Getting to Know Your Child

Child's Name_____ Nickname (if applicable) _____

Has your child been in an early learning program or child care before? **Yes or No**

- If **yes**, would you share some information with us? (Where? When? For how long? Reason for Leaving?)

_____

Does the child have any unusual eating problems or food dislikes? (Explain) _____

_____

Does the child have any allergies? **Yes or No**

- If **yes**, what are they? How severe? and What steps should be taking if you child has a reaction?

_____

_____

Are there any important routines at drop off/pick up/naptime/etc. that would be helpful to know about?

_____

Does the child usually nap? _____How long? _____ What Times? _____

What are the child's fears? _____

Does the child have any nervous habits? _____

- If yes, when does the child show them? _____

What is your attitude towards discipline? _____

Any further information that might be helpful in understanding the child (visual or physical handicaps, for example):

_____

_____

Names and ages the child's brother(s) and sister (s): _____

How do you prefer to receive communication from us (email, paper or both)? _____

What are your expectations for your child from our program? _____

_____

Where did you hear about us? (Please Circle) Internet Search, Our Website, ELRC, Phone Book, Parent Referral, Center Referral, Other (please explain): _____

For office use Only

Start Date: _____

Reviewed By:

Director: _____ Date: _____

Group Supervisor: _____ Date: _____

Emergency Contact/Parental Consent Form

55 PA CODE CHAPTERS 3270.124(a)(b); 3270.181 & 182; 3280.124(a)(b); 3280.181 & 182; 3290.181 & 182

Child's Name:	Birth Date:	Enrollment Date:

Child's Address:

_____ Street/Apt #/PO Box _____ City _____ State _____ Zip Code

Mother/Legal Guardian Contact Information:	Father/Legal Guardian Contact Information:
Name:_____	Name:_____
Home #: ( )_____	Home #: ( )_____
Mobile #: ( )_____	Mobile #: ( )_____
Work #: ( )_____	Work #: ( )_____
Email Address: _____	Email Address: _____
Home Address: ☐ ***same as child***	**Home Address:** ☐ ***same as child***
_____ Home Address	_____ Home Address
☐ **Employment OR** ☐ **School:** Business or School Name:	☐ **Employment OR** ☐ **School:** Business or School Name:
_____ Address:	_____ Address:

Emergency Contact Person(s) (*in addition to the parents)* **Name, Relationship, and Phone #**:

1. _____
2. _____
3. _____

I give permission for my child to be released to any of the following person (s) (18 years of age of older) when I am unable to pick my child up from the classroom or bus stop (*in addition to the parents)*. Name, Address, Relationship & Phone #

1. _____
2. _____
3. _____
4. _____

Physician Name: _____

Physician Address: _____

Physician Phone #: _____

Insurance Information: _____

ID#:_____ Group #: _____

Allergies:_____

Special Disabilities / Medical Conditions / Special Needs / Dietary Restrictions:

Parent/Legal Guardian Permission:

Obtaining Emergency Medical Care _____ *Initials*

Transportation by Facility _____ *Initials*

Admin. Of Minor First Aid Procedures _____ *Initials*

Walks and Trips _____ *Initials*

X _____

Signature of Parent or Guardian

Date: _____

Agreement

55 PA CODE CHAPTERS 3270.123 & 181 (c); 3280.123 & 181 (c); 3290.123 & 181 (c)

Name of Child:

Private Pay Amount: $_____per week; due Monday prior to attendance

Agency Amount: $_____per week; due Monday prior to attendance

Services to be provided as part of the day care fee (example: transportation, care, meals, etc.)

- We shall provide a safe and pleasant environment that will enhance your child's growth and development.
- We provide good and nutritious meals aligned to the FDA program standards (Breakfast, Am Snack, Lunch, PM Snack based on arrival and departure time).
- We enhance your child's social and emotional skill with peers and staff members.
- We provide opportunities for your child to enhance gross and fine motor skills both indoors and outdoors.
- We provide opportunities for your child to engage in problem solving.
- We enhance your child's language abilities through speaking, listening and checking for understanding through discussions and story books.
- We also teach proper writing skills to each child.

Childcare

___Monday __Tuesday ___Wednesday ___Thursday ___Friday ___Days Vary

☐ Pre-School Only (3-day Minimum)
☐ Pre-K Only (3-day Minimum)

Extra services to be provided at an additional fee if applicable:

- NSF checks will accrue a $36.00.
- Registration Fee: $25/Family
- Annual Supply Fee: $25/Family
- $3.00 per day diapering fee for Pre-Schooler still in diapers
- Technology Fee $3 per Month/Family (billed on 15th of every month)
- A late payment fee of $25.00 will occur on Wednesday for nonpayment of previous week of service.
- Overtime fee will be charged on a prorated rate of $6.00 an hour for late pickups that are over 10 hours of service
- Late pickup fee of $25, for After business hour pickups.

Childs Arrival Time: _____ AM/PM (Approx.) **Childs Departure Time: _____ AM/PM (Approx.)**

After Hour Fee: $25 After 6PM
Late Pick Up fee of $6.00 per hour for over 10 hrs. of Service

Person(s) designated by parent to whom child may be released: SEE EMERGENCY CONTACT SHEET

I, the parent/guardian:

☐ **Received complete written program information at the time of enrollment.**
(§ 3270.121, 3280.121, 3290.121)

☐ **Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum.**

(§ 3270.121, 3280.121, 3290.121)

_____ _____ **X**_____ _____

Signature– Director **Date** **Signature– Parent/Guardian** **Date**

Date of Child's Admission:_____ **Date of Child's Withdrawal:_____**

Permission Form

Child's Name: _____ Date: _____

I give permission for my **child** to be transported to and from Pre-K Kids Learning Center. _____ **Initials**

This permission form Authorizes Pre-K Kids Learning Center to transport my child in any emergency.

If child named above has special needs or problems that require special care while being transported, such as seizures or motion sickness, please write instructions on back of this form.

I give permission for Pre-K Kids Learning Center to photograph my child for the following purposes: _____ **Initials**

Please check one for each line

Type of Use	Yes	No
Display photos in teacher made books that may go home with current clients. (Only first names may be displayed with their pictures in teacher made books)		
Display still photos on Pre-K Kids Learning Center website		
Send photos through our parent communication system (ex: Kidreports) possibly containing your child to current clients		
Post photos on Pre-K Kids Facebook page		

I give Pre-K Kids Learning Center permission to apply the following on my child, as needed. _____ **Initials**

I understand that only products I have supplied will be used.

Circle One

Sunscreen	Yes	No
Diaper Cream	Yes	No

I give permission to for my child to walk to Shenango Park with Pre-K Kids Learning Center Staff. _____ **Initials**
I/We understand all reasonable safety precautions will be taken at all times by Pre-K Kids Learning Center and its agents during the events and activities.

I understand that it is my responsibility to update this form if I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____

(Parent or Guardian Signature)

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO	**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**	
	VISION (subjective until age 3)	
	HEARING (subjective until age 4)	
	LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Pre-K Kids Learning Center Inc.
2740 Ellwood Rd. New Castle, PA 16101
(724) 652-0922 - www.prekkidslearningcenter.com

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **[Name of Center]** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [(Name of Center, address, phone number].**
2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.
3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application. Children in households participating in WIC may be eligible for reduced price meals.
4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
5. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.
6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed, by source, each household member received last month. 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 month'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 Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, or FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **[name, address, phone number].**
9. **We are in the military, do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **724-652-0922.**

Sincerely,

Eduviges Miller
Director

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) 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.

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, (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:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

Fax: (202) 690-7442

Email: program.intake@usda.gov.

Instructions for Completing the CACFP

Child Care Center Meal Benefit Income Eligibility Form

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.

Part 2: List the case number for any household members (including adults) receiving **State SNAP** or **State TANF** or **FDPIR** benefits.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.

Part 6: Answer this question if you choose.

FOSTER CHILDREN HOUSEHOLDS, will follow these instructions:

A Meal Benefit Form is not required to be completed. Contact the center at *[insert sponsor telephone number]*; OR

If some of the children in the household are foster children:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have a case number, skip this part.

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]. If not, skip this part.

Part 4: Follow these instructions to report total household income for this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if she/he doesn't have one.

Part 6: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income for this month or last month.

Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
Box 2: List the amount each person got for the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if she/he doesn't have one.

Part 6: Answer this question if you choose.

PRE-K KIDS LEARNING CENTER

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

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 [State SNAP], [FDPIR], or [State 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 center director, 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 Privacy Act 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

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

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native
❑ Not Hispanic or Latino	❑ 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: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: _____

Reason for Denied:_____

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	$22,459
2	$30,451
3	$38,443
4	$46,435
5	$54,427
6	$62,419
7	$70,411
8	$78,403
Each additional person:	$7,992

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) 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.

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, (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:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

Fax: (202) 690-7442

Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Child and Adult Care Food Program
Child Enrollment Form (Sample)

Sponsor:_____

Center:_____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:**					**Withdrawal Date:**			
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:**					**Withdrawal Date:**			
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:**					**Withdrawal Date:**			
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FOURTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:**					**Withdrawal Date:**			
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FIFTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:**					**Withdrawal Date:**			

Signature

_____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY:

_____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This portion of the form can be used to capture multi-year annual updates.
****

Annual Time Period Covered by Signature: ________________ **to** ________________
Signature Parent/Guardian____ **Date** ________________
Signature Center Administrator/Home Provider_________________________ **Date** ________________
****

Annual Time Period Covered by Signature: ________________ **to** ________________
Signature Parent/Guardian____ **Date** ________________
Signature Center Administrator/Home Provider_________________________ **Date** ________________
****

Annual Time Period Covered by Signature: ________________ **to** ________________
Signature Parent/Guardian____ **Date** ________________
Signature Center Administrator/Home Provider_________________________ **Date** ________________
****

Annual Time Period Covered by Signature: ________________ **to** ________________
Signature Parent/Guardian____ **Date** ________________
Signature Center Administrator/Home Provider_________________________ **Date** ________________
****

Automated Payments Processing
Safe – Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize **Pre-K Kids Learning Center** to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

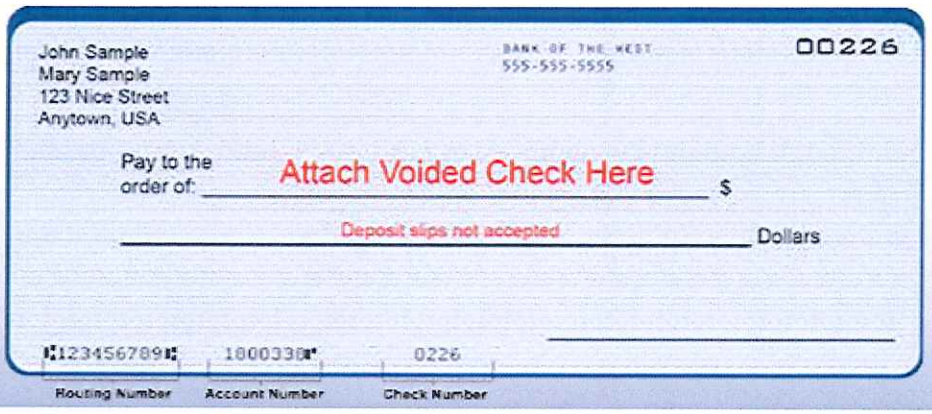
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ Checking ☐ Savings ☐

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



A service of procare SOFTWARE®