



Cortelyou Early Childhood Center, Inc.

Main Office

1110 Cortelyou Road
Brooklyn, NY 11218

Phone: 718-282-6077

Fax: 718-282-2919

Annex

386 Marlborough Road
Brooklyn, NY 11226

Phone: 718-856-2880

Academy Building

2739 Bedford Avenue
Brooklyn, NY 11210

Phone: 718-421-9581

Fax: 718-421-2891

E-Mail: info@mycecc.com

Website: www.mycecc.com

Dear After School Parent,

Welcome to CECC! Thank you for choosing our program for your after school needs. In addition, we also provide half-day, full day, holiday and summer camp services when public/charter schools are closed. These services are provided at an additional cost.

Please fill out all attached forms and return them to our Main or Academy office. The fee for our After school program is as follows:

Registration: \$100 (Paid Annually)

Monthly Fee: \$400

Late Payment Fee: \$50 (if payment is not received by the 5th of the month)

Please Note: A completed medical form **MUST** be submitted in order for your child to start in our after school program.

Thank you again for your support and cooperation.

Sincerely,

Cortelyou Administration

Please fill out and return with application.

Child's Name: _____

Grade: _____

School's Name: _____

Child's Teacher: _____

Location of Pick up: _____

(PS 139, 217, 245, 152, 152 Annex, or 315)

**Updated as of 1/10/2023*



Photo
Optional

Cortelyou Early Childhood Center

After School Application

Student Information

Applicant's Name: _____ ☐ Male ☐ Female

Date of Birth _____ Place of Birth _____

Current School _____ Grade: _____ Teacher: _____

Parent(s) /Guardian(s) Information

Name: _____	Name: _____
Relationship to applicant _____	Relationship to applicant _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Home Phone _____
Cell Phone _____	Cell Phone _____
Work Phone _____	Work Phone _____
Email _____	Email _____
Present Occupation _____	Present Occupation _____
Employer _____	Employer _____

Principal Contact (Please check one): ☐ Both ☐ Mother ☐ Father

Parent/Guardian Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic

If principal contact cannot be reached, whom do we contact in case of an emergency?

Name of person(s) authorized to pick-up your child:

List any food allergies, medical conditions, or dietary restrictions: (eg. lactose intolerance, peanuts, asthma, etc.)

Is there anyone who is **NOT** allowed to have access to your child? (Please submit a copy of any special documentation.) _____

Consent Form

I hereby give permission to allow my child, _____ to be taken on trips to points of interest throughout the New York City area, under the supervision of **Cortelyou Early Childhood Center**, via private means of transportation. I also grant permission for my child to be taken on walking trips throughout the neighborhood when accompanied by his/her teacher. (Initial Here: _____)

Photograph & Video Release

I hereby give permission for images of my child, captured during regular and special school activities through video, photo and digital camera, to be used solely for the purpose of **Cortelyou Early Childhood Center** promotional material and publication including websites, brochure, handbooks etc., and waive any rights of compensation or ownership thereto. (Initial Here: _____)

I have read the policy and agree to comply with the forms as stated.

Print Name _____

Parent's Signature _____ Date: _____

OFFICIAL USE ONLY

☐ Registration Fee Paid Voucher Program: ☐ Yes ☐ No

☐ ACD /HRA Copayment: _____

Date Received: _____ Rec'd by: _____

Comments: _____

HEALTH RECORD FOR CHILDREN IN DAY CAMP, AFTERSCHOOL & YOUTH CENTERS

(This side is to be completed by Parent before presenting to Physician)

NAME OF PROGRAM: Cortelyou Early Childhood Center

CHILD'S LAST NAME

CHILD'S FIRST NAME

DATE OF BIRTH

☐ FEMALE ☐ MALE

HOME ADDRESS

CITY/STATE/ZIP CODE

HOME TELEPHONE NUMBER

PARENT'S OR GUARDIAN'S NAME

CONTACT TELEPHONE

FATHER'S PLACE OF EMPLOYMENT

TELEPHONE

MOTHER'S PLACE OF EMPLOYMENT

TELEPHONE

IN CASE OF EMERGENCY-NOTIFY

TELEPHONE

IF PARENT OR GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY, NOTIFY: (FAMILY PHYSICIAN)

1. _____

OR

TELEPHONE

2. _____

TELEPHONE

IMPORTANT: Please notify Camp Officials if Child was/is exposed to any communicable disease at anytime three weeks prior to Camp attendance.

☐ NO ☐ YES If YES, please give type of exposure:

HEALTH HISTORY (Check, giving approximate dates):

Asthma: _____ Behavior: _____ Chicken Pox: _____

Convulsion: _____ Diabetic: _____ Ear Infection: _____

Hay Fever: _____ Insect Stings: _____ Ivy Poisoning, etc: _____

Measles: _____ German Measles: _____ Mumps: _____

Past Illness: _____ Contagious illness: _____

Other Drugs: _____ Penicillin: _____ Rheumatic Fever: _____

Operations or Serious Injuries (Dates): _____

Hospitalization: _____

Chronic or Recurring Illness: _____

Other Diseases or details of above: _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

Permission for all program activities unless otherwise noted by physician:

Suggestion from Parent(s) or Guardian: _____

SIGNIFICANT HEALTH HISTORY AND CURRENT CONDITIONS

PLEASE LIST:

Medication taken: _____

Appliance worn (Glasses, Hearing Aid, etc.): _____

Conditions that modify activity (seizures, asthma, heart condition, etc.): _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby give my consent/authority to the Staff of the Day Camp, year round Afterschool, and Youth Center Program to obtain the necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship: _____ Signature: _____ Telephone: _____ Date: _____

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the need of the aforementioned Child in Day Camp and Afterschool and Youth Center programs.

DPT or DT or TD –	DATE: _____	DATE: _____	DATE: _____	DATE: _____	DATE: _____
POLIO -	DATE: _____	DATE: _____	DATE: _____	DATE: _____	DATE: _____
MEASLES-	DATE: _____				
MUMPS-	DATE: _____				
RUBELLA-	DATE: _____				

Tuberculin Test given: _____ (most recent) Result: _____

☐ ☐
m m

CODE: S = SATISFACTORY X = NOT SATISFACTORY (EXPLAIN) O = NOT EXAMINED

HEIGHT	WEIGHT	BLOOD PRESSURE	HGB. TEST
URINALYSIS	POSTURE & SPINE	THROAT/TONSILS	
EYES	VISION	GLASSES	EXTREMETIES
HEART	EARS	HEARING	FEET
LUNGS	SKIN	NOSE	TEETH
ABDOMEN	HERNIA	GENITALIA	

DESCRIBE ABNORMAL FINDINGS AND/OR HANDICAPPING CONDITIONS:

HAS CHILD EVER RECEIVED PRODUCTS CONTAINING HORSE SERUM? ☐ NO ☐ YES If YES, Please explain.

SPECIAL DIET

MEDICAL MEDICATION (GIVE NAME AND DOSAGE)

PARENT/GUARDIAN SEEKING SPECIAL MEDIATION?

SWIMMING

DIVING

STRENUOUS ACTIVITY

GENERAL APPRAISAL :

I HAVE EXAMINED THE INDIVIDUAL HEREIN DESCRIBED, REVIEWED HIS/HER HEALTH HISTORY AND IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP/YEAR ROUND AFTERSCHOOL AND YOUTH CENTER ACTIVITIES. EXCEPT AS NOTED ABOVE.

PHYSICIAN'S SIGNATURE M.D. _____
DATE

ADDRESS _____ CITY/STATE _____ ZIP CODE _____

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: Cortelyou Early Childhood Center

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPRI)
4. Currently has a foster child enrolled in day care

SECTION A
Food Stamp Case Number _____
TANF Number _____
FDPRI Number _____
Foster Child's Name _____
Foster Child's Personal Monthly Income \$ _____
<p>An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p> <p>Signature: _____</p> <p>Date: _____</p>
FOR SPONSOR USE ONLY
Sponsor Agreement Number <u>3409</u>
Total Household Members _____
Total Income \$ _____
Free _____ Reduced _____ Paid _____
Signature of Determining Official _____
Date Determined ____ / ____ / ____

Complete SECTION B if SECTION A does not apply:

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

SECTION B														
<p>List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received last month in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, welfare payments, child support and any other sources of income.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; padding: 5px;">Name of Household Members</th> <th style="text-align: center; padding: 5px;">Monthly Gross Income</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">1. _____</td> <td style="padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">2. _____</td> <td style="padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">3. _____</td> <td style="padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">4. _____</td> <td style="padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">5. _____</td> <td style="padding: 5px;">\$ _____</td> </tr> <tr> <td style="padding: 5px;">6. _____</td> <td style="padding: 5px;">\$ _____</td> </tr> </tbody> </table>	Name of Household Members	Monthly Gross Income	1. _____	\$ _____	2. _____	\$ _____	3. _____	\$ _____	4. _____	\$ _____	5. _____	\$ _____	6. _____	\$ _____
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<p>An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p> <p>Signature: _____</p> <p>Print Name: _____</p> <p>SS# _____ - _____ - _____ Date: _____</p>														

DAY CARE CENTER ENROLLMENT FORM

Center Name: **CORTELYOU EARLY CHILDHOOD CENTER**

Child's Name: _____

Male _____ Female _____ Date of Birth _____ Home Phone _____

Home Address _____

Mother/Guardian Name _____

Father/Guardian Name _____

Parent/Guardian Address and Phone, if different _____

In case of emergency, notify _____ Phone _____

Second person to notify _____ Phone _____

Physician's name _____ Phone _____

TIME MEALS SERVED

Breakfast _____ am to _____ am Lunch _____ am/pm and _____ pm Afternoon Snack _____ pm to _____ pm

If your child is in care during these times, he/she will receive the meal or snack that is being served.

What days will your child usually be at the center? M _____ Tu _____ W _____ Th _____ F _____ Sat _____ Su _____

What hours will your child usually be at the center? Arrive _____ am pm

Depart _____ am pm

Signature of a parent/guardian _____ Date _____



After 1 year of care

Is all the information above still correct? Yes _____ No _____

If no, what has changed? _____

Signature of a parent/guardian _____ Date _____

Section 9

Unless you list the Food Stamp, TANF or FDPIR number for the child or a household member or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the Social Security Number of the household member signing the application or indicate that the household member signing the application does not have a Social Security Number. You do not have to list a Social Security Number, but if a Social Security Number is not listed or an indication is not made that the adult household member signing the application does not have a Social Security Number, CACFP cannot approve the application. The Social Security Number may be used to verify the correctness of the information stated on the application. This may include program reviews, audits and investigations and may include contacting employers to determine income, contacting a Food Stamp, TANF or FDPIR office to determine current certification for Food Stamp, TANF or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) public assistance or welfare payments; (7) unemployment compensation; (8) government civilian employee or military retirement, or pensions or veteran's payments; (9) private pensions or annuities; (10) alimony or child support payments; (11) regular contributions from persons not living in the household; (12) net royalties; (13) military benefits received in cash, such as housing allowance; and (14) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR COMPLETING DOH-3688

Instructions for Parents or Guardians:

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household receives Food Stamps, Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the Food Stamp, TANF or FDPIR number (do not use your ACD or DSS child care subsidy number) and sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, complete Section A only. Write in the foster child's name and any income that the child receives from social services for his or her personal use. Write in 0 if the foster child does not receive any income. A separate application must be completed for each foster child. The foster parent or an official who represents the child must sign and date the form and then return it to the child care center.

Section B: Write in the names of all the people living in your household, even if they do not have any income. Include yourself and all other adults and children in the household, including unrelated people. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income. The signature and Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*.

Instructions for Centers and Sponsors:

The For Sponsor Use Only section is to be completed, signed and dated by child care center or sponsor staff.

The sponsor/center representative must review the income eligibility application and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The sponsor agreement number.

Total household members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care.

Total Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the application must be categorized as *paid*.

Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete applications (missing signatures, income information, or Food Stamp, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility application is valid until the last day of the month one calendar year from the date of submission. For example, a form submitted on May 12, 2010 is valid until May 31, 2011.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES**CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS
HEALTH SCREENING ONE-TIME ATTESTATION**

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.*** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers “Yes” to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are “Yes,” individuals **cannot** enter the program. If the answers are “No” to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer “No” to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
 - Cough (new or worsening)
 - Shortness of breath (new or worsening)
 - Trouble breathing (new or worsening)
 - Fever
 - Chills
 - Muscle pain (new or worsening)
 - Headache (new or worsening)
 - Sore throat (new or worsening)
 - New loss of taste
 - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered “NO” to all questions, you have passed and may enter the program.

If you have answered “YES” to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature

Date

Signature

Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.