Western Indiana Community Action Agency
Carole Barr, Executive Director

WICAA CHILD CARE
CONFIDENTIAL ENROLLMENT APPLICATION
2014-2015

There is a $10.00 registration fee, per child.

For office use only
Scholarship _____ Registration Fee _____ Emergency Rate _____ CCDF _____

Name of Child:_____ Age_____ Sex_____

Address:_____City_____Zip_____

Phone:_____ Birth date_____

Child resides with (Please circle one): Both Parents Mother Father Other
Comments_____

Father/Guardian's Name_____ Daytime Phone_____

Place of Work_____ Alternate Phone_____

Mother/Guardian's Name_____ Daytime Phone_____

Place of Work_____ Alternate Phone_____

Parent email address:_____

Do you give consent for your child to be photographed or videotaped for the purpose of advertisements or grants?
_____

Additional people we may contact or that may pick up your child in an emergency:

Name_____ Daytime Phone_____ Relationship_____

Name_____ Daytime Phone_____ Relationship_____

Name of Hospital you prefer for emergency treatment. _____

Does your child have any medical conditions, allergies, routine medications or other concerns we should know about to better care for your child? ***Food allergies must have a doctor's statement before we can serve your child an alternate snack.***_____

Do you give consent for Head Start to share information with WICAA Child Care Program office? All information will be kept confidential between the two programs.
Yes I give permission to share information between the two programs:
Parent Signature_____

No I do not give permission for the two programs to share information:
Parent Signature_____

Do you approve of Basic CPR or First Aid treatment for your child when necessary? _____

Does your child receive services from Covered Bridge Special Education District? _____
If yes, what is the diagnosis? _____

2014 - 2015 Rate Schedule

Full Time weekly rate-$95.00

Part Time Rates

Hours (per week)	1 Child	2 Children	3 Children
.25 – 8.25	$25.00	$20.00	$15.00
8.5– 16.5	$50.00	$45.00	$40.00
16.75 – 24.75	$75.00	$70.00	$65.00

In case of illness or injury of my child, and in the event that all efforts to reach me fail, I herby give my permission to WICAA Child Care to follow the appropriate procedure to secure the medical attention needed for my child. I will assume responsibility for the necessary expenses involved in the treatment of my child. I also grant permission to release my child to the people listed above in the event they cannot contact me. I understand that in the event my child is not picked up by 6:00pm, and all attempts to contact parents/emergency contacts have failed, WICAA Child Care will contact the appropriate authorities.

By signing below, I acknowledge that I am responsible for payment of all childcare expenses and that the cost of childcare has been explained to me. I will pay off and/or swipe my CCDF Voucher card to cover my Child Care balance on a weekly basis, either by paying the childcare providers at drop off or pick up, mailing a check to the WICAA Child Care office, or bringing a payment into the office at 5th and Deming. If I become delinquent in my payments, I understand that I may receive a letter in the mail explaining that my childcare privileges have been terminated until I pay my balance in full. For future child care services I further understand that I will have to pay in advance.

Signature of Parent/Guardian: _____ Date: _____

I have received a parent handbook.

Signature of Parent/Guardian: _____ Date: _____

Upon completion of application, please submit by:
-Mail @
705 South 5th Street
Terre Haute, IN 47807
or
-Bring to the WICAA Child Care office
Phone: 812-232-1264 Fax: 812-232-9634