ADVENTURELAND CHRISTIAN PRESCHOOL: ENROLLMENT CHECKLIST

www.AdventurelandPreschool.com 760-705-4732 1305 Deodar Rd, Escondido, CA 92026

Child's Name: _____ **Date of Birth:** _____ **Start Date:** _____

Parent/ Guardian Name: _____ **Phone Number:** _____

Parent/ Guardian Name: _____ **Phone Number:** _____

E-mail: _____ **E-mail:** _____

Allergies: _____ **Days Requested:** _____

☐ 1. Handbook Agreement

☐ 2. LIC 700 – Identification and Emergency Information *)*

☐ 3. LIC 627 – Consent for Medical Treatment

☐ 4. LIC 701 – Physician's Report - Child's Health Evaluation **(completed by a pediatrician)**

☐ 5. Copy of Immunization Record *(copy of yellow card or print out from dr's office)*

☐ 6. LIC 702 - Parent's Report - Child's Health History

☐ 7. LIC 613a – Personal Rights

☐ 8. LIC 995 – Receipt of Notification – Parent's Rights

Food Program

___ CACFP program Letter to parents/ guardians and confidentiality statement.

___ Non-Discrimination Statement.

☐ 9. Meal Benefit Form for Children (Supports our ability to provide free meals and snacks)

☐ 10. Fluid Milk Substitution request.- If applicable

☐ 11. Declining participation to receive snacks and lunches- If applicable

___ Wic Program information

Completed by Director/Administrator

☐ Admission Agreement

☐ LIC 9224 – Licensing Reports

☐ PM 286 – CA School Immunization Record

- ☐ Immunination requirements complete.
- ☐ Or follow up on missing immunizations- set due date.

Adventureland Christian Preschool

Handbook Agreement

I have access via www.AdventurelandPreschool.com to receive an electronic or printed copy of the Adventureland Parent Handbook. I understand that I may request a printed copy from the school at any time.

I understand and agree that it is my responsibility to read and familiarize myself with the information in this booklet.

I agree that my child can be included in observations, or reports that might be done for the purposes of supporting the Adventureland program, licensing and educational training.

By signing below I am agreeing to all policies, tuition and fees in this handbook.

_____

Child's Name

_____ _____

Parent / Guardian Signature **Date**

I have no objection to my child being included in school activity pictures. I understand that these pictures will be used for school projects, bulletin boards, website, marketing brochures, etc.

_____

Parent / Guardian Signature **Date**

Revised February 2013

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION
CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )

ADDRESS NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE

FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )

MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )

HOME ADDRESS NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )

PERSON RESPONSIBLE FOR CHILD LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Adventureland Christian Preschool
FACILITY NAME
TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME
. THIS CARE MAY BE GIVEN UNDER

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

Adventureland Christian Preschool . This Child Care Center/School provides a program which extends from 7 : 0
(NAME OF CHILD CARE CENTER/SCHOOL)

(a.m.)/p.m. to 5:30 a.m./(p.m.), 5 days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

_____ _____
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: Allergies: medicine:

Vision: Insect stings:

Developmental: Food:

Language/Speech: Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

SCREENING OF TB RISK FACTORS (listing on reverse side)

☐ Risk factors not present; TB skin test not required.

☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
___ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY *(*For infants and preschool-age children only)*

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐ Chicken Pox		☐ Diabetes		☐ Poliomyelitis	
☐ Asthma		☐ Epilepsy		☐ Ten-Day Measles (Rubeola)	
☐ Rheumatic Fever		☐ Whooping cough		☐ Three-Day Measles (Rubella)	
☐ Hay Fever		☐ Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

DAILY ROUTINES *(*For infants and preschool-age children only)*

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)		WHAT ARE USUAL EATING HOURS?
	BREAKFAST	BREAKFAST
	LUNCH	LUNCH
	DINNER	DINNER

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE	DATE

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

(a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.

(6) Not to be locked in any room, building, or facility premises by day or night.

(7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Community Care Licensing- Riverside County Regional Office

ADDRESS

3737 Main Street, Suite 700

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Riverside, CA	92501	(951) 782-4200

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
Adventureland Christian Preschool	1305 Deodar Rd, Escondido 92026

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

CHILD CARE CENTER
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing- Riverside County

   Licensing Office Address: 3737 Main Street, Suite 700. Riverside, CA 92501

   Licensing Office Telephone #: (951) 782-4200

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender"database, go to www.megansiaw.ca.gov

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS
(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Adventureland Christian Preschool
Name of Child Care Center

_____ _____
Signature (Parent/Authorized Representative) Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender"database go to www.megansiaw.ca.gov

California Department of Social Services
Child and Adult Care Food Programs Branch

Child and Adult Care Food Program
CACFP 09 (Rev. 06/2024)

Letter to Parents (Nonpricing Program)

Dear Parent/Guardian:

The Adventureland Christian Preschool child care center participates in the Child and Adult Care Food Program (CACFP) offered by the U.S. Department of Agriculture (USDA) and serves meals at no separate charge to all enrolled children. The reimbursement received from the CACFP helps with our food costs, and therefore, enables us to keep our fees for care as low as possible.

Please help us comply with the requirements of the USDA CACFP. Please complete, sign, and return the attached meal benefit form (MBF) to the center as soon as possible. However, you are not required to submit the MBF to participate in the program. All children enrolled in our center receive their meals at no separate charge, but the determination of eligibility category affects the amount of funding received by our center. This information is necessary to receive the reimbursement for the meals we serve to children in our program. If your first language is not English, you have a right to ask us for written or oral translation of these materials free of charge in your native language.

If your household currently receives benefits under the CalFresh Program (formerly Food Stamps), the California Work Opportunity and Responsibility for Kids (CalWORKs), or the Food Distribution Program on Indian Reservations (FDPIR), you only need to list your current CalFresh, CalWORKs, or FDPIR case number on the MBF. You must also have an adult sign and date the MBF.

However, if your household does not receive benefits under CalFresh, CalWORKs, or FDPIR, please complete the MBF and make sure you:

- Provide the names of all household members and their income by source; and
- Have an adult sign, date, and provide the last four digits of their Social Security number (SSN) or check the box Check here if no SSN (only if the adult does not have an SSN).

For All Households

The USDA defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses). Therefore, the income reported on the MBF must include the gross income of all members of your household by source.

The income you report must be the total gross income received last month, listed by source for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last year's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Eligibility Guideline chart, the center receives a higher level of reimbursement for meals served to your child(ren).

Once properly approved for free or reduced-price benefits, whether through income or proof of benefits as supported by a current CalFresh, CalWORKs, or FDPIR case number, your child(ren) will remain eligible for those benefits for 12 months.

Foster Children

For households with foster children, please contact us for additional information.

Confidentiality of Information on the Meal Benefit Form

We will use the information on the form to decide the level of reimbursement our center is eligible to receive. We will place the MBF in our food program files and keep the information confidential. Only upon your request will we share the information on your form with officials of other child nutrition, health, and education programs so they can use it to determine benefits for those programs.

Thank you for your cooperation. If you have any questions or need assistance in filling out the MBF, please contact:

Center Representative:

Kyara Mieritz

Phone Number:

(760) 705-4732

U.S. Department of Agriculture (USDA) 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.

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; or

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

3. Email: program.intake@usda.gov

This institution is an equal opportunity provider.

Meal Benefit Form for Children
Program Year _____

Name of Child Care Center: Adventureland Christian Preschool

Please read the instructions. If you need help completing this form, please call: 760-705-4732

Complete, sign, and return this form to: Kyara Mieritz (AKA Ms.Kiki)

1. Child Information

List names of all children enrolled for care.

Last Name	First Name	Middle Initial	Foster Child?

If all children listed are foster children, skip to Section 4.

2. Benefits

If you are receiving CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), or Food Distribution Program on Indian Reservations (FDPIR) benefits for your child, list the case number and **do not complete Section 3.** Skip to Section 4.

CalFresh Case Number: _____

CalWORKs Case Number: _____

FDPIR Case Number: _____

3. All Other Households

Complete this section if you did not complete Section 2. List all household members including children enrolled for care. List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

☐ Check here if this household receives no income. Skip to Section 4.

Applicants without income are requested to write a zero in the applicable field or mark no income. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

Names of all household members, including child(ren) listed above	Earnings from work before deductions	Child support, alimony	Payments from pensions, retirement, Social Security	Earnings from any other income
Example: Janet Smith	*$200/weekly*	*$150/twice a month*	*$100/monthly*	*$0*

4. Last Four Digits of Social Security Number (SSN) and Signature

Penalties for misrepresentation: I certify that all of the above information is true and correct and that the CalFresh, CalWORKs, FDPIR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the meal benefit form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Printed Name: _____

Last Four Digits of SSN: _____ Check Here if No SSN: ☐

Signature of Parent or Guardian: _____ Date: _____

Privacy Act Statement

The Richard B. Russel National School Lunch Act (NSLA) 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 SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKs), Program or 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 an SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. Racial/Ethnic Identity

You are not required to answer these questions. If you choose to do so, please mark one or more of the following racial identities:

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

If you choose to do so, please mark one of the following ethnic identities:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

How to Complete the Meal Benefit Form

1. **Child Information**
   a. Print your child's name.
   b. Indicate **yes** to the right of a child's name if they are a foster child.

2. **Benefits:** If you receive any benefits listed in this section, complete this section, and then skip to Section 4 and sign the form.

   a. List your current CalFresh, CalWORKs, or FDPIR case number(s) for your child(ren).

   b. Sign the form in Section 4. An adult household member must sign. You do not have to list an SSN.

3. **All Other Households:** Complete this section only if you do not have a case number for the benefits listed in Section 2.

   a. Complete this section and sign the form in Section 4. Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.

   b. Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). **If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported.** Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.

   c. If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.

   d. Sign the form and include the last four digits of your SSN in Section 4. If you do not have an SSN, place a checkmark next to **No SSN.**

4. **Last Four Digits of SSN and Signature:**

   a. The form must have a signature of an adult household member.

   b. The adult household member who signs the statement must include the last four digits of their SSN. If they do not have an SSN, they will place a checkmark next to the No SSN line.

   c. The last four digits of the adult household member's SSN is not needed if a CalFresh, CalWORKs, or FDPIR case number is provided.

5. **Racial/Ethnic Identity:** You are not required to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

Income to Report

Earnings from Work

- Wages, salaries, or tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self-employment

Child Support or Alimony

- Public assistance payments
- Alimony or child support payments

Pensions, Retirement, or Social Security

- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

Other Monthly Income

- Disability benefits
- Cash withdrawn from savings
- Interest dividends
- Income from estates, trusts, or investments
- Regular contributions from persons not living in the household
- Net royalties, annuities, or net rental income
- Military allowance for off-base housing
- Any other income

Description of Racial and Ethnic Categories

The federal government has established the following five racial categories and two ethnic categories:

Race:

American Indian or Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

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.

Black or African American—A person having origins in any of the black racial groups of 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.

White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Ethnicity:

Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

Not Hispanic or Latino

PARENTAL REQUEST FOR A FLUID MILK SUBSTITUTION FOR CHILDREN IN CHILD CARE

NAME OF AGENCY	NAME OF SITE	SITE TELEPHONE NUMBER
CHILD'S NAME		DATE OF BIRTH
NAME OF PARENT/LEGAL GUARDIAN		TELEPHONE NUMBER ( )

The above listed child does not have a disability, but the parent or legal guardian is requesting a fluid milk substitute due to a medical or other special dietary need. This form is not intended to accommodate children who drink fluid milk substitutions such as soy milk due to taste preferences. The child care agency has the discretion to select a specific brand of milk substitute since acceptable products must meet specified nutrient requirements. Juice cannot be offered as a fluid milk substitute for children with medical or special dietary needs that **do not** rise to the level of a disability.

This written statement will remain in effect until the parent or legal guardian revokes such statement or until the child care agency discontinues the fluid milk substitution option. Child care agencies participating in federal nutrition programs are encouraged, but not required, to accommodate reasonable requests. **The child's parent or legal guardian must sign this form.**

MEDICAL OR OTHER SPECIAL DIETARY NEED REQUIRING A FLUID MILK SUBSTITUTION

SIGNATURE OF PARENT/LEGAL GUARDIAN	PRINTED NAME OF PARENT/LEGAL GUARDIAN	DATE

The information on this form should be updated, as needed, to reflect the current medical and/or nutritional needs of the child.

DECLINING PARTICIPATION IN THE CHILD AND ADULT CARE FOOD PROGRAM

All facilities participating in the Child and Adult Care Food Program (CACFP) are required to offer meals/snacks to enrolled participants in their care according to Title 7, *Code of Federal Regulations*, Part 226 and applicable state laws.

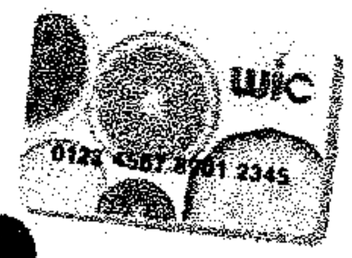
As the participant or parent/guardian, you choose to decline the agency's meals/snacks and will furnish all food for yourself or the enrolled participant. Return this form to the child/adult care agency.

PARTICIPANT'S NAME	
REASON FOR DECLINING PARTICIPATION IN THE CACFP	
PARTICIPANT'S OR PARENT/GUARDIAN'S SIGNATURE	**DATE**

FOR AGENCY USE ONLY

COMMENTS	
CENTER/REPRESENTATIVE'S SIGNATURE	**DATE**

KEEP A COPY IN PARTICIPANT'S FILE



Sign Up for WIC!

The Women, Infants, and Children (WIC) Nutrition Program provides healthy foods, nutrition tips, breastfeeding support, health care referrals and community information.

You may qualify if you:

- Are pregnant, breastfeeding, just had a baby; or
- Had a recent pregnancy loss; or
- Have a child or care for a child under age 5; and
- Have low-to-medium income; or
- Receive Medi-Cal, CalWORKS (TANF), or CalFresh (SNAP) benefits; and
- Live in California

Visit **www.phfewic.org** or call **888-942-2229** for more information.

Local Agency Information

www.phfewic.org
Text "Apply" to 91997
(888) 942-2229

Newly pregnant individuals, working families, including military and migrant families are encouraged to apply! WIC welcomes dads, grandparents, foster parents, and guardians who care for eligible children.

This institution is an equal opportunity provider.

¡Inscríbase en WIC!

El Programa de Nutrición para Mujeres, Bebés y Niños proporciona alimentos saludables, consejos sobre nutrición, apoyo con la lactancia materena, refrencias para recibir atención médica e información comunitaria.

Es posible que usted califique si:

- está embarazada, dando pecho, o acaba de tener un bebé
- tuvo una pérdida de embarazo reciente
- tiene o cuida a un niño menor de 5 años de edad
- tiene un ingreso bajo a mediano
- recibe beneficios de Medi-Cal, CalWORKS (TANF), o beneficios de CalFresh (SNAP) y
- vive en California

Visite el sitio web **www.phfewic.org** o llame al **888-942-2229** para obtener más información.

Su Programa de WIC Local

www.phfewic.org
Envie "Aplicar" al 91997
Llame al: (888) 942-2229

¡Se les anima aplicar a mujeres embarazadas, familias aun si trabajan, incluyendo familas de militares y familias migrantes! Padres, abuelos, padres de crianza o tutores con niños a su cuidado que son elegibles para WIC son bienvenidos.

Esta institución es una proveedora que ofrece igualdad de oportunidades