

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance
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PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

Yes No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number
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AUTHORIZATIONS

- Yes No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- Yes No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
- Yes No I give permission for my child to participate in Transported Walking field trips and other activities during operating hours.
- Yes No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed
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HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address ~ Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date ~ First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number ~ Home	Telephone Number ~ Work	Telephone Number ~ Cellular
Name	Telephone Number ~ Home	Telephone Number ~ Work	Telephone Number ~ Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name ~ Physician	Address ~ Medical Facility	Telephone Number
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SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.	No-Ad	SPF 45
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.	Repel	29

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
- | | | |
|--|---|--|
| <input type="checkbox"/> No specific medical condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / seizure disorder | <input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism |
| <input type="checkbox"/> Cerebral palsy / motor disorder | <input type="checkbox"/> Other condition(s) requiring special care ~ Specify. | |
- Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
- Food allergies ~ Specify food(s).
- Non-food allergies ~ Specify.

OVER

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

a.

b.

c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE ~ Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within 30 school days (6 calendar weeks) of admission to the day care center. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (1) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.
 Yes year _____ (Vaccine is not required)
 No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).
²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.
³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).
⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR
 IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

Physician's Signature Required

For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian

Date Signed

LEGAL NOTICE

Required Immunizations for Admission to Wisconsin Day Care Centers

To the Parent, Guardian or Legal Custodian of _____

The Wisconsin Student Immunization Law requires that all children in day care centers meet a minimum number of required immunizations. These requirements can be waived only for health, religious or personal conviction reasons. According to our records, your child is not compliant because either a record is not on file at the center or an immunization is needed (see reason for noncompliance as marked below). To remain compliant with the law, please provide the month, day and year your child received the required immunization (s) on the attached Day Care Immunization Record or select one of the waiver options prior to _____ (Date). Failure to do so may result in a fine of up to \$25 per day or possible exclusion from the day care center.

In past years, thousands of Wisconsin children caught diseases such as measles, pertussis (whooping cough) and rubella, and many were left with severe disabilities. The Student Immunization Law was passed to keep these and other vaccine-preventable diseases from harming the health of our children.

Reason for noncompliance:

No Record at Day Care Center

Your child needs the following checked vaccine(s):

DTP/DTaP/DT/Td

- 1st Dose
- 2nd Dose
- 3rd Dose
- 4th Dose
- 5th Dose

Polio

- 1st Dose
- 2nd Dose
- 3rd Dose
- 4th Dose

Hib

- 1st Dose
- 2nd Dose
- 3rd Dose

PCV*

- 1st Dose
- 2nd Dose
- 3rd Dose

Hepatitis B

- 1st Dose
- 2nd Dose
- 3rd Dose

MMR

- 1st Dose
- 2nd Dose

Varicella (chickenpox)**

- 1st Dose

* PCV means pneumococcal conjugate vaccine

** If your child already had chickenpox disease, varicella vaccine is not required. Check "yes" to the chickenpox disease question on the attached Day Care Immunization Record and enter the date of disease if known.

Your immediate cooperation is appreciated.

SIGNATURE - DAY CARE OFFICIAL DATE SIGNED

Day Care Center: Please be sure to attach a blank Day Care Immunization Record (F-44192).

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)
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Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

Yes No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)
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SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination
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Building For the Future

This facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving child care, participating in afterschool programs, or residing in homeless shelters.

Each day, more than 2.6 million children participate in the CACFP across the country. Participating facilities are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of child care, afterschool programs, and homeless shelters, and making it more affordable for low-income families.

Meals Participating facilities must follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities

Many different facilities operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Programs:** Centers in low-income areas provide free meals and snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility

State agencies reimburse facilities that offer services to the following participants:

- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool programs in needy areas and homeless shelters.

Contact

Information

If you have questions about the CACFP, please contact one of the following:

Participating Agency Contact Information	State Agency Contact Information
<i>Contact Person</i> Sara Oughton	Amanda Kane, RDN, CD, Director
<i>Agency Name</i> Shining Stars Learning Center	Community Nutrition Programs
<i>Agency Address</i> 784 South Main Street, Fond du Lac, WI 54935	Wisconsin Department of Public Instruction
	P.O. Box 7841
<i>Agency phone number</i> 920.929.8688	Madison, WI 53707-7841
	608-267-9129



This institution is an equal opportunity provider.



Parent/Guardian Instructions:

Use a separate form for each enrolled child. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child, to meet the annual updating requirements.**

GENERAL INFORMATION		
Child's Name	Child Care Facility	Child's Age

HOURS AND MEALS WHILE IN CARE										
Days Normally in Care (Check ✓)	Hours Normally in Care				Meals Normally Received While in Care (Check ✓)					
	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Monday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tuesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wednesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thursday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information

Signature of Parent/Guardian ➤	Date Signed <i>Mo./Day/Yr.</i>
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ANNUAL UPDATE 1

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➤	Date Signed <i>Mo./Day/Yr.</i>
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ANNUAL UPDATE 2

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➤	Date Signed <i>Mo./Day/Yr.</i>
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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](https://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer), (AD-3027) found online at: <https://www.ascr.usda.gov/filing-program-discrimination-complaint-usda-customer>, 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.

Dear Parent or Guardian:

Shining Stars Learning Center, LLC

(Name of Agency)

is enrolled in the CACFP, a USDA program which

provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. **In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year. Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files.** Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher ("Free" or "Reduced-price") meal reimbursement rates for your enrolled children, for 12 months from the *Effective Month of Determination* regardless of any change in your household size and/or income or termination from Benefits Programs.

• You are not required to complete this HSIS if no one in your household receives benefits from FoodShare WI (the Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), or the W-2 (Wisconsin Works) Cash Assistance Program and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

Determining Eligibility based on Participation in Benefits Programs → Complete Part 1 and Part 3 of HSIS form

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDPIR, or W-2 Cash Assistance.

W-2 Cash Assistance is Wisconsin's Temporary Assistance for Needy Families (TANF) program. **It provides temporary cash assistance through work placement and training programs and IS NOT the Wisconsin Shares Child Care Subsidy Program.** W-2 Cash Assistance Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), W-2 Transitions (W-2 T), Custodial Parent of an Infant (CMC), and At Risk Pregnancy (ARP).

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDPIR, W-2 Cash Assistance:

- | | |
|---|--|
| <p>(a) The names of your enrolled children;</p> <p>(b) <u>Checked box</u> for the benefit your household receives <u>and its case number</u>; and</p> <p>(c) The signature of an adult member in the household & signature date</p> | <ul style="list-style-type: none"> • DO NOT list case numbers for: Medicaid, SSI, OR Wisconsin Shares Child Care Subsidy program AND • DO NOT list the 16 digit Quest Card number for FoodShare WI |
|---|--|

Determining Eligibility by Household Size and Income → Complete Part 2 and Part 3 of HSIS form

Household-Size Income Scale (Effective July 1, 2019 to June 30, 2020)

Household Size	Annual Income Level (at or below)
1	\$ 23,107
2	\$ 31,284
3	\$ 39,461
4	\$ 47,638
5	\$ 55,815
6	\$ 63,992
7	\$ 72,169
8	\$ 80,346
For each additional Household Member, add:	+ \$ 8,177

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates ("Free" or "Reduced-price" meal rate) for your children.

For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):

- (a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
- (b) Income received by each household member identified by source of income and its pay frequency;
- (c) Total number of household members;
- (d) The signature of an adult member of the household and signature date; and
- (e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.

• Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children

enrolled in Head Start: Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below.

• Please note: These children's **eligibility for Free meals does not extend to other children in your household.**

The respective documentation is required for these children to be eligible for Free Meals:

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, the W-2 Cash Assistance Program, or FDPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

Sharing Eligibility Information: Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, **unless you tell us not to.** This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Please note that filling out this HSIS does not automatically enroll your children in these programs. **If you do not want your information to be shared with these programs, please notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement.** Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](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; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider.

Sara Oughton

Signature of Agency Representative

HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household.

Refer to the accompanying Household Letter for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren)	Center Shining Stars Learning Center
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PART 1: BENEFITS

If no one receives these benefits, skip to PART 2.

If any member of your household currently receives benefits from:	Check the box for the benefit received AND list the case number	<ul style="list-style-type: none"> • DO NOT list a 16 digit Quest Card number for FoodShare • Wisconsin Shares Child Care Subsidy benefits is NOT W-2 Cash Assistance.
FoodShare Wisconsin (10 digit #) <input type="checkbox"/>	_____	
Wisconsin Works (W-2) Cash Assistance (10 digit #) <input type="checkbox"/>	_____	
FDPIR (9 digit #) <input type="checkbox"/>	_____	

PART 2: TOTAL HOUSEHOLD SIZE AND INCOME (Complete a, b, and c)

If you completed PART 1, you do not need to list household and income information below.

a) List full names of all household members below , including yourself and all children.	b) List all income on the same line as the person who receives it. <ul style="list-style-type: none"> • Record each income source only once. • Check the box for how often each income source is received. 																																																																																																																																																																														
Household Member: anyone who is living with you and shares income and expenses, even if not related.																																																																																																																																																																															
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c) Record total # of household members: _____																																																																																																																																																																															

PART 3: ALL HOUSEHOLDS

ETHNICITY AND RACE DATA COLLECTION – Completion is optional

This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. **Please answer both questions.**

IS YOUR CHILD(REN) HISPANIC OR LATINO? Yes, Hispanic or Latino No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):

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

ADULT HOUSEHOLD MEMBER SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SS#)

If Part 2 is completed, the adult signing the form must list the last four digits of his/her SS# OR check "None" if he/she does not have a SS#.

I CERTIFY (promise) that all information on this form is true, and that all income is reported unless eligibility is established by receiving FoodShare, W-2 Cash Assistance, and/or FDPIR. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	Signature Date Mo./Day/Yr.	Last 4 digits of SS# (or check "None" if you do not have a SS#) ***-**-____ <input type="checkbox"/> None
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FOR CENTER USE ONLY – Complete all 3 sections and the Effective Month of Determination

<p>Section 1: Basis of Determining Eligibility (A or B)</p> <p>A. Household Size & Income</p> <p>Total Household Size _____</p> <p>*Total Income \$ _____ / _____ (\\$ Amount) (Time Period)</p>	<p>Section 2: Eligibility Determination</p> <p><input type="checkbox"/> Free</p> <p><input type="checkbox"/> Reduced</p> <p><input type="checkbox"/> Non-Needy</p>	<p>Section 3: Determining Official's Initials & Approval Date</p> <p>_____</p> <p>**Effective Month of Determination</p> <p>_____</p> <p>Month/Year</p>
<p>B. Benefits/Foster</p> <p><input type="checkbox"/> FoodShare WI</p> <p><input type="checkbox"/> W-2 Cash Assistance</p> <p><input type="checkbox"/> FDPIR</p> <p><input type="checkbox"/> Foster Child(ren)</p>		

*Convert to yearly income only when multiple pay frequencies are reported, using only these multipliers:

Weekly x 52	Twice a month x 24
Every 2 weeks x 26	Monthly x 12

**This form expires one year from the Effective Month of Determination.



Media/Photography: Consent & Release Form

Shining Stars Learning Center would appreciate it if the parents completed this consent form in order to allow their children to be photographed during special events or normal day to day activities organized at Shining Stars Learning Center. In order for a child to have their photograph taken, they must have a consent form on file at Shining Stars Learning Center.

If you do not want to have your child photographed, please do not hesitate to indicate this in the section below. As well, if you do object, please ensure that your child is aware of this.

As the parent of a child/children at Shining Stars Learning Center, I agree to the following:

- I understand that my child (ren) whose name(s) are listed below may be photographed or images recorded at Shining Stars Learning Center during normal daycare hours, fieldtrips, or activities which may be used in school newsletters, mounted on the Shining Stars Learning Center website, or in publications.

The following are the names of my children attending Shining Stars Learning Center:

(Please print your child's full name):

- () Yes, I confirm that I have read and understood the above, and agree to have my child (rens) photos mounted on the Shining Stars Learning Center website or newsletters.
- () No, I do not wish to have my child(ren) photographed.

Name (please print): _____

Date: _____

Signature: _____

Acknowledgement of receipt and understanding

I acknowledge that I have received the Shining Stars Learning Center Family Admission Policy & Procedures and I have read and understand the policies.

I understand that this Handbook represents current policies. Shining Stars Learning Center retains the right to change these policies, as it deems advisable and will notify you in writing of any changes or additions.

I further understand that I am obligated to familiarize myself with the Shining Stars Learning Center's policies and procedures as outlined in this book or in other documents.

Parents and Caregivers have an opportunity participate in a committee which provides input regarding policies and procedures for the center. This committee meets annually the first Friday in November starting at 6:00pm. If you are interested in participating, please check the box below.

Signature Date

Please Print Your Name

Parent or Guardian of the following children:

Parent/Child Orientation:

- Tour of the facility
- Introduced to teaching staff
- Parent visit with the classroom teacher
- Discussion of expectations of family and the needs of the child
- Overview of available family support resources and activities
- Interpreter available if needed
- Opportunity for extended visit in the classroom by both parent and child for a period of time to allow both to be comfortable in the new surroundings

Committee Involvement

Yes No

