



WEST

4910 Wyalusing Avenue

Philadelphia PA. 19131

Phone: 215-473-7981

Fax: 215-473-8241

Email: Childspacewest@aol.com

Website: Childspacecenters.org

ENROLLMENT PACKET

THE PHILOSOPHY OF OUR PROGRAM

The Childspace philosophy is that children learn by experience. We believe that children must first feel emotionally and physically secure to be able to explore and learn from their environment. We are concerned with all aspects of children's growth: social, emotional, cognitive and physical. We plan our program at each development level to provide opportunities for children to try new things both individually and in groups, make new friends and have activities that are provided in the classrooms, outdoors, in the gym and on trips. Our toys are kept on open shelves for easy accessibility to children.

In group activities, we recognize that each child is an individual and we encourage children to express themselves according to their own personalities through art, music, circle time, body movement, games, imaginary play, block play, book time and cooking. We set limitations primarily with regard to the safety of all children. We try to teach children to respect each other's person as well as their feelings and introduce children to the diversity found in society. We attempt to structure the classroom and activities in a way, which allows choice and flexibility within the security of a consistent schedule and pattern of expectations. We encourage parents to get involved in our program, make suggestions and ask questions.

Childspace West

Statement of Operating Procedures

1. **Food:** CHILDSpace provides breakfast, lunch and one snack per day, including a variety of beverages. Breakfast is served from 8:00 a.m. to 9:00 a.m. Lunch is served between 11:30 a.m. and 12:30 p.m., and afternoon snack is given between 3:00 p.m. and 4:00 p.m.
2. **Clothing:** Children should be brought to CHILDSpace wearing seasonally appropriate play clothes and an extra set of clothing (pants, shirt, underpants and socks). Flip-flops and open toed sandals are not appropriate for active play.
3. **Sleeping:** CHILDSpace provides a crib or sleeping mat for each child. Parents are responsible for bringing in a crib or mat sheet and blanket. Parents must wash bedding once every week. To reduce the risk of Sudden Infant Death Syndrome, infants are placed on their backs to sleep.
4. **Arrival Time:** CHILDSpace hours of operations are 7:30 a.m. to 6:00 p.m. Your start time may vary (see enrollment contract). However, we request that all children arrive by 10:00 a.m. This ensures a smoother transition from home to school and affords children the time to adjust and explore the room before formal group time begins. We understand that there are individual circumstances, such as doctor's appointment, that require you to bring your child in after morning activities are underway. If this is the case, please call CHILDSpace to let us know that s/he is coming.
5. **Pick-up:** CHILDSpace is not responsible for children after 6:00 p.m. You will be assessed a late fee (see enrollment agreement). Please make alternative arrangements for pick-up if you are going to be delayed. If we are unable to reach you or your emergency contact, we will, as a last resort, call the local police district and Department of Health Services to pick up your child.
6. **Alternative Escorts:** If someone other than the child's parent is to pick up the child, that person should be listed on the parental consent form and classroom staff should be informed. Permanent changes in designated escorts may be made on your consent form at any time.

If it is necessary to send an escort that is not on your list, you must call in advance to provide contact information. The escort will be asked to show a photo identification in order for the child to be released.

7. **Illness:** Please call to inform us whenever your child will not attend CHILDSPACE due to illness. Your child should not be brought to CHILDSPACE if s/he is unable to fully participate in all activities, including outdoor play. Your child may not attend

CHILDSPACE if s/he has a fever, diarrhea, or vomiting. If a child becomes ill during the day staff may request parents to arrange to pick their child up early. It is important for parents to have a back-up plan for childcare when your child is ill. IN CASE OF AN EMERGENCY, we will try to reach you (the parent or guardian). If unable to reach you. CHILDSPACE will call 911 and have your child transported to the closest hospital.

8. **Medication:** If your child is on medication at any time during the year, you must complete a consent form in order for staff to administer the medication. You will be required to provide specific written information. All prescription medicine must be delivered to CHILDSPACE in its original container with the prescription intact. Never leave medicine in your child's cubby or diaper bag.
9. **Visits:** Once children are enrolled in CHILDSPACE, parents are free to visit at any time. Please do not send non-parent visitors to classrooms without previous clearance from staff or the director.
10. **Growth and Development Reports:** CHILDSPACE will provide parents with written information about their child's growth and development every six months. Formal conferences are held twice a year, or more often as requested by the parent or staff. Staff is responsible for providing parents information about their child's development, verbally, at least on a quarterly basis.
11. **Questions:** Any questions or concerns should be addressed to the staff or Head Teacher of the classroom. If you have any concerns or problems that cannot be resolved at the classroom level, please see the Director.

We welcome you to the Childspace family and look forward to providing a safe, nurturing, and educational environment for you and your child/ren.

Childspace West

Enrollment Agreement

This agreement must be signed and returned before the beginning of the new school year, September 1, for your child to be enrolled at Childspace West.

1. **Enrollment Year:** The enrollment year begins September 1, 2018. All enrollment agreements effective on or after September 1, 2018 are considered valid through August 31, 2019 except as indicated in item 6.
2. **School Year Calendar:** CHILDSPACE will be closed on the following days during 2018-2019:

Monday, September 3, 2018: Labor Day
Tuesday, September 4, 2018: Staff In-Service Day
Thursday, November 22 and Friday, November 23, 2018: Thanksgiving
Monday, December 24, 2018 through January 1, 2019: Winter Break
Monday, January 21, 2019: Martin Luther King, Jr. Day
Wednesday, May 1, 2019: Staff In-Service Day
Monday, May 27, 2019: Memorial Day
Thursday, July 4, 2019: Independence Day

In addition, CHILDSPACE will close at 4:00 pm on the following dates:

Tuesday, October 23, 2018
Wednesday, February 27, 2019
Tuesday, April 16, 2019
Wednesday, June 5, 2019

3. **Hours:** Supervised care for children will be provided from 7:30 am to 6:00 pm.
4. **Late Fees:** Parents arriving after their scheduled pick-up time will be charged additional fees at the following per minute rate:

1-10 minutes - \$10.00
11-20 minutes - \$ 15.00
21-30 minutes - \$ 20.00
31-40 minutes - \$ 25.00
41-50 minutes - \$ 30.00

5. **Fees:** Fees must be paid by cash or money order (made payable to: CHILDSPACE) and can be delivered directly to the CHILDSPACE office. weekly co-payment fees must be paid on Early Learning Resource Center

(ELRC) Monday, prior to the week of service. Childspace is required to report delinquent of co-pay fees to ELRC on Friday. ELRC will only pay for absences up to 25 days. After the 25th absence you will be charged CHILDSpace's daily rate to cover the cost of the absence.

6. **Snow Policy:** If CHILDSpace is closed for the day, opening late, or closing early due to hazardous weather conditions please visit www.1060.com and click school closing for information. The CHILDSpace code number is 3045. The center is not mentioned by name. If enrolled you will also receive a robocall.
7. **Termination of Enrollment:** CHILDSpace reserves the right to terminate the enrollment of a child if it appears to be in the best interest of either the child or CHILDSpace.
9. **Statement of Operating Procedure:** Attached to this contract is a statement of operating procedures outlining what CHILDSpace will provide and what parents are required to provide.

Childspace West

HEAD START 2018-2019 Calendar

September 3	First Day of Head Start
September 4	Staff Inservice
September 6	Head Start Parent Meeting
September 12	Triple P Intro / Back to School
October 23	Home Visits /Conference Week
November 22, 23	Thanksgiving
December 24 through January 1	Winter Break
January 21	Martin Luther King, Jr. Day
February 27	Home Visits /Conference Week
April 16	4 pm early closing
May 1	Staff In-Service Day
May 27	Memorial Day
June 4	Last Day of Head Start
June 5	4 pm early closing
July 4	Independence Day

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APPLICATION FORM

Date: _____

Child's Full Name: _____

Sex: _____ Date of Birth: _____

Home Address: _____

City/State: _____ Zip Code: _____

Home Phone Number: _____

Cell Phone Number: _____

Email Address: _____

PARENTS' WORK INFORMATON

_____	NAME	_____
_____	SOCIAL SECURITY #	_____
_____	EMPLOYER	_____
_____	WORK ADDRESS	_____
_____	WORK PHONE #	_____
_____	OCCUPATION	_____

Person to contact about this application: _____

Probable days you would need care: _____

Full Days or Half Days: _____ Beginning what date? _____

Present child care arrangements: _____

Childspace affirms its commitment to admit children of any race, color, national or ethnic origin.

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b) 3270.1d1 &

3230.124 (a) 3280.181 -182; 3290.124 (a) 3290.181 & 182

CHILD'S NAME		BIRTHDAY
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S) NAME		TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME		ADDRESS
TELEPHONE NUMBER WHEN CHILD IN CARE		
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (F ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION, SPECIAL SITUATION
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFIT		POLICY NUMBER (REQUIRED) INDICATE
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO OBTAINING EMERGENCY MEDICAL CARE		
WALKS AND TRIPS		PARENTAL CONSENT ADMIN. OF MINOR FIRST-AID PROCEDURES
TRANSPORTATION BY THE FACILITY		SWIMMING
		WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN	DATE
SIGNATURE OF PARENT or GUARDIAN	DATE

WHITE COPY (Original)

YELLOW COPY (Child Care Space)

PINK COPY (Excursion)

CY 367 5/07

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(c); 3280.123 & 181(c); 3290.123 181 (c)

NAME			
FEE AMOUNT	NUMBER OF DAYS	PAYMENT DUE DATES	
Services to be provided as part of the day care fee (examples: transportation. care, meals, etc.)			
Meals. Breakfast, Lunch & Snack NDS Food Program			
High Quality Educational Program			
Crib or Sleeping mat			
Development Assessment twice a year			
Parent Teacher Conference twice a year			
CHILD'S ARRIVAL TIME	CHILD S DEPARTURE TIME	PERSONS, DES'GNMEO BY PARENT TO WHOM CHILD MAY BE RELEASED	
\$ 10.00	\$5 per 10 mins		
Extra services to be provided at an additional fee if applicable			
Transportation			
<p>the parent/guardian, -</p> <p style="margin-left: 40px;">received complete written program information at the time of enrollment (S 3270.121. 3280.121, 3290.121)</p> <p style="margin-left: 40px;">agree to update the emergency contact parental consent form information whenever changes occur or every 6 months at a minimum. (S 3270.124. 3280.124. 3290.124)</p>			
SIGNATURE - OPERATOR	DATE	SIGNATURE - PARENT OR GUARDIAN	DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW	
SIGNATURE - PARENT OR GUARDIAN	DATE

CIVIL RIGHTS COMPLIANCE

PARENT AWARENESS

In accordance with applicable Federal and State Civil Rights laws and regulatory requirement, you as client of this agency, have the right.

To be provided services at the agency, and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, age or sex.

To file a complaint of discrimination if you feel your have been discriminated against on the basis of your race, color religious creed, disability, ancestry, national origin, age or sex.

Complaints of discrimination may be filled with any of the following:

Provider's Name & Address:

Office for Civil Rights
U.S. Department of Health
Suite 372, Public Ledger Bldg.
150 S. Independence Mall west
Philadelphia, PA 10106-9111

Pennsylvania Human Relations Commission
Philadelphia Regional Office
110 North 8th Street, Suite 501
Philadelphia, PA 19107

Commonwealth of Pennsylvania
DPW Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107
American with Disabilities Act Director
Governor's Office
Room 238 Main Capitol
Harrisburg, PA 17120

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
P.O. Box 2676
Harrisburg, PA 17105

Child's Name (Please Print)

Date

Parent/Guardian Signature

Date

Staff Signature

Date

Childspace West

Getting to Know You

Child's Name: _____ **Birthdate:** _____

1. Who lives in the home? _____.
2. Are there any parents that do not live in the home? _____. Does your child visit this parent? _____.
3. Does your child have any siblings (names and ages)? _____.
4. Does your family have any pets? _____.
5. Does your child respond to any nicknames? _____. Family members nicknames? _____.

Child Information

6. Has your child been in an early learning program or childcare before? _____.
If yes, would you share some information with us? (Where? When? And for how long)

What kind of care (family day care, group, relative/neighbor or center? _____
How did you child react to other children and adults? _____.
7. Does your child have any imaginary friends? _____.
8. Are there any special problems or fears that we should know about? _____
_____.
9. Does your child have any of the following (check all that apply)?
_____ Nail biting
_____ Biting
_____ Thumb sucking
_____ Stuttering
10. Does your child have any allergies?
Food Allergies _____
Environmental Allergies _____
11. How are you child's allergies threatad? _____.

12. Does your child have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.?) _____.
13. Regarding toilet habits, what words does your family use for bowel movements and urination? _____, any special terminology for private parts? Is your child toilet trained? _____.
14. Does your child need to be reminded to go to the toilet during waking hours? _____.
15. Is there information that will help us make the first few days in our program easier for your child? _____.
16. Is there other information you would like to share? _____.
17. Do you have any questions or concerns? _____.

Daily Routines (Infants Only)

18. What does your child eat? _____ How often? _____.
19. How do you put your child to sleep? _____.
20. Does your child nap? If so when? _____.
21. How many bottles will your child take while in our care? _____.
22. Does your child take a pacifier, suck fingers or use teething rings? _____.

Any additional information that we should be made aware of? _____

Parent Signature _____

Teacher Signature _____

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ALLERGY RELEASE

I give Childspace Day Care Center permission to post a listing of my child's allergies in an area of the classroom where it is accessible to all staff.

CHILD'S NAME: _____

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

PHOTO RELEASE

I, _____ the parent/guardian of _____ hereby consent that photographs, videotapes, and/or electronic images of my child can be used by Childspace Day Care Centers for news and publicity purposes.

CHILD'S NAME: _____

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		WORK PHONE:
FACILITY PHONE:	COUNTY:	
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION
 This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
VISION (subjective until age 3)							
HEARING (subjective until age 4)							
LEAD							

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Brazelton Touchpoints Center
Parent/Guardian Release Form

Childspace West and the Brazelton Touchpoints Center are collaborating to evaluate the new parenting program, Triple P at Childspace West. The purpose of the evaluation is to help Childspace West understand the best ways to implement a parenting program for parents and their young children. In order to evaluate the helpfulness of the program, we will be asking you for information from the enrollment forms you completed at the beginning of the school year, parent surveys, and child social-emotional skills assessments.

All information collected will be kept confidential, and no identifying information will be released in any summaries or reports to the funding agency. We ask you to include your name and contact information so that we can follow up with you over the next few years. If you choose not to participate in the evaluation it will not affect your eligibility to receive services. By signing your name below, you are giving Childspace West permission to share your information with the program evaluators.

For questions please contact: Teresa Mansell at childspacewest@aol.com

Signature: _____

Today's Date: ____/____/____

Printed Name: _____

Names of children enrolled at Childspace West:

Caregiver Engagement Initiative: Intake Form

Childspace West – Triple P

Your Name: _____		Your birth date: ___/___/___		Your relationship to child(ren): _____	
Your mailing address: _____					
Your email address: _____			Your phone number: _____		
Your Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian American				<input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Biracial/Multiracial/Other <i>Please describe:</i> _____	
				Your Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
				Your Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	
What language(s) is spoken in your home? _____					
Your current marital status (Please check one) <input type="checkbox"/> Married <input type="checkbox"/> Not married, living with partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never married/single <input type="checkbox"/> Widow/er					
Number of adults in your household: _____			Number of children in your household: _____		
Which best describes the household in which your children are presently living? (Please check one) <input type="checkbox"/> Original family (both biological/adoptive parents present) <input type="checkbox"/> Step-family (two parents, one being a step-parent) <input type="checkbox"/> Single parent family <input type="checkbox"/> Other (Please describe): _____					
What is your highest level of education? <input type="checkbox"/> No HS diploma/GED <input type="checkbox"/> GED <input type="checkbox"/> High school graduate <input type="checkbox"/> Some college credits/two-year (AA) degree <input type="checkbox"/> 4-year college degree or higher <input type="checkbox"/> Other (Please describe): _____			What is your partner's highest level of education? <input type="checkbox"/> No HS diploma/GED <input type="checkbox"/> GED <input type="checkbox"/> High school graduate <input type="checkbox"/> Some college credits/two-year (AA) degree <input type="checkbox"/> 4-year college degree or higher <input type="checkbox"/> Other (Please describe): _____		
Are you currently in paid employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours a week? _____ hrs.			Is your partner currently in paid employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours a week? _____ hrs.		
Does your family receive any government benefits or pension? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate which benefits you receive (check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Unemployment <input type="checkbox"/> TANF <input type="checkbox"/> Social Security Disability (SSD)					
Did you come to today's session with anyone (not including children)? Yes _____ No _____ <i>Name of person with you:</i> _____ <i>Relationship to You:</i> _____					

Please complete for your child

Childspace West – Triple P

Child 1 Name: _____	Sex (Please check one): <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: ____ / ____ / ____
Race (Please check one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Biracial/Multiracial/Other <i>Please describe:</i> _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	This child attends (for children 0-6): <input type="checkbox"/> Childspace – Mt. Airy <input type="checkbox"/> Childspace – West <input type="checkbox"/> Childspace – Germantown <input type="checkbox"/> Other: _____

If you only have ONE child, you may skip this section

In the table below, please enter the name, birth date, gender, race, and ethnicity of all the children in your home.

CHILD 2	CHILD 3	CHILD 4
Name: _____	Name: _____	Name: _____
Sex (Please check one): <input type="checkbox"/> Male <input type="checkbox"/> Female	Sex (Please check one): <input type="checkbox"/> Male <input type="checkbox"/> Female	Sex (Please check one): <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of birth: ____ / ____ / ____	Date of birth: ____ / ____ / ____	Date of birth: ____ / ____ / ____
Race (Please check one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Biracial/Multiracial/Other <i>Please describe:</i> _____	Race (Please check one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Biracial/Multiracial/Other <i>Please describe:</i> _____	Race (Please check one): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Biracial/Multiracial/Other <i>Please describe:</i> _____
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
This child attends (for children 0-6): <input type="checkbox"/> Childspace – Mt. Airy <input type="checkbox"/> Childspace – West <input type="checkbox"/> Childspace – Germantown <input type="checkbox"/> Other: _____	This child attends (for children 0-6): <input type="checkbox"/> Childspace – Mt. Airy <input type="checkbox"/> Childspace – West <input type="checkbox"/> Childspace – Germantown <input type="checkbox"/> Other: _____	This child attends (for children 0-6): <input type="checkbox"/> Childspace – Mt. Airy <input type="checkbox"/> Childspace – West <input type="checkbox"/> Childspace – Germantown <input type="checkbox"/> Other: _____

Part III. SWYC Adapted Family Questions¹

1. Does anyone who lives with your child smoke tobacco?
 Yes No
2. Are you currently sharing the housing of others due to economic hardship, lack of alternative housing, loss of housing, shelter care, or living in alternative housing?
 Yes No
3. Within the past 12 months, we worried whether our food would run out before we got money to buy more.
 Never true Sometimes true Often true
4. In the last year, have you ever drunk alcohol or used drugs more than you meant to?
 Yes No
5. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
 Yes No
6. Has a family member's drinking or drug use ever had a bad effect on your child?
 Yes No

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
7. Having little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No tension	Some tension	A lot of tension	Not applicable
9. In general, how would you describe your relationship with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No difficulty	Some difficulty	A lot of difficulty	Not applicable
10. Do you and your partner work out arguments with:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any additional comments?

If you have any questions, or if this survey has raised any issues for you that you would like to discuss, please contact Teresa Mansell at childspacewest@aol.com.

¹ Floating Hospital for Children at Tufts Medical Center (2016). The Survey of Well-being of Young Children. Retrieved from: www.theSWYC.org.

CHILDSPACE 2018-2019 RATE SCHEDULE

(Due 1st of The Month)

NUMBER OF DAYS PER WEEK	INFANT 0-2years WEEKLY RATE	INFANT 0-2years MONTHLY RATE	TODDLER 2-3 years WEEKLY RATE	TODDLER 2-3 years MONTHLY RATE	Preschool 3 - 5 yrs WEEKLY RATE	Preschool 3 - 5 yrs MONTHLY RATE
2	\$206.00	\$886.00	\$192.00	\$826.00	\$179.00	\$770.00
3	\$243.00	\$1,045.00	\$230.00	\$989.00	\$197.00	\$847.00
4	\$279.00	\$1,200.00	\$259.00	\$1,114.00	\$222.00	\$955.00
5	\$288.00	\$1,238.00	\$270.00	\$1,161.00	\$236.00	\$1,015.00

PART TIME SCHEDULES

	5 1/2 DAYS	PER ADDITIONAL 1/2 DAY	PER ADDITIONAL FULL DAY
INFANTS 0-2 YEARS OLD	\$914.00 MONTHLY \$ 212.00 WEEKLY	\$63.50	\$88.50
TODDLER 2-3 YEARS OLD	\$864.00 MONTHLY \$ 201.00 WEEKLY	\$57.25	\$83.25
PRESCHOOL 3-5 YEARS OLD	\$801.00 MONTHLY \$ 186.00 WEEKLY	\$54.00	\$79.00

Please note that all payments not received by 6:00 P.M. on the first business day of the due date will be subject to a \$25.00 late fee. This fee schedule is based on a yearly contract. Monthly payments must be paid regardless of absence due to illness or vacations.