



Rosa Venerini
Early Childhood Center

1840, Van Vranken Ave., | Ph: (518) 372 5961
Schenectady, NY 12308 | Fax: (518) 372 7337

Student Enrollment Form

Child's Name: _____ Sex: M F

Birthdate: _____ Birth Place: _____ Ethnicity: _____

Child's Home Address: _____

Home Phone: _____

1st Parent's Name: _____

Occupation: _____ Employer: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Address: (if different from child) _____

2nd Parent's Name: _____

Occupation: _____ Employer: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Address: (if different from child) _____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ other: _____

Emergency Contact(Other than parents)

1. _____ Phone #: _____

2. _____ Phone #: _____

Pediatrician: _____ Preferred Hospital: _____

Parent Signature: _____ Date: _____

Registration Fee: \$75 Cash or Check # _____
Office Staff Signature: _____ Date: _____



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2019-2020

School Year Programs

Full Day School (9am-3pm)

_____ T/TH \$80/wk
_____ M/W/F \$110/wk
_____ 5 Days \$165/wk

Half Day School (9am - 12:30pm)

_____ T/TH \$225/mo
_____ M/W/F \$250/mo
_____ 5 Days \$305/mo

Before Care Program

8:00 am Drop-Off

_____ 5 Days \$40/wk

7:00 am-8:00 am Drop-Off

_____ T/TH \$30/wk
_____ M/W/F \$35/wk
_____ 5 Days \$55/wk

After Care Program

4:00 pm Pickup

_____ 5 Days \$55/wk

4:00 pm-5:30 am Pickup

_____ T/TH \$40/wk
_____ M/W/F \$50/wk
_____ 5 Days \$70/wk

Child care hours needed: _____ to _____

****Any additional hours must be Pre-approved by Director & Pre-Paid****

Additional Hours are billed by the hour at a \$15/hr. (This fee is not divided in halves or quarters)

Sibling Discount: 10% Off on Lower cost tuition

✧ Parent Contract MUST be read and signed by parent(s)/guardian(s) before child begins school



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Personal Data : Family & Social History Form

Child's Name: _____ DOB: _____

Parent Info

Legal guardian 1: ☐ Mother ☐ Father ☐ other: _____

Name: _____ Age: _____

Legal guardian 2: ☐ Mother ☐ Father ☐ other: _____

Name: _____ Age: _____

Marital Status: ☐ Married ☐ Living Together ☐ Separated ☐ Divorced ☐ Step-parent

Custody/Visiting arrangements: _____

Brothers & Sisters

Name: _____ Age: _____ Grade in School: _____

Name: _____ Age: _____ Grade in School: _____

Name: _____ Age: _____ Grade in School: _____

Child Experiences

Has child had group play experience? _____ Where? _____

Does child have playmates? _____

What are your child's favorite indoor/outdoor activities? _____

Does your child have fears that you are aware of? _____

Development History

At what age did your child:

Crawl: _____ Name simple objects: _____ Sit up on own: _____

Repeat short sentences: _____ Begin toilet training: _____

Sleep through night: _____ Complete toilet training: _____

What word does your child use for Urination: _____ Bowel Movement: _____

Does child dress self? ☐ Y ☐ N Undress self? ☐ Y ☐ N



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Personal Data : Family & Social History Form Cont.

NAPPING AGREEMENT

☐ **Infants***: I agree to have my child nap in/on a ☐ **mat**, ☐ **crib**, ☐ **pack & play** placed in the infant room.

☐ **Toddlers**: I agree to have my child nap in/on a ☐ **mat or** ☐ **cot** placed in the classroom.

☐ **Preschool/Pre-K/UPK** : I agree to have my child nap in/on a ☐ **mat or** ☐ **cot** placed in the classroom.

*Sleeping arrangements for **infants** require that the infant be placed on his or her back to sleep, unless medical information is presented by the parent that shows that this arrangement is inappropriate for that child.

Sleep Schedule: Regular bed time : _____ to _____ Does your child have interrupted sleep? ☐ Y ☐ N

Do you have concerns about your child's development?

☐ Speech ☐ Fine Motor ☐ Gross Motor ☐ Behavior ☐ Social/emotional

How would you best describe your child's personality? _____

What are your daycare expectations? _____

Please explain any special family traditions or celebrations that you would like to share with us:

Home Language Questionnaire

1. What language(s) is spoken in student's home or residence?

☐ English ☐ Other: _____

2. What language(s) are spoken most of the time to the student, in the home or residence?

☐ English ☐ Other: _____

3. What language(s) does the student Understand?

☐ English ☐ Other: _____

4. What language(s) does the student speak?

☐ English ☐ Other: _____

5. In your opinion, how well does the student understand and speak English?

Very Well

Only a Little

Not at all

Understands English

☐☐☐

Speaks English

☐☐☐



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Emergency Authorization Form for Medical Emergency Treatment

Child's Name: _____ DOB _____

As parent or legal guardian of _____, a minor, I hereby give my consent to Rosa Venerini ECC or Schenectady UPK to seek medical treatment in the event of an emergency. I hereby give my consent to ELLIS HOSPITAL to provide any treatment and conduct any tests which are required necessary treatment to the above named minor in my absence.

Pediatrician Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

Last Tetanus: _____ Religion: _____

In the event of any emergency in which the above named physicians are not available, I give my consent to provide treatment by ELLIS HOSPITAL Medical/Dental staff member on duty.

Other Pertinent Medical Information: _____

Insurance Information:

ID Number: _____ Group Number: _____

Subscriber Name: _____

Billing Address: _____

Parent/Legal Guardian Employer: _____

Employer Address: _____

Parent/Legal Guardian Phone: _____ Address: _____

Signature of Parent/Legal Guardian: _____ Date: _____



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Health History

Child's Name: _____ DOB _____

Does your child have a history of:

- ☐ High Fevers ☐ Ear Infections ☐ Colds ☐ Chicken Pox ☐ Scarlet Fever
☐ Diabetes ☐ Hepatitis ☐ Mumps ☐ Measles

Is your child on any medication? Please list medications and dosage: _____

Has your child ever been hospitalized? When and for what? _____

Has your child had any serious accidents? Describe. _____

Allergies

Does your child have any allergies? ☐ Y ☐ N ☐ Unknown

List child's allergies: _____

Signs of allergic reaction:

- ☐ Asthma ☐ Difficulty Breathing ☐ Swelling ☐ Hay Fever ☐ Hives

☐ Other: _____

Do you know what the allergy is caused by? _____

Has your child been to the dentist? ☐ Y ☐ N Dentist: _____

Has your child had: Vision Screening: ☐ Y ☐ N Hearing Screening: ☐ Y ☐ N

Is there anything you would like to share about your child's health?

Medical Release

I hereby give consent to the following healthcare agency

to release medical information on

(Child's Name)

Signature: _____ Date: _____



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Authorized Release Form

I, _____, give the following people permission to pick up my child, _____, from Rosa Venerini ECC. I, & the people listed below, understand that if someone other than myself, the parent, pick up my child, he / she will be required to present photo identification. The child will not be able to leave the center with an adult who 1. Is not listed on the registration form as a parent or 2. Is not listed on this authorization form or 3. Does not have a photo identification.

1. Name: _____
 Relationship: _____
 Phone: _____
2. Name: _____
 Relationship: _____
 Phone: _____
3. Name: _____
 Relationship: _____
 Phone: _____
4. Name: _____
 Relationship: _____
 Phone: _____

Parent Signature: _____

Date: _____

I grant permission to Rosa Venerini ECC to use my child's picture for the following purposes:

☐ Newspaper ☐ Center Website ☐ Grant Proposals ☐ Displays ☐ Video ☐ TV ☐ Social Media

-OR-

☐ I do NOT want my child's pictures used for anything other than Bloomz

Parent Signature: _____

Date: _____



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Infant Enrollment Form

Child's Name: _____ Sex: M F

Birthdate: _____ Birth Place: _____ Ethnicity: _____

Child's Home Address: _____

Home Phone: _____

1st Parent's Name: _____

Occupation: _____ Employer: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Address: (if different from child) _____

2nd Parent's Name: _____

Occupation: _____ Employer: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Address: (if different from child) _____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ other: _____

Emergency Contact(Other than parents)

1. _____ Phone #: _____

2. _____ Phone #: _____

Pediatrician: _____ Preferred Hospital: _____

Parent Signature: _____ Date: _____

Registration Fee: \$75 Cash or Check # _____

Office Staff Signature: _____ Date: _____



Infant Enrollment Form

Child's Name: _____

2019 – 2020

Hours: 7:00 am - 5:30 pm

☐ T/TH \$130/wk

☐ M/W/F \$180/wk

☐ M-F \$265/wk

****As per the OCFS requirement infants are allowed to stay in child care for a maximum of 9 hours**

Child care hours needed: _____ to _____

****Any additional hours must be Pre-approved by Director & Pre-Paid****

Sibling Discount: 10% Off on lower cost tuition

✧ Parent Contract **MUST** be read and signed by parent(s)/guardian(s) before child begins the daycare