



SCAP Early Learning Program Application for Enrollment

Applications will only be reviewed once all of the following is received:

- A copy of the child's birth certificate or other acceptable proof of age
- Documentation to verify household income received within the previous year
- Proof of Residency dated within the last 30 Days
- Photo identification for all parents/ guardians in the child's home
- Copy of the child's most recent physical (SCAP form attached)
- Copy of immunization records (SCAP form attached)

Accepted Documents:

Income Tax Forms (1040) **(preferred)**

W-2 Forms

Public Assistance

SSD or SSI Award Letter

Unemployment Compensation

Rental Property (If you have tenants that pay rent)

At least 4 Paystubs or Pay Envelopes from the previous year

SCAP Early Learning Centers

Bigelow Avenue Early Learning Center 377-8539
100 Bigelow Avenue | Schenectady, NY 12304

Yates Village Early Learning Center 381-4195
2450 Van Vranken Avenue | Schenectady, NY 12308

Bellevue Early Learning Center 377-7300
2000 Broadway | Schenectady, NY 12306

Glen Worden School Early Learning Center 381-4195
30 Worden Road | Scotia, NY 12302

First Parent/Guardian Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to child: _____

Phone Number: _____ E-Mail address: _____

Are you currently:

_____ Attending School

Where and what hours:

_____ Working

_____ In a Training Program

Primary Language: _____

Primary Ethnicity: Latino/Non-Latino (circle one)

Race: Asian / Black / Middle Eastern / Bi-Racial / Multi-Racial / Caucasian / Native American / Other (circle one)

Second Parent/Guardian Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to child: _____

Phone Number: _____ E-Mail address: _____

Are you currently:

_____ Attending School

Where and what hours:

_____ Working

_____ In a Training Program

Primary Language: _____

Primary Ethnicity: Latino/Non-Latino (circle one)

Race: Asian / Black / Middle Eastern / Bi-Racial / Multi-Racial / Caucasian / Native American / Other (circle one)

Child Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Language: _____ Primary Ethnicity: Latino/Non-Latino (circle one)

Race: Asian / Black / Middle Eastern / Bi-Racial / Multi-Racial / Caucasian / Native American / Other (circle one)

PLEASE LIST ALL OF THE PEOPLE THAT LIVE IN YOUR HOUSEHOLD IN THE SPACES PROVIDED BELOW:**If you need additional space, please attach a separate sheet of paper.**

Name:	DOB:	Relationship To Applicant:	Special Needs:
1.	___/___/___		
2.	___/___/___		
3.	___/___/___		
4.	___/___/___		
5.	___/___/___		
6.	___/___/___		
7.	___/___/___		

Please Check All That Apply. Your Information Will Be Kept Confidential

<input type="checkbox"/>	Special Needs	<input type="checkbox"/>	Child from EHS
<input type="checkbox"/>	Child Protective Services	<input type="checkbox"/>	Military Deployment
<input type="checkbox"/>	Medical Issues	<input type="checkbox"/>	Foster Child
<input type="checkbox"/>	Domestic Violence	<input type="checkbox"/>	Grandparent Primary Caregiver
<input type="checkbox"/>	Incarcerated Parent	<input type="checkbox"/>	Parent Needs Interpreter
<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	Receiving SCAP Services

Does your child have health insurance?
YES _____ NO _____

Check all that apply:

_____ Medicaid
_____ Child/Family Health Plus
_____ Private Insurance
_____ No Insurance
_____ Other _____

Has your child ever been evaluated by Early Intervention Services?
YES _____ NO _____

Is the child receiving any services for special needs or disabilities?
Check all that apply:

_____ Special Education _____ Behavior
_____ Occupational Therapy _____ Speech
_____ Physical Therapy _____ Other

Do you have any concerns about your child's development?
YES _____ NO _____

If yes, please explain: _____

Does the child have any food or health restrictions?
YES _____ NO _____

Please list: _____

Does anyone have concerns about the child's health or development?
YES _____ NO _____

If yes, please explain: _____

Does the child have any siblings in:

_____ Parsons Early Head Start _____ SCAP Early Learning Program
_____ YWCA / YMCA _____ Other _____

Person to contact if we are unable to reach you:

First name: _____ **Last name:** _____
Phone #: _____ **Relationship to child:** _____

Please submit any one of the following documents to provide proof of income:					
	Wage Statements (previous year)		Supplemental Security Income		Child Support
	Tax Form		TANF Letter / PA Budget		Disability
	Letter From Employer		Unemployment Letter		Financial Aid / Grants

Please submit proof of your child's age. Physical AND Immunization Records are REQUIRED before your child can attend					
	Birth Certificate				Current Physical (w/in 12 months)
	Benefit Card				Immunization Record

I declare under penalty of perjury and the laws of the State of New York that the above information is true and correct to the best of my knowledge.

Parent/Guardian Signature

Date

The Head Start Reauthorization Act has guidelines for providing services to homeless children and families.
Please help us by answering the following questions.

QUESTIONNAIRE

Did you/your family recently move to Schenectady County?

YES NO

When and for what reason: _____

How long have you lived at the address provided on this application?

Do you:

Rent
 Own your home

Please indicate which, if any, of the following situations apply to your family:

- Family is sharing a residence with one or more families, relatives, or friends, temporarily
- Family is living in a motel or hotel
- Family is living in a shelter (domestic violence, emergency, or transitional housing unit)
- Family is living in a car, park, campground, or other public place
- Family is living in a place without adequate facilities (no running water, heat, electricity)
- None of these apply

Is this temporary living arrangement due to loss of housing or economic hardship?

YES NO

Please briefly explain your current situation:

Please note:

If a false claim is made about your living situation, enrollment may be effected.
Please notify our office (518-377-8539) if your living status changes.

Parent's Signature

Date



Schenectady Community Action Program Early Learning Centers

Child Well Care Medical Report

****ATTENTION PROVIDER: All components MUST be completed and immunization record attached****

This form follows AAP recommendations for Well Care Visits and NYS Health Dept. EPSDT Guidelines.

Part 1: Child's Personal Information:		
Child Name:	Date of Birth:	Parent/Guardian Name:

Part 2: Child's Health History, Examination, Results and Recommendations. (Please provide screening and testing results)					
Date of Exam:	BP:	Hct/Hgb Result:	Weight:	Height:	Did the child see a Dentist in last year?
		<input type="checkbox"/> Nrmal <input type="checkbox"/> Abnl			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Referred
			BMI: _____		

Health Concerns:	Referred or Treated	Health Concerns:	Referred or Treated
Dental-Oral Health <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Speech <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Asthma <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Vision <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Development <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Vision Acuity Right: _____ Left: _____	
Behavioral/Emotional <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Hearing <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX
Learning/Attention <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Type: _____ Result: _____	
Language <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX	Neurologic <input type="checkbox"/> None <input type="checkbox"/> Yes	<input type="checkbox"/> Referred <input type="checkbox"/> Under RX

A. Significant health history, conditions, communicable illness or restrictions that may affect participation at school or play?

None Yes, please detail:

B. Significant allergies or health conditions that may require medication, special treatment, accommodations or emergency care at school?

None Yes, please detail: (Medication at school requires a separate consent and instructions from both the doctor and parent.)

C. Participation in Daily Activities: Diet and Activity Restrictions require a statement of condition and duration.

Can child have a Regular Diet at school, including milk? Yes No, please detail:

Can child participate in daily outdoor activity and gym exercise? Yes No, please detail:

Part 3: Tuberculosis and Lead Exposure Risk Assessment and Testing				
TB	PPD Test Date:	Results:	<input type="checkbox"/> CXR Negative <input type="checkbox"/> CXR Positive	<input type="checkbox"/> Treated, please detail any follow-up plan
		_____ mm		
Lead Current if no previous test	Lead Test Date:	Result:	<input type="checkbox"/> Treated, please detail any follow-up plan	

Part 4: Required Provider Certification and Signature

On the basis of my findings, indicated above, and knowledge of the above named child, I find that: (s)he is up to date with NYS EPSDT guidelines free from contagious and communicable disease and is able to participate in all SCAP Early Learning Programs

Yes
No

Signature of Examiner	Address, City, State, Zip
Name (Please Print) and Title	Date:
()	Phone Number

(Continued on Back)

Part 5: Immunization Information (please fill in or attach copy of immunization record)

Diphtheria-Tetanus-Pertussis	1st	2nd	3rd	4th	5th
Polio	1st	2nd	3rd	4th	5th
Hemophilus Influenzae B (HIB)	1st	2nd	3rd	4th	
Prevnar	1st	2nd	3rd	4th	
Hepatitis B (HBV)	1st	2nd	3rd		
Hepatitis A	1st	2nd			
Measles-Mumps-Rubella (MMR)	1st	2nd			
Varicella/Chicken Pox	1st	2nd			

Other Immunizations:

Type of Immunization:	Date:
Type of Immunization:	Date:

Note: Those children who have received at least one dose of each required vaccine and have an appointment schedule to receive the remainder of the required doses are considered "**in process**" of receiving the vaccines and may remain in school as long as the appointment schedule is kept and the parent provides verification the vaccines have been administered.

FOR DOCTORS ONLY

Medical Exemption:

The physical condition of the child is such that one or more of the immunizations would endanger life or health.

Signature of Doctor/Medical Provider

Date

FOR PARENTS ONLY

Religious Exemption:

In accordance with Public Health Law, the sincere religious beliefs of the child's parents prohibit immunization.

Do you wish to exercise those rights? Yes No

Any child not fully immunized for any reason must be excluded from care whenever there is an outbreak.
The child may return only upon approval of the local county health department.

Signature of Parent or Person Legally Responsible

Date