COMMUNITY CHILD CARE CENTER
TUITION INFORMATION / AGREEMENT
ST JAMES
Effective date: September 1, 2024

Child's Name: _____ Siblings:_____

Person responsible for paying tuition / copayment:_____

Address:_____

Source of payment: Personal funds_☐_ DSHS Subsidy_☐_ Financial Aid/Loans_☐_

Tuition is to be paid in advance and is due by the 10th of the month. Any account not paid in full by the 1st of the following month may be assessed a late fee of 1.5% on the balance. New tuition rates take affect September 1st. Parents will be notified in writing of any changes in fees at least four weeks in advance. **You can receive a 3% discount if you sign up to make your payments electronically with your bank account. We also accept check, credit and debit card payments.**

Tuition Policy: There will be no tuition credit given for occasional days missed, holidays that CCCC is closed or personal vacation days. During extended leaves, CCCC will provide a 50% tuition discount to children who are absent for 3 or more consecutive weeks. If a child is absent for one month or more, no tuition will be charged.

Community Child Care Center accepts DSHS subsidized childcare. Arrangements must be made by the parent/guardian through DSHS prior to enrollment. Children accepted on subsidized childcare must have written verification on file with CCCC prior to enrollment. Parents/guardians are responsible for any hours of service beyond DSHS authorizations and all co-payments as well as any late fees or fines.

Parents need to call when their child will be absent from the center.

Our operating hours are **7:15 a.m.** to **5:30 p.m.** We need parents to respect these hours.

Late Charges: We will charge $15.00 per child for any pickup time between 5:30pm-5:45pm. Each minute after 5:45pm will be charged $1.00 a minute per child.

Is your child enrolled in any other preschool programs? HS/ECEAP_☐_ Other _____

Please circle below/ Indicate here what schedule you will need for this school year:_____

School Year 2024/2025 tuition:

Full-Time Tuition: (Monday - Friday)	**Monthly**
Dinos - 12 months to 3 years	$ 1,310
Bears / Firebirds - 3-5 years	$ 1,195
Head Start / ECEAP Wrap-Around	$ 892
After School	$ 455
Before School (7:15 - 8:15 a.m.)	$ 157
Part - Time Tuition: (Under 5 hours)	**Monthly**
Dinos - 12 Months to 3 years	$ 817
Bears / Firebirds - 3-5 years	$ 774

Drop-in rates will be $10.00 per hour.

Please call to check on availability before dropping off your child!

I have read the above agreement and accept the conditions stated herein.
I have received the parent handbook, which includes important policies and procedures including the Internal Disaster Plan and Pesticide Policy.

Signature _____ Date_____
Parent/Legal Guardian

COMMUNITY CHILD CARE CENTER

1410 NE Stadium Way Pullman WA, 99163

ECEAP Early Childhood Education & Assistance Program
Washington State Department of Children, Youth & Families

Head Start/EHS/ECEAP

FOR OFFICE USE ONLY

DEPOSIT PAID $_____DATE_____

DISENROLLMENT DATE_____

☐ FOOD ALLERGY
☐ HEALTH CONDITION
☐ SOCIAL/ FAMILY CONCERN

EMERGENCY AND MEDICAL INFORMATON FORM

Child's Name _____ Birthday _____Gender _____Start Date _____
School Age Children Only - School _____ Grade _____

Primary residence of child is with: _____

Are there any court orders/parenting plans in effect concerning the custody of the child? ☐**Yes** ☐**No**
If so, please provide us with a copy of these documents prior to enrollment.

Is your family currently involved with the State of Washington Department of Children, Youth & Families (CPS)? ☐**Yes** ☐**No**

Legal Guardian Name | Home Phone | Cell Phone | Email Address

Address of Guardian | Place of Employment | Work Phone

The best way to reach me (i.e. email, text, phone call) | The best time to reach me

Legal Guardian Name | Home Phone | Cell Phone | Email Address

Address of Guardian | Place of Employment | Work Phone

The best way to reach me (i.e. email, text phone call) | The best time to reach me

Local Emergency Contacts (These persons are authorized to pick up the child):

1. _____ _____
Name | Relationship to Guardian | Phone Number(s)

2. _____ _____
Name | Relationship to Guardian | Phone Number(s)

Physician/Dentist Information:

Physician Name | Phone | Last Appt. Date | Dentist Name | Phone | Last Appt. Date

*(if you do not have a Doctor or Dentist please let our staff know and we can provide you with a list of local providers)

Medical Insurance Information:

Company: _____ Plan Number: _____

Allergy & Medical History

Allergies, medication/medical conditions_____ **If none, check here** ☐

Permission for Emergency Treatment

At the time of an emergency, medical treatment is urgent. I authorize Community Child Care Center staff to call emergency aid (911) or transport my child to the nearest hospital or my child's physician to receive immediate care. I also give permission for CCCC to give first aid for minor injuries. I understand that I will be responsible for all expenses connected with the seeking of emergency care.

Signature _____ **Date** _____

COMMUNITY CHILD CARE CENTER
1410 NE Stadium Way Pullman WA, 99163
ECEAP Early Childhood Education & Assistance Program
Washington State Department of Children, Youth & Families
Head Start/EHS/ECEAP

PARENT CONSENT FORM

Child's Name _____

I give permission for the following services to be provided to my child. I understand that by selecting "yes," permission is granted for the specific service and by circling "no," permission is not granted and my child will be excluded from the activity.

Example of specific tools:

0-3 year old children receive:
Ages and Stages Developmental Checklist
HELP- Hawaii Early Learning Profile
Hearing, vision, height, & weight screenings

3-5 year old children receive:
ESI-R - Motor, Cognitive, and Language Screen designed to identify children who may be in need of further developmental evaluation
Teaching Strategies Gold Dev. Assessment
Hearing, vision, height, & weight screenings

☐**Yes/**☐**No** - I grant permission for my child to receive all standard screenings and assessments used by the program, age appropriate for my child. These tools are used to assess children in the areas of language and cognition, visual and auditory, fine and gross motor, physical growth, and social/emotional development. The results will be used to plan appropriate curriculum for your child, and determine the need for any further evaluations. All results are shared with parents.

☐**Yes/**☐**No** - I grant permission for an employee to **apply sunscreen (Banana Boat SPF 30 or higher), lip balm, lotion and/or diaper ointment (A+D Diaper Ointment)** if applicable to my child when necessary.

☐**Yes/**☐**No** - I grant permission for my child to use hand sanitizers or hand wipes with alcohol (if over 24 months) when necessary.

☐**Yes/**☐**No** - I grant permission for my child to use toothpaste with fluoride daily (if over 24 months).

☐**Yes/**☐**No** - I grant permission for my child to be **photographed or videotaped** by staff and/or child care parents.

☐**Yes/**☐**No** - I grant permission for my child's **photographs to be hung up in the classrooms.**

☐**Yes/**☐**No** - I grant permission for **pictures or videotapes** of my child be taken and used in **advertising, newspapers, newsletters, displays, CCCC's FACEBOOK page,** or other types of educational/promotional publications.

☐**Yes/**☐**No** - I grant permission for my child to leave the school premises under the supervision of staff members for visits to close-by parks and **field trips** in an authorized vehicle with a notice ahead of time.

☐**Yes/**☐**No** - I grant permission for CCCC/HS/EHS/ECEAP to provide transportation for my child. I hereby give permission to the staff to sign my child in and out of the program when my child is being **transported by CCCC and during emergency situations (e.g. COVID-19 pandemic).** Washington state law requires parents to sign their children in upon **arrival and upon departure** out of the center.

☐**Yes/**☐**No** - I grant permission for CCCC to share/consult with CCCC's Contracted Registered Nurse regarding my child's health.

☐**Yes/**☐ **No** - I grant permission for administrators, teaching staff, and regulatory authorities, on request, to **access my child's file.** I understand that as a parent or legal guardian, I also will be granted immediate access to my child's records upon request.

_____

Parent Signature Staff Signature Date

Introducing My Family and Me

Child's formal name:_____ Age:_____

Name my child likes to be called: _____

Race/Ethnicity/Family Structure and traditions that are important to our family:

My child lives with these adults:

My child lives with _____other children. Their names and ages are:

My child is close to:

☐ Mom/Mama
☐ Dad/Pap
☐ Grandfather/Abuelo
☐ Grandmother/Abuelita
☐ Aunt/Tia
☐ Uncle/Tio
☐ Step Mom/Madrastra
☐ Step Dad/Padrastro
☐ Others/Ostros (please explain):

We speak the following languages in our family:

Has your child been in any of the following settings?

☐ Preschool
☐ Child Care
☐ In home childcare setting
☐ Watched by family/friend
☐ Never been in care

Please describe your child's personality:

What activities does your child really enjoy?

Does your child have any fears or phobias we should know about or has your child experienced any traumatic events?

How do you think your child will respond to new things they might experience in the classroom setting?

What helps your child respond to new social settings or new challenges?

What do you think might be challenging for your child?

As their guardian what is the most important thing you would want me, their teacher, to know about your child?

What skills do you want your child to develop and work on while in the classroom?

Additional Comments:

COMMUNITY CHILD CARE CENTER
1410 NE Stadium Way Pullman WA, 99163
ECEAP Early Childhood Education & Assistance Program
Washington State Department of Children, Youth & Families
Head Start/EHS/ECEAP

CCCC Health History Form (1-5 years)

Child's Name (Last, First, Middle) | Sex | Birth Date (MM/DD/YY) | Country of Birth

Health History

Name of child's Health Care Provider

Name of child's Dentist

Child's Weight at Birth: Pounds **Ounces** **Grams**

Type of Delivery:

Yes	No	Please Answer the Following:
☐	☐	Were you told your child was born early or premature? How Early?
☐	☐	Were drugs, alcohol or cigarettes part of family life during pregnancy?

Does your child have any of the following?

Yes	No	Health Concerns	If yes, Describe:
☐	☐	**1. Anemia**	
☐	☐	**2. Breathing Problems*** (Asthma, RSV, RAD, other) Must answer the question on the right. Do not leave blank.	**When was the last time your child had to use medication for the breathing problem?** **Has your child been hospitalized overnight two or more times in the past year for breathing problems?** ☐Yes ☐No **Has your child been seen in the emergency room three or more times in the past year for breathing problems?** ☐Yes ☐No **Comments:**
☐	☐	**3. Bowel/bladder problems**	
☐	☐	**4. Diabetes***	
☐	☐	**5. Frequent earaches or infections**	
☐	☐	**6. Hearing Concerns**	
☐	☐	**7. Heart Conditions***	
☐	☐	**8. Frequent nose bleeds**	
☐	☐	**9. Seizures***	

**Child Health Plan Required/Potentially life-threatening condition*

Yes	No	Health Concern	If Yes, Describe:
☐	☐	**10. Skin condition**	**Is medication or lotion applied at home??** ☐Yes ☐No **Are there things to avoid (e.g. certain soaps, grass, water play)?** ☐Yes ☐No Comments:
☐	☐	**11. Tuberculosis Exposure**	
☐	☐	**12. Walking/climbing difficulties**	
☐	☐	**13. Vision concerns/wears glasses**	
☐	☐	**14. Secondhand smoke exposure**	
☐	☐	**15. Lead Exposure** **a. Lived in a house with peeling paint built before 1978?** **b. Has a sibling/relative or close friend with lead poisoning?** **c. Lives with an adult whose job or hobby involves lead? (i.e. welding, stained glass or pottery)** **d. Lived near a smelter/battery plant/ car repair shop or other lead related industry?** **e. Have you or your family used home remedies such as:** ☐**Azareon** ☐**Greta** ☐**Kohl** ☐**Pavlooah**	
☐	☐	**16. Has your child ever been tested for lead?**	
☐	☐	**17. Other health concerns? (Please List)**	
☐	☐	**18. Has your child experienced any of the following? Chicken Pox, Measles, Mumps, Whooping Cough, other? please describe.**	
☐	☐	**19. Has your child experienced any serious illness/injury, surgery, or seen a specialist? If yes, when and for what?**	
☐	☐	**20. Is tobacco currently in use in your home (i.e. smokeless tobacco, cigars, pipe, cigarettes?**	
☐	☐	**21. Are drugs currently in use in your home?**	
☐	☐	**22. Is alcohol currently used in your home? If yes, what does this look like?**	
☐	☐	**23. Has your child been exposed to violence in the home?**	
Time {Hours)		**24. How much time does your child spend being physically active each day? (running, jumping, dancing, etc.)**	
Time (Hours)		**25. How much time does your child spend each day watching TV/videos, playing computer/ gaming systems, on tablet?**	

Child's Name: _____

Yes	No	Please answer the following:
☐	☐	26. When riding in a car/truck, does your child use a car seat/booster?
☐	☐	27. When your child rides a bike/trike, does he/she wear a helmet?

Non-Food Allergies

28. Does your child have allergies or severe reactions to any of the following: ☐ Yes ☐ No
If yes, please check only those that apply: 2

☐ Insect Bites/bee stings* ☐ Animals ☐ Pollens/Hay Fever ☐ Medications ☐ Other (Please Specify)

Please describe your child's allergic reaction:

How do you treat your child's allergy?

Has the allergy been diagnosed by a doctor? ☐ Yes ☐ No

**Child Health Plan Required/Potentially life-threatening condition*

Medications

Yes	No	Please answer the following:
☐	☐	29. Does your child take any medications? Please list ALL medications:
☐	☐	30. Will your child need to take any medications during scheduled programming? (Staff: Please review Medication Administration Procedure; additional action required)

Dental

Yes	No	Please answer the following:
☐	☐	31. Has your child complained about pain in the teeth or gums? If yes, please describe:
☐	☐	32. Does your child use fluoride toothpaste at home?
☐	☐	33. How many times per day does your child brush teeth at home?
☐	☐	34. Does your child go to bed with a bottle or sippy cup? If yes, what is in the sippy cup? (Staff: provide some education about sitting sugars and tooth decay)
☐	☐	35. Has your child visited the dentist?

Nutritional Information

Yes	No	Please answer the following:
☐	☐	36. Is your child receiving services through WIC?
☐	☐	37. Does your family receive benefits through the SNAP program?
☐	☐	38. Do you have questions about feeding your child? If yes, Please explain:
☐	☐	39. Do you have concerns about what your child eats? How many meals_____ and snacks_____ are offered. Please Explain.
☐	☐	40. Do you share meals together as a family? If no, where does your child eat in the home?
☐	☐	41. Does your child drink from a cup?
☐	☐	42. Does your child drink from a baby bottle?
☐	☐	43. Do you have any concerns about your child's growth? Please explain:
☐	☐	44. Do you have any concerns about your child's weight? Please explain:
☐	☐	45. Does your child take a prescribed iron supplement? Why? How often? Please explain:
☐	☐	46. Does your child currently use any nutritional supplements (Pediasure, ensure, multivitamins, herbs, etc.) If yes, which ones, how often, and for what reason.
☐	☐	47. Does your child eat any nonfood items? (Example: crayons, marbles, paper, etc.). Please list:
☐	☐	48. How would you describe your child's appetite?
☐	☐	49. Does your child need assistance with feeding self?

Food Allergies, Intolerances, and Preferences

Yes	No	Please answer the following:
☐	☐	50. Has a medical provider ever told you that your child has a food allergy or intolerance? If yes, please explain:
☐	☐	Does your child have an Epi-Pen?
☐	☐	Is this a life-threatening food allergy?*

Child's Name: _____

Yes	No	Please answer the following:
☐	☐	**51. Are there foods that your child cannot eat for cultural/religious reasons? If yes, please list:**

_____

If your child has a food allergy or intolerance that has been diagnosed by a doctor, we will ask for documentation from your medical provider that includes a list of foods that can be substituted.

****Child Health Plan Required/Potentially life-threatening condition***

List Health and Nutritional Education Resources Shared with Parents

☐ **Lead Information**

☐ **Nutritional Information**

☐ **Fluoride Information**

☐ **Other (please list):**
(i.e. tobacco cessation, helmet, car seat, safety, other)

Signatures - First Year

Parent _____ **Date** _____

Staff who reviewed with Parent _____ **Date reviewed with parent** _____

Interpreter (if applicable) _____ **Date** _____

Signatures - Second Year

Parent _____ **Date** _____

Staff who reviewed with Parent _____ **Date reviewed with parent** _____

Interpreter (if applicable) _____ **Date** _____