Welcome to Building Blocks Learning Center!

Prior to your child's first day at BBLC, these forms are required to be filled out:

- Completed Application Packet
- Emergency Contact
- Child Pick Up Authorization
- Allergy Information (If Applicable)
- Service Agreement Form
- Custody Information (If Applicable)

****

On your child's first day of care, the following items will be needed:

- Small Backpack and Blanket
- Change of Clothes in a Ziploc Bag
- Diapers & Wipes (If Applicable)
- **Infant Parents**: Family Picture, Pack-n-Play Sheet, Pre-Made Bottles for the day, Pacifier (if needed)

****

What to Expect on the First Day?

The first few morning drop-offs for your child can be emotional. Reassure your child and let them know you will be back. Though it is not easy, we ask that you keep the drop off short and supportive. You are welcome call to check on how your child's first day is going.

At pick-up time, your child will be excited to see you and tell you about their day. Younger children may cry when they see you – this is an expression that is normal during the first few days. They are happy to see you and are overwhelmed with excitement.

We use an electronic communication system called Tadpoles. This is a program that we use daily to send parents information on how their child's day was and any upcoming events or notes for the parents. The program requires a valid email address for each parent.

Each BBLC center is a locked facility. We have a clock in/out system that is computerized and personalized to each family. On your first day at BBLC you will receive your family's personalized code to enter the building. This code also tracks your child's attendance.

Payment Information:

All payments are co-pays are due weekly, on Monday by 5:30pm.
Please make all checks payable to Building Blocks Learning Center.
If the payment is not received by Monday at 5:30pm you will be subjected to a $25.00 late fee.

****

If you have any questions, please contact us at:_____
Contact Person: _____

Application for Child Care Services

Name of Child: _____

Date of Birth: _____

Address: _____

City/State/Zip Code: _____

****

Parent's Name (or legal guardian):_____

Address: _____

Phone (Home):_____ (Cell): _____

(Work): _____ Hours: _____

Occupation: _____ E-Mail: _____

Parent's Name (or legal guardian):_____

Address: _____

Phone (Home):_____ (Cell):_____

(Work):_____ Hours: _____

Occupation: _____ Email: _____

****

Any previous child care experience: _____

Usual eating schedule: _____

Foods child likes: _____ Dislikes: _____

Elimination Patterns (Toileting/Diapering): _____

Things that comfort child: _____ Scare child: _____

Allergies: _____

_____ _____

Parent/ Legal Guardian's Signature **Date**

_____ _____

Parent/ Legal Guardian's Signature **Date**

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), 3290.18 & .182

Child's Name	Birthdate
Address	
Parent/Legal Guardian	Home Phone # / Cell Phone #
Address	
Business Name	Business Telephone Number
Address	
Parent/Legal Guardian	Home Phone # / Cell Phone #
Address	
Business Name	Business Telephone Number
Address	

Emergency Contact Person(s) Other than Child's Parents

Name	Relationship	Telephone Number When Child is in Care

Person(s) To Whom Child May Be Released

Name	Relationship	Address	Telephone Number

Name of Child's Physical/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 Conditions
Additional Information on Special Needs of Child	
Health Insurance Coverage for Child or Medical Assistance Benefits	**Policy Number (Required)**

Parent is Signature is Required for Each Item Below to Indicate Parental Consent

Obtaining Emergency Medical Care/ Emergency Transportation	**Admin. of Minor First-Aid Procedures**
Outdoor Walks & Playground Use	**Photography**
Diaper Cream Provided By Parent & Applied By Center	**Sunscreen Provided By Parent & Applied By Center**

_____ _____

Signature of Parent or Guardian **Date**

Periodic Review Completed in May

_____ _____

Signature of Parent or Guardian **Date**

Child Pick-Up Authorization Form

I, _____, authorize the **Building Blocks Learning Center** to release my child(ren) to the person(s) designated below. This is in consonance with the **Building Blocks Learning Center** Emergency Plan.

Child's Name	**Designated Guardian (s) Name & Relationship**
_____	_____
_____	_____
_____	_____

_____

Your Signature Relationship Date

_____

Print Name

_____

Address (Street)

_____

Address (City, State, & Zip Code)

(Home Phone)_____ (Work)_____ (Cell)_____

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

PLEASE PRINT CLEARLY.

Health Policy

To prevent the spread of illness and preserve the health of all the children enrolled at Building Blocks Learning Center, we have decided that it is necessary to enforce the following health policies:

1) **Children must be excluded from care if they are experiencing the following:**
   - **Vomiting**
   - **Diarrhea**
   - **Leakage from eye/conjunctivitis**
   - **Having a fever of 101.0 ^{o}F and over**
   - **Undiagnosed rash**
   - **Any other communicable disease**

2) **Children will be sent home from the center if they are experiencing any of the above (vomiting 2 times, diarrhea 3 times) or if they are unable to participate in the activities of the center due to an illness.**

3) **Children will not be allowed to return to the center unless they have been free from the above symptoms for 72 hours or have been cleared by their doctor to return with a doctor's note.**

4) **Children must have an up-to-date health assessment form on file at the center at all times. Your child's initial health assessment form must be submitted within 4 weeks of enrollment. Subsequent forms are due at the following ages: 6 months, 1 year, 1 ½ years, 2 years, 3 years, 4 years, 5 years, 6 years, 7 years, 8 years, 9 years, 10 years, 11 years, and 12 years of age.**

We hope you understand that these policies are necessary for the well-being of the children, and we appreciate your cooperation. Please sign and date the form below to indicate that you have read and agree to comply with the above policy.

*** In order to maintain a healthy environment, hand sanitizers are placed in the lobby. We require everyone entering the center to wash their hands and/or to use our conveniently placed hand sanitizers.**

I, _____, parent/guardian of _____,
Parent/guardian's name **Child's Name**

have read and agree to comply with Building Blocks Learning Center's Health Policy.

_____ _____
Signature **Date**

Medical Treatment Consent & Release

Child's Name: _____ Date of Birth: _____

Pediatrician: _____Phone #: _____

Medical Insurance Company: _____ Policy #: _____

Child's Hospital: _____ Phone #: _____

Child's Dentist: _____ Phone #: _____

When there is a medical emergency, or when a child needs medical attention, the provider will take all reasonable steps to see that the child(ren) in his/her care receive adequate medical care. When appropriate, the provider will call 911 and the parent(s). If the parent(s) cannot be reached, the provider will call the person(s) listed below who are authorized by the parent(s) to give permission for the medical treatment of the child. Authorized person(s) must be a relative/family member and must be present at the medical facility when medical treatment is performed.

The person(s) authorized to do so are:

Name: _____ Phone #: (Home): _____
(Work): _____
(Cell): _____
Name: _____ Phone #: (Home): _____
(Work): _____
(Cell): _____

If the child must be taken to the hospital, the provider will take the child to the child's hospital identified above. If, under the circumstances, it is more reasonable to bring the child to another hospital, the provider will do so. In the event where a parent(s) or authorized person(s) cannot be reached, the hospital will stabilize the child until either the parent(s) or authorized person(s) is present.

***Please list any medical conditions or allergies we should be aware of.**

_____

_____

By signing this form, you are releasing Building Blocks Learning Center from liability for administering treatment to children with severe allergies and taking other necessary actions set forth in the Medical Consent form, provided BBLC exercises reasonable care in taking such actions.

Parent Signature: _____ Date: _____
Parent Signature: _____ Date: _____

COVID-19 PUBLIC HEALTH EMERGENCY
SPECIAL PROGRAM ATTENDANCE
ACKNOWLEDGMENT AND DISCLOSURE for FAMILIES

Please read and initial each statement below.

1. ☐ I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter the facility beyond the designated drop-off and pick-up area. I understand that this procedure change is for the safety of all persons present in the facility and to limit to the extent possible everyone's risk of exposure. I understand that it is my responsibility to inform any Emergency Contact persons of the information contained herein.

2. ☐ I understand that IF there is an emergency requiring me to enter the facility beyond the designated drop-off and pick-up area I MUST wash my hands before entering, remove my shoes and wear a mask. While in the facility I must practice social distancing and remain 6ft from all other people, except for my own child.

3. ☐ I understand that to enter upon the facility premises my child must be free from COVID-19 symptoms. If, during the day, any of the following symptoms appear my child will be separated from the rest of the people in the center. I will be contacted, and my child MUST be pick-ed up from the facility within 30 minutes of being notified.

   Symptoms include,

   - fever of 100 degrees Fahrenheit or higher
   - dry cough
   - Shortness of Breath
   - Chills
   - Loss of taste or smell
   - Sore Throat
   - Muscle aches

   While we understand that many of these symptoms can also be related to non-COVID-19 related issues we must proceed with an abundance of caution during this Public Health Emergency. These symptoms typically appear 2-7 days after being infected so please take them seriously. Your child will need to be symptom free without any medications for 72 hours before returning to the facility.

4. ☐ I understand that my child's temperature will be taken twice throughout the day while on facility premises.

5. ☐ I understand that my child will not be required to wear a mask while in care. I understand that if I want my child to wear a mask, my child will be permitted to wear one. I understand that my child will be in a group environment with other children who may or may not be wearing masks. (Please note, DHS State Regulations do not require children to wear a mask while in childcare)

6. ☐ I understand that my child will be required to wash their hands using CDC recommended handwashing procedures throughout the day using warm running water and rubbing with soap for at least 20 seconds.

7. ☐ I understand that I must bring my child a pair of shoes to the facility that will ONLY be worn inside this facility and will be left here each evening. I MUST remove my child's shoes at the entrance of the facility. Staff will have the child put on their "center only shoes" once the child washes their hands and goes into the classroom. At pick up, Staff will remove the child's "center only shoes" and the child will be brought to the entrance where I will put on my child's outside shoes prior to leaving the facility. The children's "center only shoes" will be sanitized by staff each night.

8. ☐ I understand that outside of care, in order to control my child's exposure in the community, I will comply with any and all state, county or local stay-at-home orders.

9. ☐ My child and I will limit gathering with anyone that does not live in our household. I will practice all recommended social distancing and exposure limiting practices recommended by the CDC.

10. ☐ I will immediately notify Building Blocks Learning Center management if I become aware of any person with whom my child or I have had contact exhibits any of the symptoms listed in Number 1 above, is advised to self-isolate, quarantine, or has tested positive, or is presumed positive for COVID-19. Further, I will immediately notify Building Blocks Learning Center management if anyone from my place of employment is presumed positive or tests positive for COVID-19 whether or not I have had direct contact with that person.

11. ☐ I understand and agree that I will not give my child fever reducing medications such as Tylenol or Motrin if they are showing any signs of fever or symptoms of illness in an attempt to get them through the morning screening process. I will keep my child home if they have any symptoms the night before. I understand that I will disclose with full transparency, any information regarding my child's symptoms in order to minimize the risk of exposure to all the children and staff at the center.

12. ☐ I understand that while present in the facility each day my child will be in contact with children, families and other employees who are also at risk of community exposure. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I understand that I play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined herein.

I, _____ certify that I have read, understand, and agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by Building Blocks Learning Center will result in disciplinary action up to and including termination. I acknowledge that my enrollment will be terminated if it is determined that my actions, or lack of action unnecessarily exposes another employee, child, or their family member to COVID-19.

Child's Name: _____ DOB: _____

This acknowledgement MUST be signed by BOTH parents (if applicable)

Parent's Name: _____

_____ _____

Parent Signature Date

Parent's Name: _____

_____ _____

Parent Signature Date

_____ _____

Management Team Witness Date

Building Blocks Learning Center

Permission to be Photographed / Photograph Release Form

I give permission for the faculty and staff of Building Blocks Learning Center to take photographs of my child for educational and promotional uses. I give my consent for my child's photographs to be used in print media (including newspapers, brochures, and magazines), social media (including company websites, emails, Tadpoles Daily Report emails, and Facebook pages), and public displays (including posters, display boards, flyers, pamphlets, and other promotional material). I understand that when necessary, my child's name may be included with the photograph.

Permission to be enrolled in Tadpoles Electronic Daily Report System

I also give permission for Building Blocks Learning Center to enroll my child into the Tadpoles Electronic Daily Report System. I understand and agree that pictures of my child will be taken throughout the day in their classroom and attached to the electronic daily reports. I also acknowledge that my child will be included in group pictures that will be emailed to all the parents with children in the class. I agree that my child's daily report will be recorded in an electronic account through the Tadpoles system and will be emailed to the email address that I provide each day.

By signing below, I, _____, understand & accept the above guidelines and give Building Blocks Learning Center authorization to photograph & enroll my child in Tadpoles & all other BBLC programs.

Child's Name_____

Parent/Guardian's Name(s)_____

Parent/Guardian's Signature(s)_____

Date_____

☐ No, I do not authorize my child's picture to be taken

Child's Name: _____

Parent's Name: _____

Date: _____

Guidebook Compliance Agreement

I, _____, and I, _____, have
Guardian **Guardian**

read the Building Blocks Learning Center's policies and procedures.

We understand and agree to adhere to the policies and procedures.

_____ _____
Parent/Guardian **Date**

_____ _____
Parent/Guardian **Date**

Community Stakeholders

_☐_ I have reviewed the list of community stakeholders, and I would like to add_____.

_☐_ I have reviewed the list of community stakeholders, and I do not wish to add any at this time.

_____ _____
Parent/Guardian **Date**

_____ _____
Parent/Guardian **Date**

_____ _____
Center Administrator **Date**

New Child Fact Sheet

Child's Name: ________________________

Dear Parents,
Please complete this letter from your child's perspective to help our teachers get to know your child. Feel free to add any additional information as well. Thank you!

____

Hi! My name is ____________________ and my birthday is on __________________.

My mom's name is __________________ and my dad's name is _________________.

My favorite toys to play with are ____.

When I am sad, my reaction is ____.

You can comfort me by ____.

When I am angry, my reaction is ____.

You can remind me to ____________________________________ to help me calm down.

When I am scared, my reaction is ____.

I may get frightened by ____.

You can comfort me by ____.

I really like to eat ____.

I don't really like to eat ____.

Other people that are important to me in my life are _______________________________

____.

My potty/diaper habits are ____

____.

Some other things that you might want to know about me are _______________________

____.

Thank you for helping us get to know your child!

- -

Phase In Dates/Times: _______________ ________________ _____________________

Start Date: _______________________

Allergies/Medical/Custody Information: ____

____

Child's Schedule and Hours				
Monday	Tuesday	Wednesday	Thursday	Friday

Child and Adult Care Food Program **Sponsor/Center Name:_____**

Child Enrollment Form (Sample) **Agreement #:_____**

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	☐ MONDAY ☐ TUESDAY									
NAME	☐ WEDNESDAY ☐ THURSDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST ☐ A.M. SNACK
BIRTH DATE	☐ FRIDAY ☐ SATURDAY	Other:								☐ LUNCH ☐ P.M. SNACK
AGE	☐ SUNDAY	**Enrollment Date:** **Withdrawal Date:**								☐ SUPPER ☐ EVENING SNACK
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	☐ *Same as Above* ☐ MONDAY									☐ *Same Meals as Above*
NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST ☐ A.M. SNACK
BIRTH DATE	☐ THURSDAY ☐ FRIDAY	Other:								☐ LUNCH ☐ P.M. SNACK
AGE	☐ SATURDAY ☐ SUNDAY	**Enrollment Date:** **Withdrawal Date:**								☐ SUPPER ☐ EVENING SNACK
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	☐ *Same as Above* ☐ MONDAY									☐ *Same Meals as Above*
NAME	☐ TUESDAY ☐ WEDNESDAY	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								☐ BREAKFAST ☐ A.M. SNACK
BIRTH DATE	☐ THURSDAY ☐ FRIDAY	Other:								☐ LUNCH ☐ P.M. SNACK
AGE	☐ SATURDAY ☐ SUNDAY	**Enrollment Date:** **Withdrawal Date:**								☐ SUPPER ☐ EVENING SNACK

Signature _____ _____ _____

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

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

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.

****

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) email: 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 (<u>do not complete STEP 3</u>)

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. <u>MAIL COMPLETED FORM TO YOUR SCHOOL AT:</u>

"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

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

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