EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.181 & 182; 3280.124 (a) (b), 3280.181 & .182; 3290.124 (a) (b), 3290.181 & .182

CHILD'S NAME	DATE OF BIRTH
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S) NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL SITUATION
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST-AID PROCEDURES**
WALKS AND TRIPS	SWIMMING N/A
TRANSPORTATION BY THE FACILITY	WADING N/A

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

Care, Meals, Activities and Outside play.

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $1.00	PER MIN-HR Min. after 6pm	See Emergency Contact

Extra services to be provided at an additional fee if applicable
Field Trips and Activities fee *

*Activities fee applies to School Age Summer Program

☑ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☑ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE

Discover the World Children's Center

Admissions Agreement

The center shall provide the following basic services for:

Name of child being enrolled _____ Child's Birthdate_____

Name of Parent or Guardian and relationship _____

1. I am enrolling my child for the following days Monday Tuesday Wednesday Thursday Friday
2. I am enrolling my child during the following hours _____
3. The child will be furnished with healthy meals and snacks. Each will depend on the hours enrolled.
4. The child shall be given assistance with personal care needs.
5. The child shall be provided with the opportunity to nap in the afternoon, on a cot provided by the center.
6. The child shall be involved in a program of play and learning experiences that are appropriate for the age of the child. A balance of active and quiet play is provided, with individual and group activities geared towards the social, emotional, physical, language, cognitive, and individual growth of young children.
7. The center will assume responsibility for the child after the child is signed in by the parent or guardian and will relinquish responsibilities to the parent or guardian after the child is signed out.
8. The child will be administered physician-prescribed medication, and non-prescription medication only upon the written request of the child's parents or guardian, and by filling out a form at the center. The center shall have no responsibility of any kind whatsoever for failure to provide requested prescription medication, or for adverse reactions caused by the administration of such prescription medication. We reserve the right to deny administering medication. We shall not ever give cough or flu medication under any conditions. Note: We will not be responsible for administering medication for the first time due to the risk of a possible allergic and/or adverse reaction.
9. The center shall give appropriate first aid for injured children. A parent or guardian shall be contacted if it is the judgement of the staff that immediate medical attention is necessary. If it is further the judgement of the staff that if the injury is of an emergency nature, paramedics shall be called to the center and a parent or guardian shall be contacted.
10. An ill child shall be isolated and given appropriate care until a parent or guardian, or designated representative arrives for pick-up.
11. The center shall notify the child's parents or guardians of suspected exposure to a communicable disease.
12. The director or any other staff members shall report to Children's Protective Services or Childline, any suspicion of child abuse, sexual or otherwise, neglect, or endangerment of which they may become aware.

Obligations of Parents or Guardians:

1. The parents or guardians need to complete all enrollment paperwork prior to your child/children's start date.
2. A completed health assessment from the child's physician or nurse practitioner must be completed and/or scheduled within 14 days of enrollment. If not submitted within 30 days of enrollment, child will be dis-enrolled from the program.
3. A parent, guardian, or designated representative of the child shall bring the child to the center building and into the classroom upon arrival.
4. A parent, guardian, or designated representative of the child's parents or guardians shall make sure the child's teacher is aware of the child leaving before taking the child from the premises.
5. The parents or guardians shall notify the center when someone other than those named on the Emergency Contact/Parental Consent will be picking up the child. ID is mandatory for this type of pick-up.
6. The center will provide nutritious meals and snacks for a child who is present during the following times: Breakfast 7:00-8:30 am, AM Snack 10:00-10:15am, Lunch 11:15-12:00 pm, and PM snack 2:30-3:00pm. During breakfast and lunch, the child will be able to eat as much as they choose.
7. The parents or guardians will see that the child is dressed appropriately when brought to the center. We cannot leave a child inside due to illness. We go outside daily and if the child is not healthy enough to go outside, the child cannot attend.
8. The parents or guardians shall notify the center of the child's possible exposure to a communicable disease. We will notify other parents within the center about the disease, although the name of the child will not be released.
9. The parents or guardian shall notify the center when the child is absent.
10. The parents or guardians shall abide by the parking rules of the center.
11. The parents or guardians shall notify the center when the child will not be picked up at the time specified.
12. The parents or guardians shall remain from reprimanding children of other families while on the premises.
13. The parents or guardians must give at least a two week notice when withdrawing a child. You will be charged for this time period.

Discover the World Children's Center

Termination of the Agreement:

1. The parents or guardians of the child will not allow their accounts to become delinquent.
2. Failure of the parents or guardians to honor the obligation listed in this agreement or in any rules, regulations, or manuals promulgated or provided by the center.
3. The center in its sole and unfettered discretion determines that it is unable to meet the needs of the child.
4. The center in its sole and unfettered discretion determines that is not in the best interests of the program or other children enrolled at the center to have the child in attendance.
5. Failure of the child's parents or guardians to cooperate with the center which the center determines in its sole and unfettered discretion is serious and may warrant termination of your child/children's enrollment.

Modification clause:

This agreement may be modified whenever any of the circumstances covered by this agreement changes. Such modification will be done in writing and must be signed and dated by the parties involved in order to be binding and effective. Oral modifications are not biding under this agreement and shall not be enforceable under any condition.

Other

This provides that:

The parties to this agreement are aware of the Department of Human Services right to interview the child and the center staff, and to inspect and audit all records maintained by the center, without securing the prior consent of anyone. The parties are also aware of the licensing agencies right to observe the physical condition of the child, including conditions involving abuse or neglect, and to have a licensed medical professional physically examine the child, if provided for by the laws of Pennsylvania.

Signatures to Agreement:

For services listed in this agreement, and in accordance with the terms of this agreement, I agree to pay Discover the World Children's Center Inc. the weekly sum of _____. I further agree to pay the registration fee of $75.00. If my child is absent for any reason or the center is closed I agree to pay the weekly sum. I agree to cooperate with the general policies of the center; to perform the obligations of parents or guardians set fourth in this agreement; and to abide by the rules, regulations, and manuals promulgated and provided by the center. My signature below indicates that I have read the terms of this agreement and the rules promulgated and provided by the school, as well as the parent handbook. It further indicates that I have had this material explained to me, if necessary and that all my questions have been satisfactorily answered.

Parent/Guardian _____ Parent/Guardian_____

Dated _____ Dated _____

Director_____ Dated _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Discover the World Children's Center

Individualized Education Plans (IEP) and Individualized Family Service Plans (IFSP)

Your Child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

1. I am providing a copy of my child's IEP or IFSP. ☐
2. I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child. ☐

Signature_____ Date_____

Printed Name_____

Child's Name_____

I _____, have read and understand the procedures and policies outlined in Discover the World Children's Center Family Handbook. I, as the parent or legal guardian, will adhere to the handbook.

Signature_____ Date_____

Discover the World Children's Center

I, _____, authorize Discover the World Children's Center to release my child(ren) to the person(s) designated. This is in consonance with the Bradford County Emergency Operations Plan.

Student's Name	Designated Custodians, Name and Relationship
_____	_____
_____	_____
_____	_____

Your Signature _____ Date_____

Relationship_____

Print your Name _____

Address_____

Cell Phone Number_____

Note: Parents and Guardians should designate themselves as designated custodians. Friends, neighbors, and other relatives may also be designated.

Discover the World Children's Center

You, as parents and guardians need to be informed of provisions in Discover the World Children's Center Emergency Operation's Plan. This document will provide the information that you need.

To the parents/guardians of _____:

This document is to assure you of our concern to the safety and welfare of your child/children enrolled at Discover the World Children's Center. Our Emergency Operation's Plan, provides for response to all types of emergencies. Depending on the circumstances of the emergency, we will use one of the following protective actions:

- Immediate evacuation- Students are evacuated to a safe area on the grounds of the facility in the event of a fire, etc.
- In-place sheltering- Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the building is the best immediate response.
- Evacuation- Total evacuation of the facility may become necessary if there is a danger in the area. In this case, children will be taken to one of our other locations (205 Main St., Athens; 62 Pitney St., Sayre; or 2431 Pennsylvania Ave., Sayre)
- If needed, the following relocation facilities will be used:
  South Waverly Borough Hall, Pennsylvania Avenue, South Waverly Borough, PA
  Spalding Memorial Library, Athens, PA
- A sign will be posted on the entrance door (if possible), to indicate that we have left and where we have relocated. Provisions will be made to contact parents or guardians as soon as possible. ProCare messages will be sent, if that form of communication is available.
- Modified Operation- This may include cancellation/postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems that make it unsafe for students (such as utility disruptions) but may be necessary in a variety of situations.

Please listen to the radio station 102.1 for announcements relating to any of the emergency actions listed above (if necessary or possible).

As stated above, ProCare messages will be sent if that form of communication is available.

We will contact you when we've resolved the situation and it's safe for you to pick up your child.

The facility directors may provide an alternative phone number to call in an emergency event.

The form designating people to pick up your child is included with this document for you to complete. This form will be used every time your child is released during an emergency situation. Please ensure that only those persons you list on this form attempt to pick up your child.

I specifically urge you not to attempt to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff we ask your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures please contact Lisa Scheftic.

Discover the World Children's Center

Exclusion from Child Care Policy

When a child becomes ill, but does not require immediate medical treatment, a determination must be made whether the child requires exclusion from the childcare.

The teacher/parent should determine the following:

1. Illness prevents them from participating comfortably in activities as determined by the staff of the child care program or school.
2. Illness results in a need for care that is greater than the staff of the program can provide without compromising the health and safety of other children, and their ability to proceed with the daily schedule.
3. Illness poses a risk of spreading of disease to others.

We have listed the most common conditions that do require immediate exclusion from the program. If your child exhibits any of these symptoms at home, we ask that you call us to let us know your child will not be attending. If we notice the following symptoms, we will notify you immediately to pick up your child.

- The child appears to be severely ill.
- Fever- above 100.4 degrees and behavior change or other signs and symptoms (sore throat, rash, vomiting, diarrhea)
- Diarrhea- defined by watery stool, decreased formed of stool that is not associated with changes of diet, and increased frequency of passing stool that is not contained by the child's ability to use the toilet. (if the child does not make it to the toilet the child must go home.) the child may return when the diarrhea resolves,
- Vomiting- One or more times, unless vomiting is determined to be caused by a non-communicable condition and the child is not in danger of dehydration. The child may return once the vomiting has ceased for 24 hours.
- Abdominal Pain- that continues for more than 2 hours or intermittent pain associated with fever or other signs or symptoms.
- Mouth Sores-with drooling.
- Rash-With fever or behavioral changes.
- Conjunctivitis
- Tuberculosis
- RSV-Contagious period: The virus can be shed for 3-8 days, however, infants can continue to spread the virus, even after symptoms subside, for up to 4 weeks. The child may return after being fever free for 48 hours.
- Impetigo- until 24 hours after treatment has started.
- Streptococcal pharyngitis (Strep Throat or other streptococcal infection)-until 24 hours after treatment has started.
  Head lice or nits- until after first treatment.
- Scabies- until after treatment has been given.
- Chickenpox (Varicella)- until all lesions have dried or crusted (Usually 6 days after onset of rash).
- Pertussis-Until 5 days of appropriate antibiotic treatment.
- Mumps-Until 9 days after on set of parotid gland swelling.
- Measles-Until 4 days after onset of rash.
- Hepatitis A virus infection: until 1 week after onset of illness or jaundice or as directed by the health department
- when immune globulin has been given to the appropriate children and adult contacts.
  Influenza (Flu)- Contagious from the day before signs or symptoms appear until 7 days after the onset of flu. The
- child may return after being fever free for 48 hours.
  Any child determined by the local health authority to be contributing to the transmission of illness during an
- outbreak.

Discover the World Children's Center

While your child is enrolled in this program, he/she will be involved in special activities for which we need your permission. Please read the following information carefully. You are encouraged to ask questions about anything which is unclear to you. You, of course, have the option of denying permission at any time.

Child's Name _____

Please check your choice:

I do ☐ /do not ☐ give permission for my child to go on walks with a teacher and class.

From time to time, photographs of our program will be taken for educational and publicity purposes. These pictures will be representative of the enriching experiences offered to your child during the year. Once a year, a local photographer takes individual as well as class pictures of all the children that attend Discover the World Children's Center. The same photographer takes pictures of our graduating Pre-k class once a year. These photos are available for purchase through an on-line link.

I do ☐ /do not ☐ give permission for my child to be photographed for use in educational or promotional purposes.

I do ☐ /do not ☐ give permission for my child sun block to be applied to my child. I understand that I need to supply sun block for my child.

The director is available to meet with you if you have any further questions or concerns.

This permission or lack thereof is applicable for the duration of enrollment unless otherwise notified

Signature of parent or guardian _____

Date _____

Discover the World Children's Center

Getting to know your child

Name _____

Parent and/or Guardian Name_____

Meeting Date/ Enrollment Date _____

People who live with your child _____

Do you have any custody issues we should be aware of _____

_____

Does your child go by a nickname that you would like us to call him or her _____

_____

Has your child been in an early learning program before, if so for how long_____

_____

Is there a reason for leaving the program that you would like to share _____

_____

We would be interested in previous program information about your child to help us better understand your child _____

_____

Do you have any concerns about your child's first day with us_____

_____

Any special needs that require special care by our teachers _____

_____

Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know _____

What are your child's favorite toys and games _____

Any imaginary friends _____

Special problems or fears _____

Nail biting _____

Thumb sucking _____

Stuttering _____

Discover the World Children's Center

Food likes and dislikes _____

Food allergies _____

Environmental allergies _____

Is your child toilet trained _____

Does your child have an IEP and/or IFSP _____

Allergies to medicine _____

How are the allergies treated and what are the symptoms _____

_____

Is there information that will help us make the first few days in our program easier for your child

_____

Is there any other information that you would like to share _____

_____

What are your expectations of the program_____

_____

Pease let us know if you have any further questions or concerns _____

_____

Please provide an e-mail address so that we can add you to our ProCare system. This will give you access to your child's ProCare account.

Parent Name: _____

Parent Email : _____

Parent Name : _____

Parent Email : _____

Thank You,

Lindsey Burns

pennsylvania
DEPARTMENT OF EDUCATION

CACFP Infant Enrollment Form

Center/Provider Name:_____

Dear Parent/Guardian,
This childcare center/provider participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires childcare centers/providers to follow specific meal patterns according to the age of the infant.

Childcare centers/providers participating in the CACFP **are required** to offer at least one iron fortified infant formula for infants who are enrolled in care. You may decline the infant formula offered, and supply breast milk and/or your own CACFP approved iron-fortified formula.
(NOTE: A CACFP approved iron-fortified formula must have 1 mg of iron or more per 100 calories of formula when prepared using the label directions and must be regulated by the FDA.)

Additionally, when you determine, in consultation with your physician, that your infant is developmentally ready, the childcare center/provider will also be **required** to offer iron fortified infant cereal and other infant foods.

Infant's Name_____Infant's Date of Birth_____

Iron Fortified Formula offered by the Center/Provider_____

Breast milk and/or Formula preference

Record date to indicate your preference (choose all that apply) ***I understand that I may change my decision at any time with advance notice	**Birth -5 months Date & Initial**	**6 – 11 months Date & Initial**
I will provide expressed breast milk for my infant.		
I will breast feed my infant on site at the center/provider.		
I want the childcare center/provider to provide the infant formula it offers for my infant.		
I will provide the infant formula for my infant. (must be iron fortified) **Name of infant formula I will provide: _____**		
My infant has a special dietary need that requires a formula that does not meet the criteria for an approved iron fortified formula. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, and the recommended substitution. **Name of infant formula I will provide: _____**		

Preference regarding infant cereal and other foods

Record date to indicate your preference *I understand that I may change my decision at any time with advance notice	**6 – 11 months Date & Initial**
I want the childcare center/provider to provide the iron fortified infant cereal and other foods for my infant.	
I want the childcare center/provider to provide all food items with one exception. (This option is only applicable if center/provider is providing the iron fortified infant formula) **One food item that I will provide (must be a creditable CACFP food item): _____**	
My infant has a special dietary need that requires modifications to the infant meal pattern requirements. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, the foods to avoid and the recommended substitutions	
I am aware and understand the all information provided on this form and my ability to have my infant participate in the CACFP; however, **I decline** the infant formula and food offered by the center/provider and elect to furnish ALL infant formula and food for my infant. **(Center/Provider may not claim meals for this infant)**	

_____ _____

Parent/Guardian Date Center/Provider signature Date

This supplemental infant form must be completed for all infants in care and must be maintained by center/provider and if applicable, a copy must be maintained by the Sponsoring organization

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) E-mail: program.intake@usda.gov.
This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ Reduced ○ Denied ○

Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date

Child and Adult Care Food Program
Child Enrollment Form

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD NAME BIRTH DATE AGE	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FOURTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FIFTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ EARLY MORNING SNACK ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: Effective Date of This Enrollment Form: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This portion of the form can be used to capture multi-year annual updates.

****

Annual Time Period Covered by Signature: ___________________ **to** ___________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider___________________________ **Date** ____________________

****

Annual Time Period Covered by Signature: ___________________ **to** ___________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider___________________________ **Date** ____________________

****

Annual Time Period Covered by Signature: ___________________ **to** ___________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider___________________________ **Date** ____________________

****

Annual Time Period Covered by Signature: ___________________ **to** ___________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider___________________________ **Date** ____________________

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We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) **Discover the World Children's Center** to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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