

UNITED STATES COAST GUARD
PSSU/MWR KODIAK
CHILD DEVELOPMENT CENTER

Accredited by NAEYC's
National Academy
of Early Childhood
Programs



Building N41 Corner of Mary Island Way and Albatross, Kodiak AK 99615 (907) 487-5481

Welcome to the Child Development Center (CDC).

Attached is a complete Child Development Center Registration packet. All forms must be completed and returned to the Child Development Center prior to attendance.

The registration packet contains:

- Child Development Center Registration Form (DOT, USCG, CG-5484)
- Release of Information Act Statement (DOT, USCG, CG-5484, page 2)
- Child Health Assessment Form (Commandant Inst., Encl. 4).
- Immunization fact sheet.
- Child Development Center Civilian or Military Medical Consent Form (DOT, USCG, CG-5484I & CG-5484H). This form allows the CDC to get medical attention for your child in case of an emergency when a parent cannot be reached.
- Field Trip Permission Form (DOT, USCG, CG-5484B). This form allows us to leave the Center with your child to take walks and pre-approved trips to other locations.
- The USDA Application for Free and Reduced Price Meals for Center Programs.

Other information needed include:

- Your child's current shot record (we will make a copy).
- Current leave and earning statements and/or pay stubs to participate in our sliding fee program.

If you have any questions about the Child Development Center, please do not hesitate to call the CDC at (907) 487-5481.

Children are enrolled when the completed registration packet is returned and registration fee and first payment has been made.

A parent orientation with the room lead teacher will be scheduled.

Thank you for choosing the Child Development Center at PSSU/MWR Kodiak.

CHILD DEVELOPMENT SERVICES REGISTRATION FORM

(See Privacy Act Statement on Page 2.)

Child's Name: _____
Last First MI

Address: _____

Home Phone: _____ Birthdate: _____

Parent's Name: _____
(include Rank/Rate) Father Mother

Employers' Name/Address

Father: _____ Mother: _____

Work Phone: _____ Work Phone: _____

Name of person(s) authorized to remove from child care (include phone number):

Emergency contact in the event parent/guardian cannot be reached.
(Name/phone number)

Doctor's name/phone number: _____

Any other information you believe would be helpful to caregiver in working with your child(ren):

1. All parts of this form will be completed and signed by the sponsor before the child(ren) is admitted to the child care program.
2. This form will be kept on file for all children enrolled in a child care program.
3. A copy of the Emergency Medical Authorization form must be carried by staff if child is away from the site on a field trip so that emergency medical treatment may be obtained, if needed.
4. This form to be renewed at the beginning of each year.

RELEASE OF INFORMATION/PRIVACY ACT STATEMENT

Data required by the Privacy Act of 1974 (5 U.S.C. 552a)

Authority: 14 U.S.C. 632

Principle Purposes: To provide the care providers with authorization for medical treatment in emergency situations, identify children and sponsor, record required immunizations and known allergies, and to provide other information necessary for working with the child.

Routine Purposes: Form may be furnished to military or civilian doctor or hospitals in the course of obtaining medical treatment for children. Information furnished may be disclosed to any DHS component or part thereof, and upon request to other Federal, State, and local governmental agencies in the pursuit of their official duties.

Disclosure is Voluntary: The supplying of requested information is voluntary. Failure to respond will result in the denial of admission of your child to the program.

I release the information on the attached registration forms to the provider of child care services for the purpose of assessing the eligibility of the child(ren) for the program and for the routine uses listed above.

(Date)

(Signature)

CHILD DEVELOPMENT SERVICES
CHILD HEALTH FORM

To be completed by a health practitioner before admission to a child care program and renewed annually.

_____ has had a complete history and physical examination at my office on
(Child's name: Last/First/Middle)

_____. Findings for this child are indicated as follows:

Date

1. Date of most recent tuberculin test _____. Result: Positive _____ Negative _____

2. The child has the following which may significantly affect his education/care experience:

	YES	NO	COMMENTS
a. Visual problem	_____	_____	_____
b. Hearing problem	_____	_____	_____
c. Speech or language problem	_____	_____	_____
d. Other physical illness or impairment	_____	_____	_____
e. Mental, emotional, behavior problem	_____	_____	_____
f. Developmental delays	_____	_____	_____
g. Allergies	_____	_____	_____

Significant physical findings, comments, and recommendations:

3. YES / NO The child has a health condition, which may require care or emergency action while he is at child care.
(Please specify, e.g., seizures, bee sting allergy, diabetes, etc.)

Recommendations:

4. YES / NO The child has or is a known carrier of a communicable disease.

Explain:

5. YES / NO The child is on long term medication. Specify:

6. YES / NO The child requires a modified diet and/or special feeding procedures. Specify:

7. YES / NO The child is in good physical and mental health. Except as noted above, he is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all activities.

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

8. If child cannot fully participate in all areas of child care program, what areas should be limited or altered to suit this child's needs?

9. YES / NO Does child's physical activity need to be restricted? If YES, explain

10. What specialized treatments, if any, will this child require?

Instructions for care:

11. Does this child require any supportive equipment? (Braces, crutches, etc.) YES NO

If YES, please specify type _____

Special instructions for use _____

12. Additional comments:

SIGNATURE & STAMP REQUIRED

Health Practitioner (please print)

Phone

Signature of Health Practitioner

Date

Address

CHILD DEVELOPMENT CENTER IMMUNIZATION REQUIREMENTS

The Alaska Departments of Education and Child Development of Health and Social Services have revised the existing immunization regulations for students attending Alaska schools and childcare facilities. The following immunizations are required.

AGE	IMMUNIZATION
BIRTH	1 Hepatitis B
2 months	2 Hepatitis B
	1 DTaP
	1 Polio (IPV or OPV)
	1 Hib
	1 PCV
4 months	2 DTaP
	2 Polio (IPV or OPV)
	2 Hib
	2 PCV
6 months	3 Hepatitis B
	3 DTaP
	3 Polio (IPV or OPV)
	3 PCV
12 months	4 DTaP
	3 Hib
	4 PCV
	1 MMR
	1 Varicella
	1 Hep A
18 months	2 Hep A
4-6 years	5 DTaP
	4 Polio (IPV or OPV)
	2 MMR
	2 Varicella
11-12 years	Tdap
	HPV
	Meningococcal

CHILD DEVELOPMENT SERVICES
MEDICAL CONSENT AUTHORIZATION

(TO BE USED BY **MILITARY** FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. **This form is a legal document and must be filled out completely and correctly to be valid.**

TO: HEALTH CARE PROVIDER

I, _____, am the parent or legal guardian of the child named below, and entitled to medical care at your facility/practice.

Child's Full Name: _____, Age: _____

Address: _____, Phone: _____

_____, ID Card # _____

_____, Exp. Date _____

(Sponsor's Name)

(Employee ID Number)

(Duty Station)

I do appoint the Child Development Center Director, or the most senior Child Development Center personnel present at the time of the emergency, to be my Attorney-in-Fact (agent) for the purpose of obtaining medical treatment deemed necessary in the event that I cannot be immediately reached in a reasonable amount of time at the time of the emergency.

The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the _____ Medical Clinic or any duly licensed medical practitioner for the health and well being of my child aforementioned. I understand that the staff of the _____ Medical Clinic include, in addition to Physicians and Dentists, Health Service Technicians and Physicians' Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child. I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I HEREBY GIVE AND GRANT TO my said attorney-in-fact full power and authority to acknowledge and deliver any instrument under seal or otherwise, and to perform every act and thing whatsoever that is necessary or appropriate to accomplish the purposes for which this Consent Authorization is granted, as fully and effectually as I could do if I were present."

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on _____, 20____ and, unless sooner revoked or terminated by me, this Power of Attorney shall become NULL and VOID on _____, 20____.

Signature of Parent or Guardian

Date

Approval Date _____

Chief, Medical Administration Branch
Health Services Division

This form shall be notarized.

State of _____)
County of _____) ss

On this _____ day of _____, _____
(Month and Year) (Name of Notary Public)

a notary public (or person authorized to administer oaths under 10 U. S. C 1044a) for the County/City and State aforesaid,
certify that _____
(Name of Person executing Document)

who is known to me (by proper identification) to be the person whose name is subscribed to the within instrument and acknowledged
that she executed the same for the purposes therein contained, as her free act and deed before me in the County/City and State
aforesaid.

Sworn to and subscribed before me this _____ day of _____
(Month and Year)

(Notary Public)

My Commission Expires: _____

FIELD TRIP PERMISSION

I give my permission for _____
(child care provider) to take my child(ren) _____
_____ (name) on field trips and/or other outings
as long as my child(ren) is/are accompanied by competent supervision. These
outings may be walking, motor vehicle, bicycle, etc.

**The above authorization shall remain in effect for one (1) year from below date,
or until cancelled or amended by parent or legal guardian.**

(Signature of parent/legal guardian)

(Date)

Photo Release

ISC Kodiak, Child Development Center

I, _____, the parent of, _____;

(Please mark one of the following choices:)

* _____ give my permission for the Child Development Center, ISC Kodiak to post photos of my child. The CDC may use photographs for internal publications as well as publications that are available to the general public.

* _____ I do not want photos of my child in a publication that may be available to the general public. However, you may post photos of my child inside the CDC.

* _____ I do not want any photos of my child in CDC publications or posted at the CDC.

Signed _____ Date _____

Permission to Drop off / Pick up

I, _____,
give permission for the following person(s)
to pick up and/or drop off my child/
children, _____:

Name: _____

Phone #: _____

Name: _____

Phone #: _____

Parent signature: _____

Date signed: _____

ENCLOSURE (1)

Total Family Income (TFI)

Monthly Fee **Effective July 1, 2011.**

Categories	Fees
9 \$125,001+	\$685 per child
8 \$100,001-125,000	\$675 per child
7 \$85,001-100,000	\$660 per child
6 \$73,501-85,000	\$650 per child
5 \$57,751-73,500	\$630 per child
4 \$46,201-57,750	\$575 per child
3 \$35,701-46,200	\$520 per child
2 \$29,401-35,700	\$475 per child
1 \$0-29,400	\$400 per child
After School Program	\$275 per child
Part Day Preschool	\$275 per child
Drop-in fee	\$5.00 per hour/per child

TOTAL FAMILY INCOME

Standard rate is \$685 a month. If you wish to participate in the sliding fee scale, it is based on total family income. Total family income is calculated as follows: The earned income for adult members of the household, including wages, salaries, tips, long-term disability benefits received, incentive and special pay for service, or anything else of value, even if not taxable that was received for providing services. Also included are Basic Allowance for Housing and Basic Allowance for Subsistence authorized for the pay grade of military personnel, whether the allowance is received in cash or in-kind.

Total family income does not include: the geographic cost of living allowances; alimony and child support; temporary duty allowances or reimbursements for educational expenses; veterans benefits; workers compensation benefits; and unemployment compensation.

PSSU/MWR
KODIAK, ALASKA

CHILD DEVELOPMENT CENTER

PARENT "PROOF OF INCOME" WAIVER

I, _____,

PARENT(S) OF _____, OPT TO PAY

THE FULL PRICE CHILD CARE FOR THE FOLLOWING PROGRAM:

INFANT/\$685.00 TODDLER/\$685.00

FULL DAY PRESCHOOL/\$685.00 PART DAY PRESCHOOL/\$275.00

AFTER SCHOOL/\$275.00 DROP-IN CHILD CARE \$5.00 PER HOUR

SUMMER CARE \$600.00 Effective 07/01/2011.

THEREFORE, I AM NOT REQUIRED TO SUPPLY THE CHILD DEVELOPMENT CENTER WITH A LEAVE AND EARNINGS STATEMENT OR OTHER PROOF OF INCOME.

Signature: _____ Date: _____

AUTO-PAY AGREEMENT

I, _____, agree to have my monthly child care fee automatically charged to my Credit Card on the first business day of each month. If I opt for a split payment agreement my credit card will be charged the first half of my child's tuition on the first business day of the month and the second half will be charged on the fifteenth of the month, or the first business day following the fifteenth.

I reserve the right to review all additional charges, such as late fees, registration fees, and drop-in fees before I charge them to my account.

<u>CREDIT CARD</u>	<u>NAME ON CARD</u>	<u>CARD NUMBER</u>	<u>EXPIRATION DATE</u>
<u>MASTERCARD</u>	_____	_____	_____
<u>VISA</u>	_____	_____	_____

Customer Signature _____
Date

CDC Signature _____
Date

Full tuition on the 1st _____

Split pay tuition 1st/15th _____

Program: RC AS DI TB (Circle one)

Along with the **completed
Registration Packet** we
require copies of your child's
**current
vaccinations/immunizations**
and copies of current
LES's for all working
members of the household.

Thank You,
Administration

PAC For Kodiak CDC

Please Join Us!

The purpose of Parent Advisory Committee (PAC) is to promote communications and provide an avenue for direct parent input regarding policy and operation of the Child Development Center to the CDC administration including the Commanding Officer.

Meetings are held at Noon with lunch provided every other month. These meetings are a great opportunity for you to get information, voice concerns, give praise, discuss fundraising ideas, meet new caregivers, get to know other parents, and get involved in your child's care.

Meeting notices will be posted in the CDC newsletters and on flyers around the CDC building.

If you would like to participate in PAC, receive meeting notices, and other information by email, please provide your contact information below:

Name of Parent(s): _____

Email address: _____