

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information			
Operation's Name: Ready Steady Go Academy		Director's Name: Trinh Ta	
Child's Full Name:		Child's Date of Birth:	Child Lives With? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian <i>(if different from the child's)</i> :	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No
In case of an emergency, call:			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	

Consent Information
1. Transportation:
I give consent for my child to be transported and supervised by the operation's employees (Check all that apply). <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school
2. Field Trips:
<input type="radio"/> I give consent for my child to participate in field trips. <input type="radio"/> I do not give consent for my child to participate in field trips.
Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance?

☐ Yes ☐ No

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

☐ Yes ☐ No

Do you want your child to wear a life jacket while in or near a swimming pool?

☐ Yes ☐ No

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance

☐ Procedures for release of children

☐ Suspension and expulsion

☐ Illness and exclusion criteria

☐ Emergency plans

☐ Procedures for dispensing medications

☐ Procedures for conducting health checks

☐ Immunization requirements for children

☐ Safe sleep

☐ Meals and food service practices

☐ Procedures for parents to discuss concerns with the director

☐ Procedures to visit the center without securing prior approval

☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions

☐ Procedures for supporting inclusive services

☐ Procedures for parents to participate in operation activities

☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Signature — Parent or Legal Guardian

Date Signed

8. Child's Special Care Needs (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Limitations or restrictions on child's activities |
| <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Reasonable accommodations or modifications |
| <input type="checkbox"/> Existing illness | <input type="checkbox"/> Adaptive equipment (<i>include instructions below</i>) |
| <input type="checkbox"/> Previous serious illness | <input type="checkbox"/> Symptoms or indications of complications |
| <input type="checkbox"/> Injuries and hospitalizations (<i>past 12 months</i>) | <input type="checkbox"/> Medications prescribed for continuous long-term use |
| <input type="checkbox"/> Other: _____ | |

Explain any needs selected above:

Does your child have diagnosed food allergies? ☐ Yes ☐ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian _____

Date Signed _____

9. School Age Children

My child attends the following school:

School Area Code and Phone No.: _____

My child has permission to (*check all that apply*):

- ☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

- ☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian _____

Date Signed _____

Requirements for Exclusion from Compliance

- ☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- ☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ☐ Pass ☐ Fail

Signature _____ Date Signed _____

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

Signature _____ Date Signed _____

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. *(Select **only one** option.)*

- ☐ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.
- ☐ A signed and dated copy of a health care professional's statement is attached.
- ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional _____ Date Signed _____

Signature — Parent or Legal Guardian _____ Date Signed _____

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature _____

Date Signed _____

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

☐ Positive ☐ Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>

Signatures

Child's Parent or Legal Guardian _____

Date Signed _____

Center Designee _____

Date Signed _____

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature _____

Date Signed _____

Purpose:

These questions are designed to give you the information needed to provide the best, most appropriate care for children. This information is confidential and parents must be reassured it will not be shared without their written permission.

Experts in the field recommend completing an assessment form for each child. It can help start mutual trust and respect that will develop into a strong, cooperative partnership between parents and caregivers.

The assessment should be completed prior to enrollment. Give parents an opportunity to review your enrollment forms and parent handbook before you complete the assessment form. The parent handbook or operational policies set forth your program's philosophy and values.

The enrollment interview is the time to obtain critical information about the child and provide information on your program's operational policies, such as health checks (if conducted), procedures for the release of children, and illness and exclusion criteria. It also provides parents an opportunity to assess your program and determine if it is best suited for their child's needs.

Child Assessment Form

Child Name (last, first, middle)		Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)		City	County	Zip
Mailing Address (if different) -- Street or P.O. Box		City	County	Zip
Telephone No. (include A/C)				

* If applicable.

1. Health

Does your child have any allergies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what allergies does your child have?			
How should we respond if he/she has an allergic reaction?			
Does your child have an existing illness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how is the medication administered, and will it need to be administered while he/she is in care?			
Is the medication prescribed for continuous use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. Toileting:

Does your child need assistance with toileting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How can we best help?			
What are your ideas about toilet training?			
How can we best help?			

3. Behavior:

Does your child have any special fears?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child communicate his/her needs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any special words that your child uses that might not be readily recognized?			
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?			
When your child gets upset, what helps him/her calm down?			
What is a good way to distract your child when he/she is having a temper tantrum?			
Are there any particular routines that are particularly helpful at naptime?			

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	
--	--

4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	
---	--

I verify that the above assessment was discussed with the parent(s) of _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

Signature of Parent Date Signed

Additional Comments:

--

NEW ☐ UPDATE ☐ DROP IN ☐

Institution Name: RIGHT FROM THE START NUTRITION

Agreement Number: 03132

Facility/Provider Name: Ready Steady Go Academy 1066

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ **Date of Birth:** _____ **Age:** _____

Sex: ☐ Male ☐ Female

Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** _____ ☐ am ☐ pm **Depart:** _____ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ America Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box. Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)
whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the
infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date Birth - 3 months	Today's Date 4 - 7 months	Today's Date 8 - 11 months
I will bring expressed breastmilk for my infant.			
I want the provider to provide the infant formula for my infant.			
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.			

According to CACFP requirements, in order to claim meals for reimbursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them.	Please mark your preference	Today's Date 4 - 7 months	Today's Date 8 - 11 months
	I want the provider to provide the infant cereal and other foods for my		
	I will bring the infant cereal and/or other foods for my infant.		

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date Dropped: _____

Work Telephone Number: _____ Emergency Telephone Number: _____

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA Director Office of Adjudication and Compliance, 1400 Independence Avenue SW, Washington, DC 20250-9401 or call (866) 632-9992, (202) 260-1026 or (202) 401-0216 (TDD). This institution is an equal opportunity provider and employer.



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number:

NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no case number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	B. Gross income and how often it was received Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-monthly
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /
	\$ /	\$ /	\$ /	\$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, 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.** (See Privacy Act Statement on the next page.)

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.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - _____ ☐ I do not have a Social Security Number



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ Asian ☐ American Indian or Alaska Native
☐ White ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- ☐ I do elect to allow my household information to be disclosed.
☐ I do not elect to allow my household information to be disclosed.

Don't fill out this part. This is 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: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free _____ Reduced _____ Denied _____ Tier I _____ Tier II _____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Privacy Act Statement:

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, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. 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) eligibility number for the participant or other (FDPIR) identifier 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 if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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;
This institution is an equal opportunity provider.
(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.