

Western Indiana Community Action Agency
Carole Barr, Executive Director
WICAA CHILD CARE
SUMMER PROGRAM AGES 3-6
CONFIDENTIAL ENROLLMENT APPLICATION
2015

There is a \$10.00 registration fee.

For office use only
Registration Fee _____

Name of Child: _____ Age _____ Sex _____

Address: _____ City _____ Zip _____

Phone: _____ Birth date _____

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

Mother/Guardian's Name _____ Daytime Phone _____

Place of Work _____ Alternate Phone _____

Father/Guardian's Name _____ Daytime Phone _____

Place of Work _____ Alternate Phone _____

Parent/Guardian 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 or concerns we should know about to better care for your child?

Does your child have any know allergies? _____

Food allergies must have a doctor's statement before we can serve your child an alternate.

Is your child currently taking any routine medications? _____

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? _____

2015 Location, Price Rate, and Hours of Operation

Location: 705 S. 5TH St. Terre Haute, IN 47807 (Inside the Vigo County Head Start Center)

Dates: Tuesday, May 26, 2015 - Friday, August 7, 2015

Time: 6:30 AM – 5:30 PM; Monday through Friday

Fees: Payable by cash, check, money order or CCDF Voucher (Discounted rate for each additional child)

HOURS	1	2	3
	Child	Children	Children
FULL WEEK	\$95	\$180	\$265
Part-time (minimum 2 days & max 3 days) Daily rates	\$19	\$33	\$42

In case of illness or injury of my child, and in the event that all efforts to reach me fail, I hereby 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 5:30 pm, 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 child care expenses and that the cost of child care 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 child care 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 explaining that my child care privileges have been terminated until I pay my balance in full.

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

Western Indiana Community Action Agency, Inc. is an equal opportunity provider and employer. All services will be provided without discrimination because of race, age, color, religion, sex, handicap, national origin or ancestry.