Summer Camp M.A.R.S. 2025 (JACKSON)

ENROLLMENT FORM

PARTICIPANT INFORMATION **Please type or print legibly.**

Last Name: _____ **First Name:** _____

Gender: ☐ **Female** ☐ **Male** **Age:**_____ **Date of Birth**_____

School: _____

Grade attended year 2024-2025: _____ **T-Shirt Size**_____

Home address: _____

City: _____ **State/Province:** _____ **Postal/Zip Code:** _____

County: _____ **Telephone:** _____ **cell:** _____

Parent email: _____

(Include area code with telephone)

Mother's name:_____ **Father's name:**_____

Mother's Day phone: _____ **Father's Day phone:**_____

Mother's cell: _____**Father's cell:**_____

Persons authorized to pick up child:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

Emergency contact*: _____ Relationship: _____

Phone Number: _____

Specify any of your child's health problems or allergies: _____

Is your child on any medication? __No __Yes If so, please specify: _____

EMERGENCY MEDICAL RELEASE FORM

You have our permission, in the event of an emergency and in case we are unavailable, to authorize any physician, nurse practitioner or medical personnel to examine, interview, test and if necessary, treat my child_____ as they may deem necessary.

Parent/Legal guardian name_____Date_____

Student Allergies_____

Student Medical Problems_____

Doctor_____ Phone number_____

Insurance carrier_____ Policy number_____

Who is financially responsible for the student? _____

PHOTO CONSENT FORM

____I grant permission for my son/daughter to be photographed during the 2025 Summer Camp. I further agree that these photos (still and moving) may be used in a variety of contexts to spotlight the New Vineyard Community Development Center program, including the church flyers and websites, bulletin boards and newsletter, news releases for community newspapers, and the Evangelist purposes, etc.

____I don't grant permission for my son/daughter to be photographed during summer camp 2025.

LIABILITY RELEASE STATEMENT

Child's Name_____

This Consent Form gives permission to seek whatever medical attention is deemed necessary, and releases, New Vineyard Church/New Vineyard Community Development Center, and persons of any liability against personal losses of you/your child.

I / We give permission for my child to participate in all Summer Camp activities at New Vineyard Church/New Vineyard Community Development Center on June 2, 2025, through July 25, 2025.

By signing this application, I agree to pay the non-refundable $50 registration fee and the $130 weekly fee each Monday/ Tuesday.

Parent/Guardian Signature _____Date_____

Administrative Use Only:

Date of Enrollment: _____ Date of Dismissal: _____

Amount of Deposit paid: $_____ First week payment $_____

Feeding Program Enrollment: ___Free ___Reduced ___Paid

Staff Initials ____

New Vineyard Academy _____ 2025-2026 _____

ORGANIZATION NAME PROGRAM YEAR

CHILD CARE ENROLLMENT FORM

For Parents/Guardians to Complete

Participants' Name: _____ Date of Birth: _____

Participants' Home Address: _____ Participants' Home Phone: _____

Mother's Name: _____ Home Phone: _____

Mother's Employer & Address: _____

Work Phone: _____ Work Hours: _____

Father's Name: _____ Home Phone: _____

Father's Employer & Address:_____

Work Phone: _____ Work Hours: _____

Hours of Care Needed: _____

Days: ____ Monday ____ Tuesday ____ Wednesday ____Thursday _____ Friday ____ Saturday _____Sunday

Meals Needed: ____Breakfast ____ AM Snack ___ Lunch ____ PM Snack ____ Supper

Special Needs of Participants: _____

Medical Information: (Allergies, Sickness)_____

_____

NAMES OF TWO OTHER PERSONS WHO CAN BE CONTACTED IN CASE OF AN EMERGENCY

NAME _____ NAME _____

ADDRESS _____ ADDRESS _____

CITY _____ CITY _____

PHONE # _____ PHONE # _____

Parent's Signature _____ Date Signed _____

For Provider or Center to Complete

Enrollment Date _____ Participants 's Age _____

Withdrawal Date _____ Reason for Withdrawal _____

Family Meal Application for the Child and Adult Care Food Program 2024-2025

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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Your School, Homeless Liaison, Migrant Coordinator at Phone #] Homeless ❑ Migrant ❑ Runaway❑

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** 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_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

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

An adult household member must sign this form. **If Part 3 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 Statement on the back of this 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

Family Meal Application for the Child and Adult Care Food Program 2024-2025

Part 6. Participant's ethnic and racial identities (optional)	
Mark one ethnic identity:	Mark one or more racial identities:
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ American Indian or Alaska Native ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American

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: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

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

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly
1	$27,861
2	$37,814
3	$47,767
4	$57,720
5	$67,673
6	$77,626
7	$87,579
8	$97,532
Each additional person:	+$9,953

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 list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case 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 eligibility information.

Family Meal Application for the Child and Adult Care Food Program 2024-2025

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.

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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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; or

2. **fax:**
   (833) 256-1665 or (202) 690-7442; or

3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.