Adirondack Community Action Program, Inc.
treet, Suite 2
P.O. Box 848
Elizabethtown, NY 12932
1-877-873-2979

WEE CARE CHILD CENTER APPLICATION

***Child to be enrolled in program*:**

First Name	M.I.	Last Name	Date of Birth	Age	M male F female

First Parent / Guardian Information:

Name of First Parent/Guardian	Relationship to child

Mailing Address	City	State	Zip Code

Primary Home Phone Number	Cell Phone	Email Address

Employment	Work Phone Number

Second Parent / Guardian Information:

Name of Second Parent/Guardian	Relationship to child

Mailing Address	City	State	Zip Code

Primary Home Phone Number	Cell Phone	Email Address

Employment	Work Phone Number

EMERGENCY CONTACTS: (Other than Parent/Guardians)

In case the Parent/Guardian cannot be reached the following people have permission to pick up my child in an event of an illness or emergency.

First Emergency Contact Information:

Name of Emergency Contact Person		
Primary Phone	Secondary Phone	Cell Phone

Second Emergency Contact Information:

Name of Emergency Contact Person		
Primary Phone	Secondary Phone	Cell Phone

Additional Authorized people who can pick up my child: (please print)

Name of Authorized Person	Contact Number
1.)	
2.)	

Medical Information:

1.) Does your child have any food allergies? ☐ Yes ☐ No
If Yes, Please list: _____

2.) Does your child have any other allergies? ☐ Yes ☐ No
If Yes, Please List: _____

3.) Is your child presently taking medications? ☐ Yes ☐ No
If Yes, Please List: _____

4.) Are there any physical conditions that the staff should be aware of concerning your child?
If Yes, Please describe: _____
_____

I agree that in case of accident or injury, emergency medical care may be given in the event that I, or the person(s) designated cannot be reached. ☐ Yes ☐ No

GENERAL INFORM

Does your family receive TANF funding? ☐ Yes ☐ No

Are you eligible for Subsidy? ☐ Yes ☐ No

What are your current child care arrangements? _____

Please provide us with special information to assist the staff in caring for your child (diet, habits, behavior, personality, likes and dislikes, nicknames, etc.). _____
_____
_____

AGREEMENTS:

Please initial each line as marked in acknowledgement.

_____Local media (press, TV stations, and newsletter publications) run news stories about ACAP and its programs. I give my permission for my child to be photographed or filmed in conjunction with news coverage of the program.

_____$50 non-refundable registration fee for all ages, due with application.

_____$145.00/wk for Infants-6 weeks to 18 months
_____$135.00/wk for Toddlers-18months to 36 months
_____$125.00/wk for Preschool-3 to 5 years

How did you learn about Adirondack Community Action Program, Inc.?	

Signature:

Parent / Guardian Signature	Date
ACAP Staff Signature	Date