

The Dr. Thomas J. Curran Early Childhood Education Center Child Care Application Form 2023-2024

ECEC Child Care Contract & Fee Schedule

***Fees are subject to change starting September 2023**

Fee Schedule: *

Before School Care - \$12.50 per day - 1.75 hours (7:00 am - 8:45 am)

	<u>5 Days</u>	<u>4 Days</u>	<u>3 Days</u>	<u>2 Days</u>
Yearly Rate	\$2,205	\$ 1,764	\$1,323	\$882
Monthly Rate	\$220.50	\$176.40	\$132.30	\$88.20

After School Care - \$21.00 per day – 3 hours (3:00 pm - 6:00 pm)

	<u>5 Days</u>	<u>4 Days</u>	<u>3 Days</u>	<u>2 Days</u>
Yearly Rate	\$3,780	\$3,024	\$2,268	\$1,512
Monthly Rate	\$378.00	\$302.40	\$226.80	\$151.20

Terms and Conditions:

Tuition and Registration Fees: If you would like to reserve a place for your child in Childcare for the 22-23 school year, please complete this form and return it to:

Mrs. Brenda McMurtry
ECEC Childcare
1100 High St Dedham, MA 02026
781-310-8029 bmcmurtry@dedham.k12.ma.us

Registration & Tuition Fees:

- A non-refundable \$75.00 registration fee is required to hold your child's space (by June 1st) and can be paid via our website under Quick Links, Tuition Payment, then use the Childcare drop down. We will no longer be able to accept checks or money orders for tuition.
- The first tuition payment is due August 1, 2023 with this contract.
- Each monthly payment is due by the first of the prior month. A late fee of \$25.00 may be assessed if the fee is not paid by the 1st of the following month.

Any permanent changes in schedules must be communicated at least two weeks in advance or full monthly balance will be required.

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Waiting List: In the event that the ECEC cannot accommodate all those children interested in attending, we will use the following procedures to determine a waiting list:

- Returning children will have 1st priority, including siblings.
- All remaining, interested children will be placed on a waiting list in the order the applications were received.
- Placements will be made on a first come, first serve basis.
- **All pages must be returned even if it does not pertain to your child
Please put N/A and sign at the bottom of the page.**

Questions and Information: All questions regarding Childcare should be directed to **Mrs. Brenda McMurtry at 781-310-8029 or bmcmurtry@dedham.k12.ma.us**. Any changes to a child's schedule for Childcare, or additions to the approved pick up list should be put in writing and sent into school with your child also emailed to Ms. Brenda by 7:00 am. Emails will not be checked during the school day, so it is imperative that these changes are communicated in a timely manner.

I hereby agree to pay the ECEC Child Care Program for before/after care for my child according to the terms and conditions set forth in this document (document must be signed by every adult responsible for Childcare costs:

Child's Name: _____

My child is enrolled _____ days per week. I understand that:

- Childcare payments are based on an annual fee that is equally distributed across the school year.
- If my child attends any extra days/hours beyond their regular schedule, additional payment will be expected.
- I am responsible to pay for the regular, agreed upon schedule, whether or not my child attends.
- My child will NOT be admitted to the program if payment is not current.
- Credit will not be provided for sick days or vacations taken outside of the regularly scheduled school vacations.**

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PLEASE PRINT CLEARLY:

Child's Name: _____ DOB: _____

Address: _____ Phone: _____

***Children must be 4 years old in order to attend Child Care.

Parents/Guardian Information:

Parent/Guardian Name

Email address

Cell #

Work # (extension if needed)

Parent/Guardian Name

Email address

Cell #

work # (extension if needed)

Siblings in program: _____

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Before School Program runs from 7:00 am – 8:45 am (Please check one)

_____ Option A (5 Days) - Monday through Friday

_____ Option B (4 Days) List Days needed: _____

_____ Option C (3 Days) List Days needed: _____

_____ Option D (2 Days) List Days needed: _____

After School Program runs from 3:00 pm – 6:00 pm (please check one)

_____ Option A (5 Days) - Monday through Friday

_____ Option B (4 Days) List Days needed: _____

_____ Option C (3 Days) List Days needed: _____

_____ Option D (2 Days) List Days needed: _____

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Child's Name: _____

Pick-up Authorization for Childcare *At least one contact needs to be local, and able to pick your child up in case of an emergency in a timely manner. If you need additional space, please use the other side of this paper.

Name: _____ Parent/guardian: _____

Address: _____ Town: _____

Home #: _____ Cell #: _____

Name: _____ **Parent/guardian:** _____

Address: _____ **Town:** _____

Home #: _____ **Cell #:** _____

Name: _____ Relationship: _____

Address: _____ Town: _____

Home #: _____ Cell #: _____

Name: _____ **Relationship:** _____

Address: _____ **Town:** _____

Home #: _____ **Cell #:** _____

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To help us know your child better, please complete the following questionnaire:

Child's Name: _____

Please list all occupants in your home and their relationship to your child:

How well does your child interact with other children?

Please describe any circumstances regarding your child's physical or emotional status that will help to understand your child better. (Fears, Lifestyle changes – ie. Divorce, Separation, Recent Move, Family Illness, or Loss).

Any other notes or concerns:

EEC Individual Health Care Plan Form

Name of child:	Date of Birth:
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

Name and Phone Number of Licensed Health Care Practitioner (please print): _____

Parental/Guardian Signature: _____ Date: _____

Program Administrator Signature: _____ Date: _____

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Topical Non-Prescription (**applied to open wound/ broken skin**) _____

My child has previously taken this medication _____

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

Child's Health Care Practitioner Signature _____ **Date** _____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date** _____

For topical, non-prescription NOT applied to open wound / broken skin (parent signature only)

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (In order to be contacted)

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

Health Insurance Coverage _____	Policy # _____
Parent/Guardian Name: _____	Phone _____ Cell _____
Parent/Guardian Name: _____	Phone _____ Cell _____

Parent /Guardian Signature

Date (valid for one year)