E. JOHN
GAVRAS
CENTER

www.gavrascenter.com

182 North Street • Auburn, New York 13021

888-255-2746 or 315-255-2746

Child Care Program

We welcome you and your child to our Child Care Program! We are excited for your child to be here with us. The E. John Gavras Center 's main focus is the safety of your child. This is done with professionally trained staff members that will be working with your child.

Our program is available from 6 am- 6 pm each day and can be operating 7 days a week. We are providing services for children from infant – 12 years old.

Our program will provide a safe and quiet location for sleeping, as well as activities for them, such as; games, snacks and meals will be provided.

Enclosed is a registration packet. Please review the forms carefully, fill them out and return them to us. We will also need a copy of your child's current physical and immunizations records.

This packet is so that we can have some background information on your child, as well as the ability for treatment if any first aid is needed. We will have your permission on file to do so.

Any questions you can contact Kenneth Ward at (315) 255-2746.

Respectfully yours,

Kenneth Ward
Principal of Educational Services

OCFS-LDSS-0792 (10/2018) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

Child's Full Name: Preferred Name/Nickname:	Date of Birth: / /	Gender:
Child's Home Address:		
Name of Person Enrolling Child:	Relationship to Child: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____	
Phone Number(s) of Person Enrolling Child: ( ) - ☐ ok to text **Email Address:**	Address of Person Enrolling Child (if different than child):	

EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	Primary Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
		☐ Yes ☐ No	☐ ok to text	☐ ok to text
		☐ Yes ☐ No	☐ ok to text	☐ ok to text

For Program Use Only Date of Enrollment: / /	*For Program Use Only* Date of Disenrollment: / /

OCFS-LDSS-0792 (10/2018) REVERSE

Child's Full Name:	Date of Birth: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

Child's Primary Care Physician's Name/ Group:	Phone Number: ( ) -
Preferred Hospital:	Phone Number: ( ) -
Child's Dental Care:	Phone Number: ( ) -

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child..... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year..... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

E. JOHN GAVRAS CENTER

Student Emergency/ Health Assessment Form

Student's Name: _____ Date of Birth: _____

Residential Address: _____ Email: _____

Mother Name _____ Father Name: _____

Home #: _____ Home #: _____

Cell # _____ Cell #: _____

Place of Employment: _____ Place of Employment: _____

Work #: _____ Work #: _____

IN AN EMERGENCY, WHEN YOU CANNOT BE REACHED BY THE SCHOOL, I AUTHORIZE THE SCHOOL TO CALL:

_____

Name of Physician Address Phone

THE FOLLOWING ARE PERSONS AUTHORIZED TO PICK UP MY CHILD/CHILDREN:

1. _____
   Name Relationship Address Phone
2. _____
   Name Relationship Address Phone
3. _____
   Name Relationship Address Phone

Custody: This school assumes that both parents have full parental and residential custody. If this is not the case, it is the responsibility of the parents to provide the school with that portion of the divorce decree or separation agreement that articulates parental and residential custody. Should any changes occur during the year, please inform the school.

_____Please check here if the school should expect a custody document.

HEALTH HISTORY/Has your child had any history of the following:

Allergies	yes___No___	Sever Headaches	yes___no___
Asthma	yes___No___	Head injury/ concussion	yes___No___
Bee sting/ hay fever	yes___No___	Heart problems	yes___No___
Asthma	yes___No___	High blood pressure	yes___No___
Anemia	yes___No___	Frequent nose bleeds	yes___No___
Arthritis	yes___No___	Back injury/ pain	yes___No___
Bladder/Kidney problems	yes___No___	Bone/ joint injury	yes___No___
Convulsions/ Seizures	yes___No___	Neck injury	yes___No___
Fainting spells	yes___No___	Ligament/ tendon injury	yes___No___
Diabetes	yes___No___	Muscle injury	yes___No___
Ear/ hearing problems	yes___No___	Stomach problems	yes___No___
Eye/ vision problems	yes___No___	History of MRSA	yes___No___
Surgery	yes___No___		

Illness or injury that lasted longer than a week or required emergency medical attention yes___No___

* If you answered "yes" to any of the above questions, please explain: _____

Medications: _____ Reason taking: _____

_____ _____

Parent/ Guardian Signature: _____ Date: _____

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Child Care Payment Policy

1. Child care is available starting at 6:00 am and ending at 6:00pm available 7 days/week. We are providing services for children from infant – 12 years old..

2. Child care Rates are as follows:
   A. Weekly rates (30+ hours/week)**
   B. Daily Rates (less than 30 hrs/wk, but at least 6 hours/day)
   C. Part-day Rates (between 3 hours and less than 6 hours/day)
   D. Hourly Rates (less than 3 hours/day)

Age of Child

	Under 1 1/2	1 ½ -2	3-5	6-12	*Special needs - any age
A	$220/wk	$206/wk	$195/wk	$180/wk	$406/wk*
B	$48/day	$45/day	$44/day	$39/day	$69/day*
C	$32/day	$30/day	$29/day	$26/day	$46/day*
D	$8/hr.	$8/hr.	$8/hr.	$7/hr.	$17/hr.*

**There will be an extra charge for additional days beyond a 5 day week for the weekly rate

3. Payment for the week is expected on the following Monday

4. As with any child care center, a schedule for your child's attendance creates the staffing for the day. Therefore, if your child does not attend on a scheduled day, you will be billed for that time missed.

5. If your child is ill, then we ask that you contact Jackie Drechsler, at (315) 406-6154. Our nurse will follow up with you regarding your child's return.

6. Should you fall behind in your payment schedule by 2 weeks, your child will not be allowed to attend child care until your obligation has been satisfied. We are not obligated to hold your placement open and can fill from our waiting list. The agency would like to avoid this situation if at all possible, and we encourage you to make immediate arrangements with the Business Office if it appears you will be unable to meet your obligations. We feel it is in the best interest of you, your child, and the Center, to work together.

7. We have several ways for you to submit payment:
   A) in person at the front office at 182 North Street (we accept cash, check or credit cards)
   B) by credit card over the phone
   C) on-line at our website – gavrascenter.com – by clicking on the "Donate" link and entering your information, please be sure to enter under #4 Additional Information – that the payment is for Child Care, as well as your child's name.

E. JOHN GAVRAS CENTER

182 North Street
Auburn, NY 13201
888-255-2746 or 315-255-2746
Fax: 315-255-2740

Emergency Treatment Release

Please complete this form and return to the E. John Gavras Center

First Name:		Last Name:	
Date of Birth:		Date:	

I hereby give my permission to the E. John Gavras Center to obtain emergency medical treatment for

_____

This permission is valid only in the event I am unavailable and cannot be contacted. If this is so, Mr. Kenn Ward, Principal of Educational Services of the Gavras Center, or his designated representative, must give authorization at the time of the emergency.

_____ _____

Date Signature (Parent/Guardian)

_____ _____

Date Kenn Ward, Principal of Educational Services

gavrascenter.com

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Sunscreen, Lotion, and Ointment Application Permission Form

Written permission is required for the Gavras Center nurse to apply sunscreen, lotions, and ointments to your child while in school. Families are responsible for providing sunscreen in its original container, labeled with the child's full name. We ask that you first test the sunscreen at home to rule out sensitivity reactions. Please do NOT provide sunscreen that has not been used on your child at home. The Health Office keeps A&D ointment, petroleum jelly, Calamine lotion, Caladryl lotion, and triple antibiotic ointment on hand for as needed use.

I will provide _____ sunscreen for my child's use during the 20__-20__ school year. This sunscreen has been previously applied to my child and did not cause a sensitivity reaction.

Please indicate below which lotions/ointments you wish to be applied to your child on an as needed basis. Items not checked will not be applied to your child.

I give permission for

_____ A&D ointment

_____Petroleum jelly

_____Calamine lotion

_____Caladryl lotion

_____Triple antibiotic ointment

to be applied to my child while he/she is in school during the 20__-20__ school year.

_____

Parent/Guardian's name (please print)

_____ _____

Parent/Guardian's Signature Date

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Auburn, NY 13021
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Fax: 315-255-2740

Napping Agreement

Day Care children are offered the opportunity to rest or nap after lunch per OCFS Regulation 418-1.7. Day Care children are provided with a cot to sleep on. Parents are encouraged to send in a blanket and/or a comfort item (i.e.: stuffed animal, doll, etc.) for their child to use during nap time. Children unable to sleep during nap time shall not be confined to a sleeping surface (cot) but instead will participate in afternoon programming.

Children will not be left without supervision at any time. All children will be within a teacher's range of vision and near enough to respond when assistance is needed. When a child day care center is in operation, an adequate number of qualified teachers must be on duty to insure the health and safety of the children in care.

Please sign and return this page if you are in agreement.

I have reviewed the Napping Agreement.

Parents Name: _____

Parent Signature: _____

Child's Name: _____

Date: _____

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Photo Release

NOTICE: To ALL individuals attending the E. John Gavras Center operated by U.C.P.A. of Cayuga County, Inc.

Name: _____ Date of Birth: _____

_____ I hereby deny any pictures to be taken.

_____ I hereby authorize and give permission to the E. John Gavras Center to use my/my child's picture. Please check the following that apply:

_____ Television

_____ Newspaper

_____ In-house presentations for parents

_____ Informational presentations for students, community groups, etc.

_____ Classroom birthday parties

_____ Special Events

_____ Field Trips

_____ Video Children/Adults for purpose of evaluating progress

_____ Class/Group Pictures

_____ E. John Gavras Center Website

_____ Child's "cubbie" (locker)

Signature of Parent/Guardian/Self is required

Signature: _____ Date: _____

Form Revised: 03/2020 62030 rev0

OCFS-6050 (03/2020)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

EMERGENCY RESERVATION FORM

Child's Full Name:	Date of Birth: / /	Gender:

Instructions

- To be completed by parent/guardian prior to emergency reservation.
- A parent/guardian signature is required.

The following questions must be answered:

☐ Yes ☐ No Within the last 14 days, has your child traveled to a country that the federal Centers for Disease Control and Prevention said should be avoided for nonessential travel or where travelers should practice enhanced precautions? (China, Iran, Italy, South Korea, Japan)?

☐ Yes ☐ No Has your child had contact with any **person with known COVID-19 or person under investigation for COVID-19**?

☐ Yes ☐ No Does your child have any symptoms of a respiratory infection (e.g., cough, sore throat, fever, shortness of breath)?

☐ Yes ☐ No Are you or anyone in your home in active quarantine status?

☐ Yes ☐ No Is your child enrolled in a school or child care program?
If yes, please provide the name(s) of your child's school and/or child care program:

☐ Yes ☐ No Is your child's school under mandatory closure due to a confirmed case of COVID-19?

☐ Yes ☐ No Is your child's current program under mandatory closure due to a confirmed case of COVID-19?

Contact Information

Child's Home Address:			
Parent's Name and Address (if different than child):			
Parent's phone contact (home, cell and work):			
EMERGENCY CONTACT NAMES/ADDRESSES	**AUTHORIZED TO PICK UP CHILD**	**PRIMARY PHONE NUMBER ( ) -**	**OTHER PHONE NUMBER/EMAIL ( ) -**
Primary Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
Emergency Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
Emergency Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text

Health Specifics		Comments
Does your child have any allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify diet and condition)	☐ Yes ☐ No	
Is a special diet required?	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Child's Healthcare Provider Information

Child's Primary Care Physician's Name/Group:	Phone Number: ( ) -
Preferred Hospital:	Phone Number: ( ) -
Child's Dental Care:	Phone Number: ( ) -

Agreements

- I consent to emergency medical treatment for my child. ☐ Yes ☐ No
- My child is up to date with required immunizations. ☐ Yes ☐ No

The above information regarding my child's health is true and accurate. To the best of my knowledge, my child is free from contagious and communicable disease and is able to participate in this program.	
Parent/Guardian Signature:	Date: / /
Printed Name:	

E. JOHN GAVRAS CENTER

Monthly Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Please fill in the days and times your child/children will be here with us so that we can ensure having enough staff. If you do not do this and return this form to us we will not be able to serve them. – Thank you

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Dear Parent/Guardian,

The Gavras Center insures that all children in program are offered a snack. The full day children are offered an AM and a PM snack.

As part of the full day programming, the Gavras Center is offering a no cost lunch, which will be supplied by the Auburn School District. If your child has a food allergy or is particular about what he/she eats, then we would ask that you supply the lunch with them.

The form that is included with this letter is needed from every family that is attending Gavras programs so that we can be reimbursed for the cost that is associated with supplying the snacks and meals. We ask that you please return this reimbursement form as soon as possible. Please know that all information that you provide will be kept confidential. We are required to send statistics to New York State Department of Health, as part of the participation agreement for this program.

If you have any questions, please feel free to call (315) 255-2746. Thank you for your time and patience as we get this program going.

Best regards,

Kenneth Ward
Principal of Educational Services
E. John Gavras Center
(315) 255-2746 ext: 2108

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME E. John Gavras Center

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER ☐☐☐☐

DATE _____

USDA is an equal opportunity provider and employer.

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Child Care Program

As part of our Child Care Program we are asking that you bring some essentials that we do not supply at our program. Some of these are necessities and some of these are just nice for the kids to have to help them feel comfortable. Please mark your child's name on all of their items. We are asking that you take your child's personal belongings home daily to clean and sanitize them.

Infants	Toddlers	Youth – Age 12
Formula	Special Dietary preferences	Water bottle (No glass please)
Bottles	Bottles/ Sippy Cups	Change of clothes
Pacifiers	Bibs	Tablets
Bibs	Wipes	Book
Wipes	Diapers/Pull Ups	Any school work to be done
Diapers	Changes of clothes	
Changes of clothes	Diaper cream	
Diaper cream	A & D ointment	
A & D ointment	Stuffed animal/toy	
Baby rattle/toy	Blanket	
Blanket	Pillow	

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Dear Families,

Governor Cuomo announced recently that CARES Child Care Scholarships are available through the CCRR agencies for essential workers earning up to 300% of poverty. The CARES scholarship will cover the time from April 20th, 2020to May 15, 2020 with the possibility of extension if funding lasts. The scholarship will pay for your weekly rate up to the Market Rate for Cayuga County.

What the Gavras Center has been told is that our families need to apply for this scholarship 1st, they are not eligible if they have already applied to LDSS; however, they can apply to LDSS (local Department of Social Services) later if this funding runs out. Please refer to the following chart for parent eligibility guidelines:

Family Size	Household Salary Eligibility (Max)
2	$51,720
3	$65,160
4	$78,600
5	$92,040
6	$105,480
7	$118,920
8	$132,360

Parent Application for CARES child care scholarship links:

a. English - https://forms.gle/MJ95dpSdP6ehMfFF9
b. Chinese - https://forms.gle/zvZnNi1fqJ3mc4Ew6
c. Spanish - https://forms.gle/qFRKZpVsaG7ZpwAx7

Please go to the website listed above, and fill out the application on line to determine if you are awarded this scholarship. It may take them a little time to get back to you with so many families going for this scholarship.

If you get denied due to lack of funding, you can then fill out forms for our local DSS. These are the income level guidelines currently in effect. If anyone has any questions about their potential eligibility prior to completing the application packet they can contact:

Jeanette Murray, Senior Examiner
Day Care Unit/Employment Unit
Cayuga County DSS
Genesee Street, Auburn, NY 13021
(315) 253-1218
Fax: (315) 253-8050 (Daycare)

If you have any questions for the Gavras Center please call 315-255-2746 and ask for Tracey Lee.

Sincerely,

Kenneth Ward
Principal of Educational Services