



## CHILD CARE CENTER AND SCHOOL AGE INTAKE/UPDATE FORM

Please Print or Type Responses

NAME OF CHILD CARE CENTER	_____		
CENTER'S ADDRESS:	_____		
	_____	_____	_____
	(city)	(state)	(zip code)
COUNTY:	_____	TOWNSHIP/BOROUGH :	_____
MAILING ADDRESS:	_____		
	_____	_____	_____
	(city)	(state)	(zip code)
TELEPHONE NUMBER:	(_____) _____	ALTERNATE NUMBER (_____) _____	
FAX NUMBER	(_____) _____		
NAME OF DIRECTOR:	_____	NAME OF CONTACT PERSON:	_____
E-MAIL ADDRESS:	_____	WEBSITE:	_____

What year did the center open? \_\_\_\_\_ What is your center's total capacity? \_\_\_\_\_

If you have a preschool, can a child enroll only in your preschool program? \_\_\_ Yes \_\_\_ No

Does your center have a separate summer program that children can attend? \_\_\_ Yes \_\_\_ No

License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Is your Program Exempt? \_\_\_\_\_

State of PA ONLY: Does your center have a license from the PA Department of Education? \_\_\_ Yes \_\_\_ No

What age children does your center accept? Youngest: yr \_\_\_\_\_ mo \_\_\_\_\_ Oldest: yr \_\_\_\_\_ mo \_\_\_\_\_

### SCHOOLS

Schools Served \_\_\_\_\_

### FUNDING

Does your center receive Head Start Funding? \_\_\_ Yes \_\_\_ No State Pre-K Funding? \_\_\_ Yes \_\_\_ No

### TRANSPORTATION

\_\_\_ Transportation Provided by Center \_\_\_ Transport B/A School \_\_\_ Transport Preschool \_\_\_ Emergency Only  
\_\_\_ Walking Distance From School \_\_\_ Field Trips \_\_\_ Transport Kindergarten  
\_\_\_ Pick Up at Home \_\_\_ Public Transportation Available \_\_\_ School Bus

### LANGUAGES

If anyone on your staff speaks a language other than English, please provide the language(s)

\_\_\_\_\_

Does anyone on your staff know sign language? \_\_\_ Yes \_\_\_ No

**PROGRAM SCHEDULE** - Which program schedule does your center offer?

- Preschool 2 mornings a week       Kindergarten-Before School Care  
 Preschool 3 mornings a week       Kindergarten-After School Care  
 Preschool 5 mornings a week       Center Based Kindergarten Program

**SHIFTS**

Days of the week:  Mon  Tue  Wed  Thu  Fri  Sat  Sun Time Open \_\_\_\_\_ Time Close \_\_\_\_\_

Schedule Options: (Please check all those that apply.)

- Full-Time  Full Year  Summer Only  Temporary/Emergency  After School  
 Part-Time  School Year  Drop-in  Before School  24-Hour

**RATES** - Please Circle FT (Full-Time) or PT (Part-Time)

	Monthly	Weekly	Daily	Hourly
Newborn to 12 months	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT
12-23 months	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT
2 year olds	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT
3 years olds	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT
4-5 year olds	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT
(Not in Kindergarten)				
Kindergarten age	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT
School Age	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT	\$ _____ FT PT

Please check all that apply:

- Provides Respite Care  For Profit  Not For Profit

Which **MEAL** options does your center provide? (Please check all that apply)

- Breakfast  Morning Snack  Lunch  Afternoon Snack  Dinner  
 USDA Food Program  Evening Snack  Nursing Moms Welcome  Formula Provided  Bring Bag Lunch

What is your center's program **PHILOSOPHY**? (Please check all that apply)

- Developmental/Hands-on  Kindergarten Readiness  Preschool Readiness  Montessori  Religious

Does your center accept or provide any of this **FINANCIAL ASSISTANCE**? (Please check all that apply)

- Head Start Funding  Pre-K Funding State  Scholarship  
 Sibling Discount  Sliding Fee Scale  State Subsidy (Purchase of Care)

Does your center offer any of the following **SAFETY** measures? (Please check all that apply)

- CPR Certified  First Aid Training  Medication Certification  Nurse On-Site

Does your center have training or experience in these **SPECIAL NEEDS** areas? (Please check all that apply)

- ADD/ADHD  Autism  Developmental Differences  Diabetes  Feeding Tube  
 Hearing Impaired  Heart/Apnea Monitor  Learning Disability  Nebulizer  Physically Challenged  
 Seizures  Sight Impaired  Speech Impaired

What type of **EDUCATION** has your center staff completed? (Please check all that apply)

- Associate's Degree, Child Related  Associate's Degree, Other  Bachelor's Degree, Child Related  
 Bachelor's Degree, Other  CDA Credential/AA Degree  College Credits. in Early Childhood Ed  
 ECE/Child Dev Degree  High School Education  Master's Degree

Does your center have any **ACCREDITATIONS** or **QUALIFICATIONS**? (Please check all that apply)

- Accredited Montessori  Middle States Accreditation  NAEYC  NKAD (Preschool, Kindergarten)

What type of **AFFILIATIONS** does your center have? (Please check all that apply)

- Community Center  House of Worship  Private School  Public School  Workplace On-Site Center  
 School-Based SACC

Are there any **PETS** at your center? (Please check all that apply)

- No Pets  Outside Only  Separate from Children  Bird  Cat  Dog  
 Gerbil/Hamster  Reptile/Snake  Rabbit  Other \_\_\_\_\_

**Please include a brochure and a printed or typed summary about your program that you would like families to see on your printed profile. This custom information is truly valued by our clients, and may influence their decision as to which referrals to contact first.**

**RETURN COMPLETED FORM TO:**

**Children & Families First  
Attention: Resource Helpline  
2005 Baynard Blvd  
Wilmington, DE 19802**

**Fax Number: (302) 479-1577**

**Please call 800-734-2388 if you have any questions:**

03/11