CCT – Nespelem / Inchelium

Child Care Center

Application

Child Care Development Program

Nespelem Child Care Center
11 Lakes St.
Nespelem WA. 99155
Phone: 509 634-2522/2523

Inchelium Child Care Center
27 Short Cut Road
Inchelium WA. 99138
Phone: 509 722-7604

Child Care Development Program: 509-634-2775
Working Connections: DSHS 1-844-626-8687
PARENT/GUARDIAN INFORMATION:

PARENT/GUARDIAN FULL NAME: __________________________ LAST ______ FIRST ______ M.I. ______

HOME ADDRESS: ____________________________________ APT/HOUSE#: __________________

CITY: ___________________ STATE: ___________ ZIP CODE: ________________________

EMAIL ADDRESS: ______________________________ HOME#: _________________________

PLACE OF EMPLOYMENT: __________________________

WORK#: ___________________ WORK CELL#: __________________________

BEST FORM OF COMMUNICATION: _________________________

COMMENTS: _______________________________________

OTHER PARENT/GUARDIAN INFORMATION:

PARENT/GUARDIAN FULL NAME: __________________________ LAST ______ FIRST ______ M.I. ______

HOME ADDRESS: ____________________________________ APT/HOUSE#: __________________

CITY: ___________________ STATE: ___________ ZIP CODE: ________________________

EMAIL ADDRESS: ______________________________ HOME#: _________________________

PLACE OF EMPLOYMENT: __________________________

WORK#: ___________________ WORK CELL#: __________________________

BEST FORM OF COMMUNICATION: _________________________

COMMENTS: _______________________________________

CHILD'S INFORMATION

CHILD'S FULL NAME: _________________________________ LAST ______ FIRST ______ M.I. ______

NICK NAME: ______________________________________ DATE OF BIRTH: ____________

SEX: ___ FEMALE ___ MALE SOC SECURITY #: ______________

CHILD RESIDES WITH: ___ MOTHER ___ FATHER ___ BOTH PARENTS ___ LEGAL GUARDIAN

CHILD'S SCHOOL INFORMATION

SCHOOL NAME: ______________________________________ PHONE #: ______________________

SCHOOL ADDRESS: _______________________________ BUS #: _________________________

CITY: _____________________________________ STATE: ___________ ZIP CODE: __________

GRADE: ___________________________ TEACHER'S NAME: ________________________
**HOURS NEEDED FOR CHILD CARE**

- [ ] MONDAY-TUESDAY 7:30 A.M. TO 4:00 P.M.
- [ ] MONDAY HOURS ____________
- [ ] TUESDAY HOURS ____________
- [ ] WEDNESDAY HOURS ____________
- [ ] THURSDAY HOURS ____________
- [ ] FRIDAY HOURS ____________

**FAMILY INFORMATION**

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**PERSONS AUTHORIZED TO PICK UP CHILD**

**PERSON #1:**

NAME: ____________________ RELATIONSHIP: ____________________

ADDRESS: ____________________ PHONE: ____________________

CITY: ________________ STATE: _______ ZIP CODE: _______

**PERSON #2:**

NAME: ____________________ RELATIONSHIP: ____________________

ADDRESS: ____________________ PHONE: ____________________

CITY: ________________ STATE: _______ ZIP CODE: _______

**PERSON #3:**

NAME: ____________________ RELATIONSHIP: ____________________

ADDRESS: ____________________ PHONE: ____________________

CITY: ________________ STATE: _______ ZIP CODE: _______

**ANY OTHER INFORMATION THAT THE CHILD CARE CENTER NEEDS TO KNOW REGARDING THE PICK UP OF YOUR CHILD:**

______________________________________________
EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT #1:
NAME:_________________________RELATIONSHIP:_________________________
ADDRESS:_________________________
CITY:_________STATE:_______ZIP CODE:_________
PHONE#:_________________________WORK#

EMERGENCY CONTACT #2:
NAME:_________________________RELATIONSHIP:_________________________
ADDRESS:_________________________
CITY:_________STATE:_______ZIP CODE:_________
PHONE#:_________________________WORK#

EMERGENCY CONTACT #3:
NAME:_________________________RELATIONSHIP:_________________________
ADDRESS:_________________________
CITY:_________STATE:_______ZIP CODE:_________
PHONE#:_________________________WORK#

INSURANCE COVERAGE INFORMATION:

IS YOUR CHILD COVERED BY MEDICAL/DENTAL INSURANCE: __YES __NO
NAME OF INSURANCE:_________________________ID#:____________________
GROUP#:____________________HOSPITAL PREFERRED:____________________
COMMENTS:_________________________________________________________

FAMILY PHYSICIAN

NAME:_________________________OFFICE PHONE#:____________________
ADDRESS:_________________________
CITY STATE ZIP CODE

FAMILY DENTIST

NAME:_________________________OFFICE PHONE#:____________________
ADDRESS:_________________________
CITY STATE ZIP CODE
MEDICAL AUTHORIZATION FORM

CHILD'S FULL LEGAL NAME:__________________________________________

DOB____________________

DATE OF LAST TETANUS SHOT:_____/_____/_____

I,_____________________________HEREBY GIVE PERMISSION FOR THE ABOVE
TREATMENT AS DEEMED NECESSARY IN THE EVENT OF AN ACCIDENT AND/OR
EMERGENCY WHILE IN THE CARE OF THE CONFEDERATED TRIBES OF THE
COLVILLE RESERVATION CHILD CARE & DEVELOPMENT CENTER.

I,_____________________________HEREBY HOLD NO ONE PERSON, PAID STAFF
AND VOLUNTEER OF THE CENTER RESPONSIBLE IF MY CHILD HAS A REACTION TO
THE EMERGENCY MEDICAL CARE GIVEN AT THE TIME OF THE MEDICAL
EMERGENCY.

I,_____________________________UNDERSTAND CARE MAY BE PROVIDED BY OUR
LOCAL HOSPITAL(S); LICENSED PHYSICIAN, NURSE OR MEDICAL PERSONNEL;
AND/OR PHYSICIAN PEDIATRIC NURSE PRACTITIONER AT THE CONFEDERATED
TRIBES OF THE COLVILLE RESERVATION CHILD CARE DEVELOPMENT CENTERS OR
THE COLVILLE RIVAL INDIAN HEALTH CLINIC.

I,_____________________________HEREBY GIVE CONSENT FOR THE ABOVE NAMED
CHILD TO RECEIVE & BE TRANSPORTED IN REGARDS TO THE SERVICES, EXAM
AND TESTS LISTED BELOW WHEN IN NEED. I ALSO UNDERSTAND THAT THESE
SERVICES ARE DEEMED NECESSARY AND/OR ANY EXAMINATIONS EXPLAINED TO
ME UPON REQUEST......

HEARING TEST       DENTAL EXAM       STRABISMUS TEST       VISION TEST
HEMAGGLOBIN/HEMOGLOBIN       MEDICAL EXAM       IMMUNIZATIONS

HEIGHT, WEIGHT, GROWTH EXAM, AND DEVELOPMENTAL SCREENING AS DEEMED
NECESSARY.

I, being the parent/guardian of the above named child, hereby give my authorization &
consent for any and all treatment screening, and examinations as mentioned above. I hereby
agree & understand this consent shall be held valid while my child attends the Colville
Confederated Tribes Child Care Development Center.

Parent/Guardian signature:________________________

Date:__________________________

_________________________________________ Date:__________________________
MEDICAL INFORMATION:

CHILD'S FULL LEGAL NAME: ____________________________________________

DATE OF BIRTH: __________________

BIRTH HISTORY: MOTHER & CHILD

DID YOU OR YOUR CHILD HAVE ANY COMPLICATIONS DURING PREGNANCY: YES or NO

IF YES PLEASE EXPLAIN: __________________________________________

DID YOU OR YOUR CHILD HAVE ANY COMPLICATIONS AFTER BIRTH: YES or NO

IF YES PLEASE EXPLAIN: __________________________________________

WAS YOUR CHILD BORN PREMATURE? YES or NO

IF YES, HOW FAR ALONG WAS YOUR PREGNANCY? ______________________

ALLERGY/DISABILITY INFORMATION

DOES YOUR CHILD HAVE ANY ALLERGIES? YES or NO

IF YES PLEASE LIST ALLERGIES: ____________________________________

DOES YOUR CHILD WEAR GLASSES/CONTACTS? YES or NO

DOES YOUR CHILD HAVE ANY MEDICAL PROBLEMS OR CONCERNS? YES or NO

IF YES PLEASE EXPLAIN: __________________________________________

IS YOUR CHILD TAKING ANY MEDICATION? YES or NO

IF YES WHAT KIND OF MEDICATION: _________________________________

DOES YOUR CHILD'S DEVELOPMENT DIFFER FROM SIBLINGS OR OTHER CHILDREN HIS/HER AGE? YES or NO

IF YES PLEASE EXPLAIN: __________________________________________
STUDENT ENROLLEMENT VERIFICATION

GENERAL INFORMATION

STUDENT'S NAME ___________________________ TODAY'S DATE _________________

OTHER NAMES USED: ___________________ PHONE#: _____________________

SOCIAL SECURITY #: ___________ DOB: __________________________

ADDRESS: _____________________________ STATE ____ ZIP CODE _____________ CITY

PARENT/LEGAL GUARDIAN SIGNATURE __________________ DATE __________

I HEREBY AUTHORIZE THE RELEASE OF MY SCHOOL ENROLLEMENT TO BE VERIFIED BY THE COLVILLE TRIBES CHILD CARE DEVELOPMENT CENTER.

SCHOOL INFORMATION

NAME OF SCHOOL: ___________________________ STUDENT ID#: _____________

ENROLLEMENT DATE: ___________ POTENTIAL DEGREE: ______________________

ENROLLEMENT VERIFICATION:

____ FALL YEAR: ___________ F/T: _______ P/T: ________

____ WINTER YEAR: ___________ F/T: _______ P/T: ________

____ SPRING YEAR: ___________ F/T: _______ P/T: ________

____ SUMMER YEAR: ___________ F/T: _______ P/T: ________

SCHEDULED HOURS OF CLASS ______ TOTAL WEEKLY HOURS ______

SCHEDULED DAYS OF CLASS_________________________ TOTAL DAILY HOURS: ____________

SIGNATURE OF SCHOOL OFFICIAL __________________ DATE __________

TITLE __________________ PHONE NUMBER ___________
EMPLOYMENT INFORMATION
This form is to be completed and signed by your Personnel Office

GENERAL INFORMATION

NAME:__________________________________________________________

DRIVER'S LICENSE NUMBER:_____________________________________

SOCIAL SECURITY NUMBER:______________________________________

SIGNATURE_________________________DATE____________________

I hereby authorize the release of my employment to be verified by the Colville Tribes Child Care Development Center.

EMPLOYMENT INFORMATION

PLACE OF EMPLOYMENT:_______________________________________

WORK ADDRESS:_____________________________________________

STARTING DATE OF EMPLOYMENT:_______________________________

___ FULL TIME       ___ PART TIME          ___ ON CALL

POSITION TITLE:_________________________SALARY:__________________

SCHEDULED HOURS OF WORK:_____________________________________

SCHEDULED DAYS OF WORK:_____________________________________

SUPERVISOR'S NAME:___________________________________________

AUTHORIZED PERSONNEL SIGNATURE ___________________DATE_______

TITLE_________________________________PHONE NUMBER_______
EMPLOYMENT INFORMATION
This form is to be completed and signed by your Personnel Office

GENERAL INFORMATION

NAME: ____________________________________________

DRIVER’S LICENSE NUMBER: _____________________________

SOCIAL SECURITY NUMBER: _____________________________

SIGNATURE ________________________________________  DATE __________

I hereby authorize the release of my employment to be verified by the Colville Tribes Child Care Development Center.

EMPLOYMENT INFORMATION

PLACE OF EMPLOYMENT: ________________________________

WORK ADDRESS: ______________________________________

STARTING DATE OF EMPLOYMENT: ________________________

FULL TIME PART TIME ON CALL

POSITION TITLE: _______________________________ SALARY: _______________________________

SCHEDULED HOURS OF WORK: ____________________________

SCHEDULED DAYS OF WORK: ____________________________

SUPERVISOR'S NAME: ________________________________

AUTHORIZED PERSONNEL SIGNATURE __________  DATE __________

TITLE: __________________________ PHONE NUMBER: __________________________
CONFIDENTIAL

TRIBAL CERTIFICATION

Parent's Name: _______________________________ Date of Birth: __________

__________________________________________

Date of Birth: __________

Social Security Number: ___ - ___

Enrollment #: __________

Social Security Number: ___ - ___

Enrollment #: __________

CERTIFIED BIRTH CERTIFICATE MAY BE REQUIRED UPON TRIBAL
ENROLLMENT OFFICER'S REQUEST

PLEASE CHECK THE APPROPRIATE BOX:

____ -- I, certify that ___________________________ is an enrolled member of the
Colville Confederated Tribes with the enrollment number of _________________.

____ -- I certify that ___________________________ is a descendant of the
Colville Confederated Tribes.

____ -- I certify that ___________________________ is neither an enrolled member,
Nor a descendant of the Colville Confederated Tribes.

Colville Confederated Tribes Enrollment Officer __________ Date __________
TO ENSURE THAT YOUR ENROLLMENT APPLICATION IS COMPLETE, AND THAT YOUR CHILD IS ENROLLED IN OUR PROGRAM, YOU MUST SUBMIT THE FOLLOWING NECESSARY DOCUMENTS:

- TRIBAL ENROLLMENT/ANCESTRY CERTIFICATION COMPLETED BY THE COLVILLE TRIBES ENROLLMENT OFFICER.

- PROOF OF INCOME SUCH AS 1040 TAX RETURN, W-2s, AND/OR PROOF OF AT LEAST TWO MONTHS OF CURRENT EMPLOYMENT OR INCOME VERIFICATION I.E. PAY STUBS, bank deposit records, child’s personal use income verification, and/or TANF VERIFICATION.

- COPY OF BIRTH CERTIFICATE

- A SIGNED EMPLOYMENT VERIFICATION COMPLETED BY PERSONNEL

- COPY OF PARENT/GUARDIAN PICTURE IDENTIFICATION I.E. DRIVERS LICENSE, WASHINGTON STATE I.D.

- COPY OF ‘ANY LEGAL DOCUMENTS PERTAINING TO THE CHILD’S GUARDIANSHIP, CUSTODY, OR VISITATION RIGHTS.

- COPY OF YOUR CHILD’S PHYSICAL EXAM; SIGNED AND DATED BY YOUR PHYSICIAN

- COPY OF CHILD’S IMMUNIZATION RECORDS

I CERTIFY THAT I WILL KEEP UP THE FOLLOWING INFORMATION UPDATED AND NOTIFY THE COLVILLE TRIBAL CHILD CARE DEVELOPMENT CENTER OF ANY CHANGES.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE

PARENT/LEGAL GUARDIAN SIGNATURE

DATE
ACKNOWLEDGEMENT OF RECEIPT

By signing this document acknowledges that I have received the Parent Handbook from the Colville Tribal Child Care Center where my child is enrolled.

__________________________________________  __________________________
Parent Signature                               Date