Four Seasons Learning Center
254 Lakeview Drive
Charlottesville, VA 22901

Phone: 434-975-4455
Email: 4seasonslcenter@gmail.com

Dear Parents,

Welcome to Four Seasons Learning Center! We are delighted to have you and your child join our community. The FSLC is a licensed and privately-owned, for-profit facility that operates Monday through Friday from 7:00 AM to 5:30 PM. We provide care for children newborn to school age in an inclusive environment that embraces diversity in race and faith.

At Four Seasons Learning Center, we are committed to offering comprehensive education and health services to families and children. Our curriculum is thoughtfully designed to meet the developmental needs of every age group and the individual needs of each child. We ensure that our equipment and adult-child interactions are developmentally appropriate and conducive to learning and growth. Our staff undergoes yearly training to remain current with all state requirements in the age groups they work with. Our dedicated team is passionate about teaching, interacting, and socializing with children; helping our students learn to work and play well together. The structured daily schedule we provide allows children to know what to expect as they move from room to room throughout their day, consistency is the key to success. We take pride in watching each child grow and thrive in every chapter of their lives.

Thank you for choosing the Four Seasons Learning Center. We look forward to partnering with you in your child's early education and development.

Warm regards,

Amanda and Wanda

Four Seasons Learning Center

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Pre-Admission

Background Information Form

The center staff needs your help to understand and plan for your child. Please fill out the following form and return it to the center before enrollment.

Date: _____

Child's Name: _____ Sex: M_____ F_____

Child's Preferred Name: _____

Complete Address:

_____

_____

Phone Number: _____ DOB: _____ Age: _____

Admission Date: _____ Termination Date: _____

Grade Level: _____ School: _____

Father's Name: _____ Occupation: _____

Company Name: _____ Address: _____

_____

Business Phone: _____ Cell: _____

Mother's Name: _____ Occupation: _____

Company Name: _____ Address: _____

_____

Business Phone: _____ Cell: _____

Is Father Living? _____ Is Mother Living? _____ Separated? _____ Divorced? _____

Please list people that are authorized to pick up your child:

_____

_____

_____

_____

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Is there anyone whom you DO NOT wish to pick up your child? _____

If so, please give name and relationship to child.

_____

_____

Please list other members of the family. (Siblings, Grandparents, etc.) living at home:

Name: Age: Relationship: Indicate Title used by Child:

_____

_____

_____

_____

_____

_____

Other members of the family (Grandparents, Aunts, Uncles, etc.) living in the community:

_____

_____

_____

_____

Has your child had any previous school experience? _____

If yes, please give the name and type of school:

_____ Length of attendance: _____

Does your child take a nap? _____ Morning? _____ Afternoon? _____

How many hours does your child sleep at night? _____

Is your child toilet trained? _____

Does your child use any special word for toileting? _____

If yes, please explain: _____

Please describe your child's appetite: _____

_____

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Are there any foods that your child may not or cannot eat? (due to allergies, religious customs, etc.) _____

_____

Are there any foods that your child dislikes? _____ If yes, please list:

_____

_____

_____

Does your child have any disabilities or special needs that should be known by the care providers?

_____

_____

Child's Special Interests: Singing _____ Painting _____ Stories _____

Trucks _____ Trains _____ Pets _____ Music _____ Outside Play _____

Coloring _____ Other _____

Is your child generally: Cooperative? ____ Shy? ____ Competitive? ____

Happy? ____ Aggressive? ____ Sensitive? ____ Submissive? ____ Angry? ____ Other?

_____

_____

Does your child usually do what is asked of him/her? _____

_____

Please list any/all behavior characteristics of your child:

_____

_____

_____

_____

_____

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INFANT

Breast fed or Formula fed? _____

If formula, what is the brand? _____

What is your child's feeding schedule?

_____
_____
_____
_____
_____
_____

Personality:

Please describe your child's personality and provide information that could be helpful for your child's adjustment. We would love for your child to adjust quickly to their new environment!

_____
_____
_____
_____

_____ _____

Signature of parent/guardian Date

DIVISION OF LICENSING PROGRAMS
DEPARTMENT OF SOCIAL SERVICES
CHILD REGISTRATION FORM (Model)

Child	Nickname	Date of Birth	Sex
Address			Home Phone
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed			
Previous Child Day Care Programs and Schools Attended			
If Child Attends this Center and Another School/Program, Give Name of School/Program			Grade

PARENT(S)/GUARDIAN(S)

Father	Place Employed	Business Phone
Home Address		Home Phone
Mother	Place Employed	Business Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Business Address		Business Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency		
Child's Physician		Phone
Two People To Contact if Parent(s) Cannot Be Reached 1.	Address 1.	Phone 1.
2.	2.	2.
Person(s) Authorized To Pick Up Child		
Person(s) NOT Authorized To Pick Up Child*		

- Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
- NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center must be included, upon the request of such noncustodial parent, as an emergency contact for events occurring during school or day care activities.

AGREEMENTS

1. The child day center agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_____ _____

Parent(s) or Guardian(s) ***Date***

_____ _____

Administrator of Center ***Date***

Date Child Entered Care: _____ Date Left Care: _____

** If there is an objection to seeking emergency medical care, a statement should be obtained from the parent(s) or guardian(s) that states the objection and the reason for the objection.

OFFICE USE ONLY
IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

Place of Birth	Birth Date	Birth Certificate Number	Date Issued
Other Form of Proof		Date Documentation Viewed	Person Viewing Documentation

Date of Notification of Local Law-Enforcement Agency (when required proof of identity is not provided):

_____

Date

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Section 63.2-1809 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding,. (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means.

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EMERGENCY MEDICAL AUTHORIZATION

Name of Child_____ Birthdate_____
Name of Parent(s) or Guardian_____
Home Address_____Phone_____
Mother Cell Phone _____Father Cell Phone _____
Place of Mother's Employment_____Phone_____
Address_____
Place of Father's Employment_____Phone_____
Address_____

The parent(s)/guardian authorizes FOUR SEASONS LEARNING CENTER to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to, his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situations that are true emergencies and only when he/she cannot be reached. Otherwise, he/she expects to be notified immediately.

1. I will be responsible for payment of medical care expenses _____
2. Medical treatment costs are covered by:
    a. Private Insurance (name and policy number)_____
    b. Medicaid Coverage Number_____
    c. Other Medical insurance_____
    Name of Insurance Company_____
    Policy Number_____
    d. No insurance_____

Child's Physician or clinic attended_____ Phone_____
Child's Allergies (if any)_____

- I authorize FSLC to provide an emergency medical care should an emergency occur when the parent cannot be located immediately. I understand that if I do not agree to emergency medical care provided by the FSLC staff, I need to submit an objection in a written form.
- I understand that the center will notify the parent when the child becomes ill and that the parent will arrange to have the child picked up as soon as possible if so requested by the center.
- I understand that as a parent I have to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

_____Date_____
(Signature of Parent(s)/Guardian)

VDOE Model Form

Authorization Form for
Non-prescription Over-the-Counter Skin Products
8VAC20-780-520

INSTRUCTIONS:
This form must be completed by the parent/guardian to authorize the use of:

- Sunscreen
- Diaper ointment or cream
- Insect repellent

_____ has my permission to apply the non-prescription
(Name of Center)

over-the-counter (OTC) skin product listed below to my child _____
Child's Name

Product Name: _____

Known Adverse Reactions (if any): _____

_____

- All OTC products must:
  - Be in the original container and, if provided by the parent, labeled with the child's name
  - Be used according to manufacturer's recommendation and instructions for application
  - Not be used beyond the expiration date of the product

- Sunscreen:
  - Must have a minimum sunburn protection factor (SPF) of 15
  - Shall be inaccessible to children under 5 yrs. & children in therapeutic or special needs programs
  - Children nine yrs. and older may self administer sunscreen if supervised

- Diaper ointment/cream and Insect repellents:
  - Shall be kept inaccessible to children
  - Record of use shall be kept that includes the child's name, date of use, frequency of application and any adverse reactions

This authorization is effective from: _____ **until:** _____
(Start date) **(End date)**

Parent's Signature: _____ **Date:** _____

(10/21-2)

CDC Over-the-counter skin product authorization

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Charlottesville, VA 22901

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PERMISSION TO USE MEDIA

I, _____ parent/guardian of _____

give Four Seasons Learning Center permission to take and use my child's picture. Pictures will be taken of your child at play or during special/fun events. FSLC will use these for many things including but not limited to emailing parents, memories, sharing with families, posting on daycare walls to create a feeling of warmth and sense of belonging.

Please choose yes____ or no____ if you would like photos taken of your child.

YES/NO – I give permission for photographs and/or videos to be taken of my child.

YES/NO – My child's daycare may publish photographs or videos of my child on its website and social media platforms.

YES/NO – I only consent to photographs or videos of my child to be used in-house by the daycare and these may not be published in print or digital form.

I understand that at any given time I can contact the Four Seasons Learning Center to make changes to this form.

_____ _____

Signature/Print Name Date:

VIRGINIA CACFP
Child and Adult Care Food Program

CACFP (CHILD) LETTER TO HOUSEHOLD (PARENTS/GUARDIANS) MEAL BENEFIT INCOME ELIGIBILITY FORM

Dear Parent or Guardian:

This center/home participates in the United States Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to enrolled children. The amount of reimbursement the center receives is based on the information provided on the attached CACFP Meal Benefit Income Eligibility Form (IEF). Part of the USDA requirement is to complete the IEF. If household income is equal to or less than the income listed in the chart below for household size, the center will receive a higher level of reimbursement. Please return the completed IEF back to the center as soon as possible.

If a member of the family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) benefits or cares for a foster child(ren) that is the legal responsibility of the Virginia Department of Social Services or the court, children are categorically eligible for meal benefits regardless of household income.

If the household income is over the income guidelines listed below, the family is not required to complete this application. Instead, please write the child's name on the IEF and return it to the center. Please notify the center staff if someone in the household becomes unemployed and the loss of income causes the household income to be within the income eligibility standards.

The information provided on the IEF will be used to determine the child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

Family Access to Medical Insurance Security Plan (FAMIS)

FAMIS is Virginia's health insurance program for children. It provides access to quality health services for children who do not have health insurance. ***FAMIS Plus*** is Virginia's name for children's Medicaid. ***FAMIS Plus*** also provides great benefits and covers children in families with low or no income, even if the children are covered by health insurance.

By signing the section on the application for *FAMIS* or *FAMIS Plus*, the family is stating they do not want information shared with the local Department of Social Services. If IEF information is disclosed, it may be used to identify the child(ren) for the health insurance program. More information on *FAMIS* is available at 1-866-873-2647 – Interpreters are available. Log onto www.famis.org to apply online.

A household with income less than or equal to the income chart for reduced-priced meals below is eligible for free or reduced-price meals:

Household Size	Yearly
1	23,828
2	32,227
3	40,626
4	49,025
5	57,424
6	65,823
7	74,222
8	82,821
Each additional person:	8,399

Please feel free to contact the center at (_____) _____ - _____ with questions or concerns.

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 on-line 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.

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

Child Care Resources
5 E 2nd Street
Richmond, VA 23224
855-427-2888

Learn more about CACFP at USDA's website:

https://www.fns.usda.gov/

USDA is an equal opportunity provider, employer and lender.

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

Virginia Child and Adult Care Food Program (CACFP)
(Child) Annual Enrollment Form (AEF)

CENTER/PROVIDER COMPLETE THIS SECTION

Four Seasons Learning Center
Center/Provider Name

254 Lakeview Drive	Charlottesville	VA	22901
Street Address	*City*	*State*	*Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate Annual Enrollment Form for each child when enrolling their child (ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 6 below.**

This form is required for:	**This form is NOT required for:**
Child Care Centers, Family Day Care Homes	Outside School Hours Care Centers, Emergency Shelters

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)

Child's First Name

Child's Last Name

Date of Birth (mm/dd/yyyy)

Age

2 DAYS OF WEEK IN ATTENDANCE

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday
- ☐ Sunday

3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK

TIME IN	TIME OUT	SPORADIC SCHEDULE (not set schedule of days)

NOTES:

4 MEALS RECEIVED

- ☒ Breakfast
- ☐ AM Snack
- ☒ Lunch
- ☒ PM Snack
- ☐ Supper
- ☐ EV Snack

5 Parent/Guardian **Signature and Date:** ***By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Annual Enrollment Form and that the information contained on this form is true and correct.***

Printed Name: *Signature:*

Street Address: *City, State, Zip Code:*

Phone Number HOME / WORK / CELL (circle one): *Date:*

Nondiscrimination Statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

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.

6 **Ethnic and Racial Identification:** ***Parent/Guardian to complete. Please select ONE Ethnicity; Please select ONE OR MORE Races***

ETHNIC IDENTIFICATION

- ○ **Hispanic, Latino or Spanish Origin:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- ○ **Not Hispanic, Latino or Spanish origin**
- ○ **I decline to answer.**

RACIAL IDENTIFICATION

- ○ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains culture identification through tribal affiliation or community attachment (includes Aleuts and Eskimos).
- ○ **Black, African American, or Haitian:** A person having origins in any of the black racial groups of Africa.
- ○ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ○ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- ○ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ○ **I decline to answer.**

Four Seasons Learning Center

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF) FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES

1 All Household Members

NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]

	First, Middle Initial, Last	Check if NO income	Ages of children in care	2 FOSTER CHILD: Skip to Part 6 if all are foster children.	3 SNAP, TANF or FDPIR CASE #: Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. SNAP AND TANF MUST BE NINE (9) DIGITS
1		☐		☐	
2		☐		☐	
3		☐		☐	
4		☐		☐	
5		☐		☐	
6		☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway — If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison or Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number box.*

XXX - XX - _____ Social Security Number

☐ I do not have a social security number.

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

_____ *Date* | _____ *Printed Name of Adult Household Member* | _____ *Signature of Adult Household Member*

7 Contact Information (Optional)

_____ *Work Telephone Number (Include Area Code)* | ( ) _____ *Home Telephone Number (Include Area Code)* | _____ *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS*, the complete health insurance program for every child in Virginia ? If yes, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS. Date: _____ Sign Here: _____

CHILD CARE REPRESENTATIVE USE ONLY - ELIGIBILITY DETERMINATION - COMPLETE SECTIONS A and B BELOW

SECTION A

Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 — Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per $_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year NUMBER IN HOUSEHOLD: _____

☐ FREE based on:			☐ REDUCED based on:	☐ DENIED Reason:	
☐ foster child	☐ migrant	☐ SNAP, TANF, FDPIR	☐ household income	☐ income too high	☐ incomplete application
☐ homeless	☐ runaway	☐ household income		☐ non-qualifying SNAP/TANF	

SECTION B Signature of Determining Official: _____ Date: _____

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Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339..

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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.

VIRGINIA CACFP
Child and Adult Care Food Program

PARENT/GUARDIAN CHOICE FORM (INFANT)

NAME OF INFANT:	_____ *(First Name, Middle Initial, Last Name)*	DATE OF BIRTH:	_____ *(mm/dd/yyyy)*

This center/provider participates in the Child and Adult Care Food Program (CACFP) and receives Federal USDA funding for serving nutritious meals to infants and children. Participation in the CACFP requires caregivers to follow specific meal patterns according to age group classifications detailed in forms *CACFP-009 Child Meal Pattern and CACFP-010 Infant Meal Pattern.*

(Center/Provider) Four Seasons Learning Center agrees to feed your infant breast milk provided by parent/guardian. The center/provider will provide iron-fortified infant formula. The formula provider is _____

Federal regulations require centers/providers participating in the CACFP to offer iron-fortified formula to infants who are in care during meal service times. Parents/guardians may decline the center/provider offered formula and supply the infant's formula, provide expressed breastmilk, or breastfeed on site.

PLEASE INDICATE PREFERENCES *(Choose all options that apply by initialing and dating in the appropriate space(s))*	BIRTH - 5 MONTHS	6 MONTHS - 11 MONTHS
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED FORMULA	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 2: PARENT/GUARDIAN WILL PROVIDE FORMULA	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 3: PARENT/GUARDIAN WILL PROVIDE EXPRESSED BREASTMILK	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 4: BREASTFEEDING WILL OCCUR ON SITE	INITIALS: DATE: _____	INITIALS: DATE: _____

BREASTFEEDING FRIENDLY CENTERS/PROVIDERS ARE ENCOURAGED!

Many centers and providers now have designated space onsite for breastfeeding.

Ask your center representative or day care home provider for details!

Federal regulations also require centers/providers participating in the CACFP to provide iron-fortified infant cereal and other foods when the child is developmentally ready.

PLEASE INDICATE PREFERENCES	BIRTH - 5 MONTHS	6 MONTHS - 11 MONTHS
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED CEREAL AND OTHER FOODS BASED ON THE CACFP MEAL PATTERN	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 2: PARENT/GUARDIAN WILL PROVIDE CEREAL AND SOLID FOODS WHEN THE TIME IS APPROPRIATE	INITIALS: DATE: _____	INITIALS: DATE: _____

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

1. THIS FORM MUST BE KEPT **CURRENT, ACCURATE AND ON FILE** FOR EACH INFANT ENROLLED IN CHILD CARE UNTIL THE INFANT REACHES 1 YEAR OF AGE OR IS NO LONGER ON BREASTMILK OR INFANT FORMULA.
2. BREASTMILK IS AN ACCEPTABLE MILK SUBSTITUTE FOR CHILDREN OF ANY AGE WITHIN THE CONTEXT OF THE CACFP.
3. AS SITUATIONS CHANGE, SUCH AS A MEDICAL AUTHORITY CHANGING AN INFANT'S FORMULA, A NEW FORM MUST BE COMPLETED.
4. IF THE PARENT/GUARDIAN DECLINES THE FORMULA AND THE CENTER/PROVIDER PROVIDES AT LEAST ONE **REQUIRED** MEAL AND/OR SNACK COMPONENT, THE MEAL OR SNACK MAY BE CLAIMED FOR REIMBURSEMENT.
5. IF THE PARENT/GUARDIAN DECLINES INFANT MEALS/SNACKS, THEY MAY NOT BE CLAIMED FOR REIMBURSEMENT.

This institution is an equal opportunity provider.

Four Seasons Learning Center.
254 Lakeview Drive.
Charlottesville, Va.22901

Phone:434-975-4455
Email:4seasonslcenter@gmail.com

First Day Reminder

* please use caution when driving in the school parking lot. Always remember to come in at a respectable speed. There are people loading and unloading throughout the day. Safety comes first

* Your child will need: a mini-crib size, fitted sheet for all infant beginning in our facility. Older children will need a regular Crib size, fitted sheet for nap time. Please also provide a blanket for your child.

* all blankets must be taken home every Friday and washed. Please remember to return all blankets at drop off on Mondays so your child will have their blanket during naptime. Fitted sheets will be washed on site.

* we provide breakfast launch and PM snack. This includes similac formula and rice and oatmeal cereal for infants. All children are categorically eligible for meal benefits, regardless of household income.

* when there is a birthday party or holiday , please remember there are no homemade baked/cooked foods allowed in our facility. Please bring store bought only.

* please have your child at four seasons learning center no later than 9:30 a.m. on any giving day. We do not accept any late arrivals past 9:30a.m. without prior notice and or a Dr. Excuse.

* only bring toys in if your class is having show and share. This is usually predetermined by your child's teacher. Please stay in direct contact with them for this information or change of schedule and activities.

* Please make sure your child has seasonal clothes that are weather appropriate, and an extra pair for any accidents that may occur.

* if your child wears pull-ups or diapers, please bring them in as needed. Teachers will let you know if, and when supplies get low.

* please make sure any and all items are labeled with your child's first and last name. This includes cups, bottles, food, backpacks, clothes, etc.

*Also, to ensure safety, we ask that all footwear be closed toe and appropriate for your child. If they cannot tie their shoes please make sure they have velcro closure or slip on shoes.

Commonwealth of Virginia
Department of Social Services
Division of Child Care and Early Childhood Development

Virginia Child Care
www.childcareva.com

APPLYING FOR CHILD CARE SUBSIDY AND SERVICES
Information You Need to Know

Anyone may apply for child care services. You must apply in the city or county in which you live. You do not need to have lived in the city or county for any specified length of time. The child(ren) for whom the child care service application is submitted must be a citizen of the United States or have legal alien status. Proof of the child(ren)'s citizenship or legal alien status must be provided. As a condition of eligibility you must cooperate with the local department of social services and the Division of Child Support Enforcement (DCSE) in obtaining support from an absent parent for the child(ren) for whom you request assistance, unless good cause for not providing the information is determined.

To find out if you are eligible to receive child care services, you must complete and return the attached application.

The local department of social services (local department) will make a decision regarding your application within 30 days. The local department must send you a written *Notice of Action* if you are not eligible for services, or if there is a delay in processing the application. Your name may be placed on a waiting list if funds are not available to immediately serve you. The local department will send written notification explaining the reason why you were added to the waiting list and a child care case manager will explain the waiting list process to you. You may request that your name be removed from the waiting list at any time.

Applicant's Rights

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, religion or political beliefs. 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. Additionally, program information may be made available in languages other than English.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS) write: ***HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).***

More information about this process may be found at *www.dss.virginia.gov/about/civil_rights/*.

You have the right to view the information in your child care case record. The local department may not release information about you without your written consent, with the exception of purposes directly connected with the administration of social service programs, or by court order.

You have the right to visit your child any time the child is in the provider's care. You also have the right to make complaints or discuss areas of concern regarding your provider's care by calling 1-800-543-7545 or on-line at www.childcareva.com.

If you do not agree with the local department's decision about your case, you have the right to ask for an appeal by means of a hearing. You may appeal to the local department or write directly to:

Director, Division of Appeals and Fair Hearings
Virginia Department of Social Services
801 East Main Street
Richmond, Virginia 23219-2901

KEEP THIS PAGE FOR YOUR RECORDS

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