate for regularly scheduled days. Please note: **Our program is tuition based and payment is expected for the days your child is contracted**. Additionally, you are responsible any emergency closure days. Please be punctual at pick up or there will be a late pick up fee of $20.00.

******Please note: There is a $40 drop in charge for Half Days unless it is a day your child typically attends******

*****Payment can be made by check or Zelle payments. Zelle payments are preferred. Please use hccbilling@gmail.com as the recipient ******

OCFS-LDSS-0792 (10/2018) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	Child's Full Name: Preferred Name/Nickname:	Date of Birth: / /	Gender:
	Child's Home Address:		
	Name of Person Enrolling Child:	Relationship to Child: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ______ ☐ Other ______	

Phone Number(s) of Person Enrolling Child: ( ) - ☐ ok to text **Email Address:**	Address of Person Enrolling Child (if different than child):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
Primary Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ ok to text

For Program Use Only Date of Enrollment: / /	*For Program Use Only* Date of Disenrollment: / /

OCFS-LDSS-0792 (10/2018) REVERSE

Child's Full Name:	Date of Birth: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (list) ______________________________

☐ Other ______________________________

Please provide information here **AND** discuss with your child care provider:

Child's Primary Care Physician's Name/ Group:	Phone Number: ( ) -
Preferred Hospital:	Phone Number: ( ) -
Child's Dental Care:	Phone Number: ( ) -

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child.......... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision.......... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.......... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child.......... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.......... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year.......... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Medical Statement of Child in Childcare

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care

☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: ___________ Mantoux Results: ☐ Positive ☐ Negative ________ mm

TB Tests are at the physician's discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ______________________________

Attach lead level statement

Health Specifics

Comments

Are there allergies? (Specify)	☐ Yes ☐ No	

ADDITIONAL INFORMATION ON REVERSE SIDE ➔

Medical Statement of Child in Childcare (cont.)

Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to Day Care Providers

____

____

____

____

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

If your child has any special health care needs please fill out the Individual Health Care Plan.
(ex: Asthma, Allergies, diabetes, Epilepsy or any medical condition requiring a special diet etc…)
If your child does not have any health care needs please leave blank.

Please note…Your child's medical form from the pediatrician must match this form. Also, if your child does have any health care needs additional paperwork may be required upon review of the Director.

This plan does not require a doctor's signature. It should be developed by the parent and shared with the program Director.

Any precautionary medication must be supplied to us in the original packaging and or boxes.

*****Please note that your child will not be able to start our program until ALL paperwork is completed properly******

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

Child Name:	Child date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name:	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
Child care provider's signature: **X**		

Signature of Parent:

X	Date: