Application

Date of Application: _____
Child's Name: _____

FSA Child Care Center
170 North Street
Dryden, NY 13053
607-844-8211 x4477
Cg069@tompkinscortland.edu
Fax: 607-844-6547

Anticipated start date: _____

Days/hours: M_____ T_____ W_____ TH_____ F_____
(time) (time) (time) (time) (time)

Enrolling Child's Information

Child's legal last name: _____ First: _____ MI: _____ Nickname: _____

Date of birth: _____ Gender: M F Primary language at home: _____

Race: Black____ White____ Hispanic/Latino____ American Indian____ Asia/Pacific (specify) ____

Multi-racial (specify) ____ Other (specify) _____

Family Information

Parent/Guardian's name: _____ Parent/Guardian's name: _____

Relationship to child: _____ Relationship to child: _____

Street Address:_____ Street Address:_____

City, state, ZIP: _____ City, state, ZIP: _____

Phone: Cell_____ Work_____ Phone: Cell_____ Work_____

Home_____ Email_____ Home_____ Email_____

Current TC3 Student: **Yes** **No** # of Credits?_____ Current 3 Student: **Yes** **No** # of Credits?_____

Currently employed? **Yes** **No** Currently employed? **Yes** **No**

TC3 employee? **Yes** **No** TC3 employee? **Yes** **No**

New York State Employee? Yes No New York State Employee? **Yes** **No**

Do you receive public assistance (TANF, WIC, EBT): **Yes** **No** Do you receive Child Care Assistance: **Yes** **No**

Family's yearly gross income (income before taxes and deductions): _____

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Family Members and significant others living in the home

First and last names of ALL the other children and household members not listed on this application:

Name:_____ Gender_____ Relationship to child_____ Age_____

Name:_____ Gender_____ Relationship to child_____ Age_____

Name:_____ Gender_____ Relationship to child_____ Age_____

Has your child been diagnosed with, or is your child suspected to have, any of the following that might require special education and related services? Do you have other concerns about your child? Please check all that apply:

Speech/Language impairment____ Physical impairment____ Emotional/Behavioral disorder____
Vision impairment/blindness____ Developmental delay____ No concerns____

Health Concerns (specify) _____

Other Concerns (specify) _____

Parent/guardian Signature: _____ Date: _____

For office use only:

Acceptance Date: _____ Start Date: _____ Weekly Tuition Amount: _____

Agreed On Weekly Schedule:

Monday	Tuesday	Wednesday	Thursday	Friday

Parent Signature: _____ Director Signature: _____