



# Rosa Venerini Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Student Enrollment Form

Child's Name: \_\_\_\_\_ Sex: M F

Birthdate: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

1<sup>st</sup> Parent's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: (if different from child) \_\_\_\_\_

2<sup>nd</sup> Parent's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: (if different from child) \_\_\_\_\_

Child lives with:  Both Parents  Mother  Father  other: \_\_\_\_\_

Emergency Contact(Other than parents)

1. \_\_\_\_\_ Phone #: \_\_\_\_\_

2. \_\_\_\_\_ Phone #: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Registration Fee: \$75 Cash or Check # \_\_\_\_\_

Office Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Rosa Venerini Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Student Enrollment Form

Child's Name: \_\_\_\_\_

2019-2020

School Year Programs

### Full Day School (9am-3pm)

_____ T/TH	\$80/wk
_____ M/W/F	\$110/wk
_____ 5 Days	\$165/wk

### Half Day School (9am - 12:30pm)

_____ T/TH	\$225/mo
_____ M/W/F	\$250/mo
_____ 5 Days	\$305/mo

### Before Care Program

8:00 am Drop-Off

\_\_\_\_\_ 5 Days \$40/wk

7:00 am-8:00 am Drop-Off

_____ T/TH	\$30/wk
_____ M/W/F	\$35/wk
_____ 5 Days	\$55/wk

### After Care Program

4:00 pm Pickup

\_\_\_\_\_ 5 Days \$55/wk

4:00 pm-5:30 am Pickup

_____ T/TH	\$40/wk
_____ M/W/F	\$50/wk
_____ 5 Days	\$70/wk

Child care hours needed: \_\_\_\_\_ to \_\_\_\_\_

**\*\*Any additional hours must be Pre-approved by Director & Pre-Paid\*\***

Additional Hours are billed by the hour at a \$15/hr. (This fee is not divided in halves or quarters)

**Sibling Discount: 10% Off on Lower cost tuition**

✧ Parent Contract MUST be read and signed by parent(s)/guardian(s) before child begins school



# Rosa Venerini Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Personal Data : Family & Social History Form

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Parent Info

Legal guardian 1:     Mother                       Father                       other: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Legal guardian 2:     Mother                       Father                       other: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:     Married     Living Together     Separated     Divorced     Step-parent

Custody/Visiting arrangements: \_\_\_\_\_

\_\_\_\_\_

### Brothers & Sisters

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_

### Child Experiences

Has child had group play experience? \_\_\_\_\_ Where? \_\_\_\_\_

Does child have playmates? \_\_\_\_\_

What are your child's favorite indoor/outdoor activities? \_\_\_\_\_

\_\_\_\_\_

Does your child have fears that you are aware of? \_\_\_\_\_

### Development History

At what age did your child:

Crawl: \_\_\_\_\_ Name simple objects: \_\_\_\_\_ Sit up on own: \_\_\_\_\_

Repeat short sentences: \_\_\_\_\_ Begin toilet training: \_\_\_\_\_

Sleep through night: \_\_\_\_\_ Complete toilet training: \_\_\_\_\_

What word does your child use for Urination : \_\_\_\_\_ Bowel Movement: \_\_\_\_\_

Does child dress self?     Y  N                      Undress self?  Y  N



# Rosa Venerini Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Personal Data : Family & Social History Form Cont.

### NAPPING AGREEMENT

**Infants\***: I agree to have my child nap in/on a  **mat**,  **crib**,  **pack & play** placed in the infant room.

**Toddlers**: I agree to have my child nap in/on a  **mat or**  **cot** placed in the classroom.

**Preschool/Pre-K/UPK** : I agree to have my child nap in/on a  **mat or**  **cot** placed in the classroom.

\*Sleeping arrangements for **infants** require that the infant be placed on his or her back to sleep, unless medical information is presented by the parent that shows that this arrangement is inappropriate for that child.

Sleep Schedule: Regular bed time : \_\_\_\_\_ to \_\_\_\_\_ Does your child have interrupted sleep?  Y  N

Do you have concerns about your child's development?

Speech  Fine Motor  Gross Motor  Behavior  Social/emotional

How would you best describe your child's personality? \_\_\_\_\_

What are your daycare expectations? \_\_\_\_\_

Please explain any special family traditions or celebrations that you would like to share with us:

### Home Language Questionnaire

1. What language(s) is spoken in student's home or residence?

English  Other: \_\_\_\_\_

2. What language(s) are spoken most of the time to the student, in the home or residence?

English  Other: \_\_\_\_\_

3. What language(s) does the student Understand?

English  Other: \_\_\_\_\_

4. What language(s) does the student speak?

English  Other: \_\_\_\_\_

5. In your opinion, how well does the student understand and speak English?

Very Well

Only a Little

Not at all

Understands English

Speaks English



**Rosa Venerini**  
Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Emergency Authorization Form for Medical Emergency Treatment

Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_

As parent or legal guardian of \_\_\_\_\_, a minor, I hereby give my consent to Rosa Venerini ECC or Schenectady UPK to seek medical treatment in the event of an emergency. I hereby give my consent to ELLIS HOSPITAL to provide any treatment and conduct any tests which are required necessary treatment to the above named minor in my absence.

Pediatrician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Last Tetanus: \_\_\_\_\_ Religion: \_\_\_\_\_

In the event of any emergency in which the above named physicians are not available, I give my consent to provide treatment by ELLIS HOSPITAL Medical/Dental staff member on duty.

Other Pertinent Medical Information: \_\_\_\_\_

### **Insurance Information:**

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Parent/Legal Guardian Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Parent/Legal Guardian Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# Rosa Venerini Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Health History

Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Does your child have a history of:

- High Fevers       Ear Infections       Colds       Chicken Pox       Scarlet Fever  
 Diabetes       Hepatitis       Mumps       Measles

Is your child on any medication? Please list medications and dosage: \_\_\_\_\_

Has your child ever been hospitalized? When and for what? \_\_\_\_\_

Has your child had any serious accidents? Describe. \_\_\_\_\_

### Allergies

Does your child have any allergies?       Y       N       Unknown

List child's allergies: \_\_\_\_\_

Signs of allergic reaction:

- Asthma       Difficulty Breathing       Swelling       Hay Fever       Hives

Other: \_\_\_\_\_

Do you know what the allergy is caused by? \_\_\_\_\_

Has your child been to the dentist?       Y  N      Dentist: \_\_\_\_\_

Has your child had: Vision Screening:  Y  N      Hearing Screening:  Y       N

Is there anything you would like to share about your child's health?

### Medical Release

I hereby give consent to the following healthcare agency

\_\_\_\_\_ to release medical information on

\_\_\_\_\_  
(Child's Name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Rosa Venerini Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Authorized Release Form

I, \_\_\_\_\_, give the following people permission to pick up my child, \_\_\_\_\_, from Rosa Venerini ECC. I, & the people listed below, understand that if someone other than myself, the parent, pick up my child, he / she will be required to present photo identification. The child will not be able to leave the center with an adult who 1. Is not listed on the registration form as a parent or 2. Is not listed on this authorization form or 3. Does not have a photo identification.

1. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

4. Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I grant permission to Rosa Venerini ECC to use my child's picture for the following purposes:

Newspaper    Center Website    Grant Proposals    Displays    Video    TV    Social Media

**-OR-**

I do NOT want my child's pictures used for anything other than Bloomz

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Rosa Venerini**  
Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Infant Enrollment Form

Child's Name: \_\_\_\_\_ Sex: M F

Birthdate: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

1<sup>st</sup> Parent's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: (if different from child) \_\_\_\_\_

2<sup>nd</sup> Parent's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: (if different from child) \_\_\_\_\_

Child lives with:  Both Parents  Mother  Father  other: \_\_\_\_\_

Emergency Contact(Other than parents)

1. \_\_\_\_\_ Phone #: \_\_\_\_\_

2. \_\_\_\_\_ Phone #: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Registration Fee: \$75 Cash or Check # \_\_\_\_\_

Office Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_



*Rosa Venerini*  
Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961  
Schenectady, NY 12308 | Fax: (518) 372 7337

## Infant Enrollment Form

Child's Name: \_\_\_\_\_

2019 – 2020

Hours: 7:00 am - 5:30 pm

- T/TH            \$130/wk
- M/W/F          \$180/wk
- M-F             \$265/wk

\*\*As per the OCFS requirement infants are allowed to stay in child care for a maximum of 9 hours

Child care hours needed: \_\_\_\_\_ to \_\_\_\_\_

\*\*Any additional hours must be Pre-approved by Director & Pre-Paid\*\*

**Sibling Discount:** 10% Off on lower cost tuition

✧ Parent Contract **MUST** be read and signed by parent(s)/guardian(s) before child begins the daycare