

Registration Information

*Reception: Please fill out at the time a registration packet is given to the parent. Once complete, place it in my mailbox.
Thanks, Sue*

Parent/Guardian registering the child _____

Contact Phone _____ [] Home [] Cell [] Work

Child's Name _____ Date of Birth _____

Projected start date _____

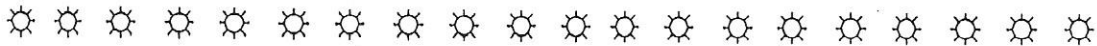
HOURS • ☐ Part-time from _____ to _____ ☐ Full-time from _____ to _____



SCHOOL AGE CHILD INFORMATION

School Attending _____

Attendance at SonShine - ☐ AM ☐ PM ☐ Both



REGISTRATION FEE - \$ _____ DATE PAID _____ [] CHECK # _____ [] CASH

Dear Parents,

All paperwork from this packet (including the Medical & Immunization Forms) **MUST BE COMPLETED AND SUBMITTED** to SonShine Child Care Center ONE WEEK prior to your child's start date.

If we do not have a COMPLETED Registration Packet from you prior to the time your child is scheduled to begin, the start date will be delayed until all paperwork is received.

We appreciate your compliance with this matter.

Sincerely,

Judith Tornabuoni

Judith Tornabene
Director
SonShine Child Care Center

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	PROGRAM NAME:		ADDRESS:		PHONE NUMBER: () -
	CHILD'S FULL NAME:				DATE OF BIRTH: / /
	PREFERRED NAME/NICKNAME:				GENDER:
	CHILD'S HOME ADDRESS:				
NAME OF PERSON ENROLLING CHILD:			RELATIONSHIP TO CHILD: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____		
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: () -			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):		
EMAIL ADDRESS:			<input type="checkbox"/> ok to text		
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	PRIMARY CONTACT:		<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text	() - <input type="checkbox"/> ok to text
FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /			FOR PROGRAM USE ONLY DATE OF DISENROLLMENT: / /		

CHILD'S FULL NAME:		DATE OF BIRTH: / /
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> Other _____		
Please provide information here AND discuss with your child care provider:		
CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:		PHONE NUMBER: () -
PREFERRED HOSPITAL:		PHONE NUMBER: () -
CHILD'S DENTAL CARE:		PHONE NUMBER: () -
Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/		
AGREEMENTS <ul style="list-style-type: none"> • I consent to emergency medical treatment for my child..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I provided information on my child's special needs to the program to assist in caring for my child..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I agree to review and update this information whenever a change occurs and at least once every year..... <input type="checkbox"/> Yes <input type="checkbox"/> No 		
SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE: / /

*you will be asked to fill out a physical copy of this upon arrival

SONSHINE CHILD CARE CENTER
Parents' Authorization for Child Pick-Up

3

PARENT: Please complete this form in its entirety authorizing anyone other than yourself (parent), to pick up your child(ren) from SonShine Child Care Center. Please provide full names, addresses and phone #s. We will compare this information to the person's driver's license to confirm their identity.

.....

The following person(s) are authorized to pick up my child _____
_____ from SonShine Child Care:

Authorized Person #1

Name: _____

Address: _____

Phone #: _____

Authorized Person #2

Name: _____

Address: _____

Phone #: _____

Parent Signature: _____ Date: _____

.....

Please list any ADDITIONAL AUTHORIZED PERSON(S) with their contact information on the back of this form.

Thank you from the staff at SonShine Child Care Center!

MY CHILD'S DAILY SCHEDULE

4

PARENT: Please complete a separate form for each child in Nursery I through Pre-K. Disregard if your child is in Kindergarten through 5th grade.

Child's Name _____

.....

My child's typical day is as follows (from waking up to going to bed):

<i>Time</i>	<i>Activity</i>	<i>Who is child with and where?</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

.....

Parent Signature: _____ Date: _____

Thank you from the staff at SonShine Child Care Center!

SONSHINE CHILD CARE CENTER
Napping Arrangement

5A

I give permission for my child _____ to nap or rest on the following
in their nap room:

- () crib – nursery 1, nursery 2 & nursery 3
() cot – rooms 108, 1089, 211, 212, 208 & 209
() mat - Pre-K and school-age, where appropriate



Parent/Guardian Signature _____ Date _____

SONSHINE CHILD CARE CENTER
Permission to Photograph

5B

Dear Parent/Guardian,

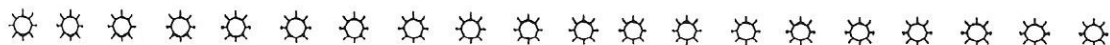
Occasionally, a teacher may wish to photograph your child – that picture to be used for a "secret" gift for you. We at SonShine Child Care need permission to photograph your child for any purpose. Please complete the following this form and return it to your child's teacher:

Child's Name: _____

____ I DO give permission for a SonShine teacher to photograph my child.

____ I DO give permission for a SonShine teacher to photograph my child with his/her friends
(in a group only).

____ I DO NOT give permission for a SonShine teacher to photograph my child for any purpose.



Parent/Guardian Signature _____ Date _____

SONSHINE CHILD CARE CENTER

6

Emergency Contact Information

PARENT: Please complete this form in its entirety to help the staff of SonShine Child Care Center best care for your child.

Child's Name: _____ Enrollment Date: _____

.....
In the event of an emergency, please contact _____
(Please print)

at _____ ☐ home ☐ cell ☐ work

or _____ ☐ home ☐ cell ☐ work

I _____, give SonShine Child Care permission for
medical treatment to be given.

(parent/guardian signature) (date)

.....

Publicity Permission Information

I DO NOT give permission for my child _____
to be photographed for publicity purposes.

I DO give permission for my child _____
to be photographed for publicity purposes – as below: (please check one)

___ I DO NOT give permission for my child to be identified by name.

___ I DO give permission for my child to be identified by name.

(parent/guardian signature) (date)

.....
Thank you from the staff at SonShine Child Care Center!

Receipt of Parent Handbook

I have read the SonShine Child Care Center Parent Handbook, including any attached addendums. I agree to abide by the rules and regulations contained therein. I understand that the rules, policies, and benefits contained in the Parent Handbook may be updated, modified, or deleted at any time, and that it is my responsibility to keep myself informed of any changes the Center will pass on.

Print Name

Signature

Date

SONSHINE CHILD CARE CENTER
Child Enrollment Information

8

PARENT: Please complete this form in its entirety to help the staff of SonShine Child Care Center to best understand your child.

Child's Name: _____ Enrollment Date: _____

.....

☼ Does your child have any unusual eating problems or food dislikes? *(Please explain)*: _____

☼ Does your child have any allergies? *(Please explain)*: _____

☼ What time does your child usually nap? _____

☼ Does your child have any security items? *(Please list)*: _____

☼ Does your child have any fears or nervous habits? *(Please explain)*: _____

☼ What is your (parents') attitude toward disciplining your child? _____

☼ What other helpful information can you tell us about your child? _____

.....

PARENT PERMISSION - I understand my child may leave the grounds with a SonShine staff for walks, field trips, etc. Younger children (Nursery I – Room 109) will be taken out for fresh air in a buggy or 6-seat stroller (weather permitting).

Parent Signature: _____ Date: _____

Thank you from the staff at SonShine Child Care Center!

6) Infant Feeding Schedule

12 MONTHS AND UNDER

9

I give permission for caregiver to mix formula for my child: _____

I will provide caregiver with bottles of mixed formula: _____

I will provide caregiver with bottles of breast milk: _____

Feeding Instructions:

- Type (bottle, cereal, baby food) _____
- Amount: _____
- Time of Day or How Often: _____

- Type (bottle, cereal, baby food) _____
- Amount: _____
- Time of Day or How Often: _____

- Type (bottle, cereal, baby food) _____
- Amount: _____
- Time of Day or How Often: _____

Comments: _____

**Parent Signature: _____ Date: _____



INFANT FEEDING STATEMENT

Baby's Name: _____ Date of Birth: _____

Dear Parent/Guardian:

This center/provider participates in the Child and Adult Care Food Program and we will give your baby **Berkley & Jensen** (name of formula) and solid food. If you want to bring your own formula or food, you can do that instead. Please let us know your choice by checking below.

FORMULA (CHECK ONE)	FOOD (CHECK ONE)
<input type="checkbox"/> The center/provider can give my baby the formula they buy.	<input type="checkbox"/> The center/provider can give my baby solid foods when I tell them the baby is ready.
<input type="checkbox"/> I will bring breast milk or formula for my baby.	<input type="checkbox"/> I will bring solid foods for my baby.

Parent's Signature: _____ Date: _____

SONSHINE CHILD CARE CENTER

11

Registration for Day Care

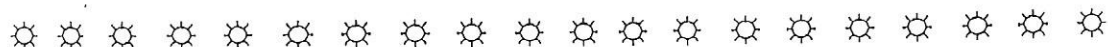
Child _____
Last Name First Name Middle Date of Birth Sex

Home Address _____
Street City State Zip

Home Phone _____ Emergency Phone _____ E-Mail: _____

Responsible Person _____
Name Relationship to child

Physician's Name _____ Phone # _____



Father (or guardian) _____ Phone # _____

Occupation _____ Employer _____ How long at job? _____

Mother (or guardian) _____ Phone # _____

Occupation _____ Employer _____ How long at job? _____

Other children in the family:

Name: _____ DOB: _____ School: _____ Age: _____

Name: _____ DOB: _____ School: _____ Age: _____

Name: _____ DOB: _____ School: _____ Age: _____

HOME LIFE (please check all that apply): ☐ parents are living together ☐ parents are separated

☐ parents are divorced ☐ child in foster home ☐ grandfather in home ☐ grandmother in home

☐ other relative(s) in home (specify): _____

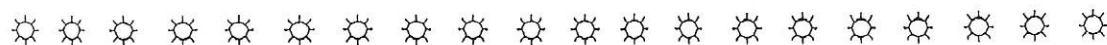
Number of persons living in the home: _____

What time will the child arrive at the center? _____ What time will the child be picked up? _____

How will child get to the center? _____

Who will pick up the child? _____

(only those with written permission on record will be allowed to pick up the child)



ENTRY DATE - _____

HOURS - ☐ Part-time from _____ to _____ ☐ Full-time from _____ to _____

FEE - \$ _____ To be paid ☐ Weekly ☐ Other _____ Deposit - \$ _____

Date of Application: _____ Signature: _____

SONSHINE CHILD CARE CENTER

Permission to Administer Over-the-counter
Topical Medications

PARENT: Diaper cream, sunscreen, and insect repellent (marked with the child's name) must be provided by parents. SonShine will provide Triple Antibiotic cream/ointment and bee sting/insect bite ointment only, unless you choose to provide your own.

I, _____ (parent/guardian) give permission to SonShine Child Care to apply topical over-the-counter medications (as noted below) to my child _____:

diaper cream	() Yes	() No
sunscreen (during mid-Spring, Summer and early Fall months)	() Yes	() No
insect repellent	() Yes	() No
triple antibiotic cream/ointment	() Yes	() No
bee sting/insect bite ointment	() Yes	() No

Please sign and date the first line* at this time. You will be required to sign every six (6) months.

* Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Thank you from the staff at SonShine Child Care Center!

Emergency Contact Verification

Please provide us with your preferred emergency contact(s) and return ASAP.

Child's Name: _____

.....

In the event of an emergency; please contact:

Name: _____
(Please print)

* Email: _____

Phone #: _____ or _____

☐ home ☐ call cell ☐ text cell ☐ work

.....

Thank you from the staff at SonShine Child Care Center!

SONSHINE CHILD CARE CENTER

Keep

CLOSINGS AND DELAYS



Occasionally, we are unable to open or are forced to close due to dangerous weather conditions. Also OCFS regulations prohibit this Center from opening in the event of a power failure.

Please note: Center closings will be announced over these local stations:

WSTM 3, CW 6, CBS 5

New Channel 9 WSYR

YNN New Channel 10

In the event our phones are down, you may reach Judy by email:

judysonshine107@gmail.com.

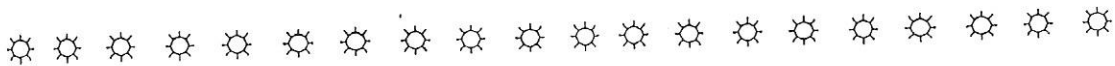
SONSHINE CHILD CARE CENTER

CACFP Annual Enrollment Form

Dear Parent/Guardian,

Please complete this form as we are required to have one on file for each child attending SonShine Child Care Center for our Child and Adult Care Food Program (CACFP).

Thank you,
Martha Daignault, Food Coordinator



Child's Name: _____

Child's Schedule: Arrival time: _____ Pick-up Time: _____

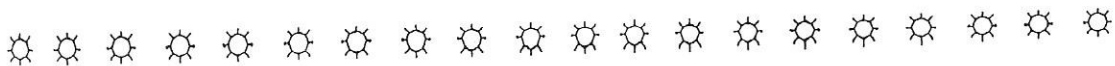
Days of the week attending: _____

Meals received while at the Center:

☐ Breakfast

☐ Lunch

☐ PM Snack



Parent/Guardian Signature _____ Date _____

SonShine Child Care Center

A ministry of
Community Covenant Church
107 Pleasant Street
Manlius, NY 13104

To: Parents of SonShine Children
From: Martha Daignault – Food Coordinator
RE: CACFP Parent Application and Annual Enrollment Form

Please sign the two attached forms in order for SonShine to participate in the state funded **Child and Adult Care Food Program**. We need the signed forms on file for each child. Please check income levels to see if you apply. You need not disclose your income if you do not qualify for free or reduced meals.

By 10-1-21

It is important that these papers are signed and returned along with the completed packet whether you qualify or not. This will keep us in compliance with the CACFP Program

July 12, 2019

SonShine Parents,

Our CACFP food program requires medical documentation must be provided for any child who has an allergy if not they must be served every component of a meal despite their preferences. If you have any questions please see Judy or Shelli. Sorry for any inconvenience this may cause.

Thank you for your cooperation,
The Administrative Staff

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

* 1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of _____
Foster Children _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

* Signature _____

* Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income \$ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of _____
Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
* 1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
7. _____	\$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

* Signature _____

* Print Name _____

LAST FOUR (4) DIGITS OF
SOCIAL SECURITY NUMBER

--	--	--	--

DATE _____

USDA is an equal opportunity provider and employer.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. 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 form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR CENTERS AND SPONSORS

The For Sponsor Use Only section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid*.

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2014 is valid until May 31, 2015.



Dear Parent, Guardian or CACFP Participant,

This center participates in the Child and Adult Care Food Program (CACFP) and provides healthy meals at no cost to all children and adults enrolled in the daycare center. By completing and returning the attached Income Eligibility Form, you will help your center receive money from CACFP for the meals that are served. If your household's income is equal to or less than the amounts indicated for your household size on the chart below, the center will receive a higher rate of funding for the meals served. The Income Eligibility Form needs to be completed every year. Your center and CACFP will keep all information private.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2021 until June 30, 2022)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	23,828	1,986	459
2	32,227	2,686	620
3	40,626	3,386	782
4	49,025	4,086	943
5	57,424	4,786	1,105
6	65,823	5,486	1,266
7	74,222	6,186	1,428
8	82,621	6,886	1,589
FOR EACH ADDITIONAL FAMILY MEMBER	+8,399	+700	+162

SPONSOR/CENTER OFFICIAL

SPONSORING ORGANIZATION

DATE

INCOME ELIGIBILITY GUIDELINES for Sponsors of Day Care Centers

INCOME ELIGIBILITY GUIDELINES (Effective July 1, 2021 until June 30, 2022)

HOUSEHOLD SIZE	FAMILY INCOME EQUALS OR IS BELOW:			FAMILY INCOME IS BETWEEN:			FAMILY INCOME EQUALS OR IS ABOVE:		
	FREE MEALS			REDUCED MEALS			PAID MEALS		
	YEAR	MONTH	WEEK	YEAR	MONTH	WEEK	YEAR	MONTH	WEEK
1	16,744	1,396	322	16,744-23,828	1,396-1,986	322-459	23,828	1,986	459
2	22,646	1,888	436	22,646-32,227	1,888-2,686	436-620	32,227	2,686	620
3	28,548	2,379	549	28,548-40,626	2,379-3,386	549-782	40,626	3,386	782
4	34,450	2,871	663	34,450-49,025	2,871-4,086	663-943	49,025	4,086	943
5	40,352	3,363	776	40,352-57,424	3,363-4,786	776-1,105	57,424	4,786	1,105
6	46,254	3,855	890	46,254-65,823	3,855-5,486	890-1,266	65,823	5,486	1,266
7	52,156	4,347	1,003	52,156-74,222	4,347-6,186	1,003-1,428	74,222	6,186	1,428
8	58,058	4,839	1,117	58,058-82,621	4,839-6,886	1,117-1,589	82,621	6,886	1,589
FOR EACH ADDITIONAL FAMILY MEMBER	+5,902	+492	+114	+8,399	+700	+162	+8,399	+700	+162

Using the Income Eligibility Guidelines – The income eligibility guidelines are used to categorize the household income reported on the income eligibility form into the free, reduced or paid category. For example, if the monthly income for a family of two is \$1,888 or less, the center would be eligible for reimbursement at the Free rate. If the household income for a family of two is between \$1,888 and \$2,686 per month, the center would be eligible for reimbursement at the Reduced rate. If the household income for a family of two is \$2,686 or more per month, the center would be eligible for reimbursement at the Paid rate.

Definition of Income – *Income* means income before any deductions such as income taxes, Social Security taxes, insurance premiums, charitable contributions and bonds. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from nonfarm self-employment; (3) net income from farm self-employment; (4) Social Security; (5) dividends or interest on savings or bonds or income from estates or trusts; (6) net rental income; (7) public assistance or welfare payments; (8) unemployment compensation; (9) government civilian employee or military retirement, or pensions or veterans payments; (10) private pensions or annuities; (11) alimony or child support payments; (12) regular contributions from persons not living in the household; (13) net royalties; and (14) other cash income.

Definition of Household – Household means *family* as defined in Section 226.2. *Family* means, in the case of children, a group of related or nonrelated individuals, who are not residents of an institution or boarding house, but who are living as one economic unit or, in the case of adult participants, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant.

This institution is an equal opportunity provider.

Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

BREAKFAST	LUNCH OR SUPPER	SNACK (TWO OF THE FIVE GROUPS)
Milk Vegetable or fruit Grains/bread or meat/meat alternate	Milk Vegetable Fruit or vegetable Grains/bread Meat/meat alternate	Milk Vegetable Fruit Grains/bread Meat/meat alternate

Participating Facilities Many different homes and centers 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 Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

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

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

Sponsoring Organization
02258
COMMUNITY COVENANT CHURCH
107 PLEASANT ST
MANLIUS, NY 13104-1838
() -

State Director, CACFP
NYS Department of Health
Division of Nutrition
150 Broadway Suite 650
Albany, NY 12204-2719
1-800-942-3858 (in NY only)
518-402-7400



USDA is an equal opportunity
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English

* You MUST use this formNEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

HA

**Medical Statement of Child in Childcare**

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child: _____

Date of Birth: _____

Date of Examination: _____

Immunizations required for entry into day care☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus Influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

TestsTuberculin Test Date: _____ Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: _____

Attach lead level statement

Health Specifics**Comments**

Are there allergies? (Specify) _____

☐ Yes ☐ No

ADDITIONAL INFORMATION ON REVERSE SIDE →

*you MUST use this form

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Medical Statement of Child in Childcare (cont.)

Is medication regularly taken? (Specify drug and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to Day Care Providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in day care.

☐ Yes ☐ No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	() Phone Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

SonShine Calendar January 1, 2021- December 31, 2021

January 1	Closed for New Year's Day
February 15	President's Day: Closed for Staff in Service Training
March 5	Beach Party Rooms 108, 109, 2
April 2	Closed for Good Friday
May 31	Closed for Memorial Day
June TBA	Vacation Bible School
June TBA	Preschool Graduation
July 5	Closed in Observance of Independence Day
September 3	Closed for Staff in Service Training
September 6	Labor Day
September 15	Rm 209 and Pre-k Field Trip to Beak and Skiff (pending COVID circumstances)
October 11	Columbus Day
November 18	Harvest Dinner
Nov. 25 & 26	Closed for Thanksgiving
December 11	Christmas Program (pending COVID circumstances)
Dec. 24 & 25	Closed Christmas Eve & Christmas Day (see Addendums attached)
Dec. 31	Closed at 3pm for New Year's Eve
Jan. 1, 2022	Closed for New Year's Day

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors **must complete a health screening questionnaire daily**. In addition, **each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time**. Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
 - ☐ Cough (new or worsening)
 - ☐ Shortness of breath (new or worsening)
 - ☐ Trouble breathing (new or worsening)
 - ☐ Fever
 - ☐ Chills
 - ☐ Muscle pain (new or worsening)
 - ☐ Headache (new or worsening)
 - ☐ Sore throat (new or worsening)
 - ☐ New loss of taste
 - ☐ New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature

Date

Signature

Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.

March 3, 2020

keep

Parents,

Please read the addendum below. Upon acknowledgement, please sign the Addendum Agreement Log located in the classroom of your youngest child.

Please keep this copy for your records, attaching it to your current Parent Handbook. Thank you.

Addendum to SonShine Child Care Center Parent Handbook: Sick Child Policy

The following is in addition to the Sick Child Policy currently established in our Parent Handbook:

- A physician's note may be required to return to care.
- For infants two months of age and younger, an unexplained fever of 100.4 or greater will cause us to have the parent pick a child up from care.
- Diarrhea and Vomiting: The child may return to care 24 hours after they were signed out. If diarrhea/vomiting continued after leaving childcare, they may return 24 hours after their last bout.
- Conjunctivitis: Crusty, runny, itchy or red eyes that do not seem related to illness or allergies will require a physician's note to return to care.
- Excessive coughing, congestion, croupy cough: The child will need to go home until they are free of the cough.
- Parents should have a back-up plan should they be unable to pick their child up in the event that s/he is sick. In addition, the parent must always be available while their child is in care. They must be certain that they can be reached at all times.
- If a child was given medication of any kind before drop off, please inform his/her teacher of the time, name and dose. This is extremely important due to adverse side effects.
- Please do not find a fever at home, give a child Tylenol or Motrin then bring them to daycare.
- If a child is sent home ill, goes to a doctor and is put on medication, they will need to be on the medication for at least 24 hours to return to care.
- Any health-related decisions beyond the scope of those described in this addendum or in the policy contained in SonShine's Parent Handbook are at the discretion of the Nurse, the Director or the Person in Charge.

Sign _____

date _____

SONSHINE CHILD CARE CENTER

Food Policy Statement

SonShine Child Care Center follows guidelines of the Child and Adult Care Food Program in providing nutritious breakfasts, lunches and afternoon snacks for your children.

At times, a classroom will have a party for a special occasion and ask parents to provide a snack of their choice. Foods supplied by teachers, parents or guardians must meet the following requirements and teachers may not accept any foods that fail to meet them:

- ☀ SonShine Child Care Center is a NUT-FREE Center.
- ☀ Foods must be store-bought and in their original packaging (to verify ingredients and prevent serious allergic reactions).
- ☀ Food produced from a parent's business must include an ingredient list provided by the business.
- ☀ Pre-packaged fruits and vegetables from a business may be served as is.
- ☀ Unpackaged fruits and vegetables must be washed and cut up by the classroom teacher using proper food handling techniques.

We strive to provide nutritious and safe snacks for our children at all times and appreciate your consideration.

Thank you from the staff at SonShine Child Care Center!

Child's Name _____

Effective Date: _____

Registration Fee: _____

(office use only)

SonShine Child Care Center**Fee Agreement**

September 6, 2021-September 2, 2022

	6 wks-18 mos.	18 mos-3 yrs	3-5 yrs	School Age
*0-26 hrs	\$12/hr	\$11.60/hr	\$11.20/hr	See
26-35 hrs	\$300.50	\$290.50	\$280.50	Separate
36-45 hrs	\$305.50	\$295.50	\$285.50	School Age
46-50 hrs	\$310.50	\$300.50	\$290.50	Agreement

Child's Schedule:

Monday: _____

Thursday: _____

Tuesday: _____

Friday: _____

Wednesday: _____

I understand that my weekly fee will be: _____

Thank you for choosing SonShine Child Care Center. We value the relationship we have with our families. Adherence to policies and procedures is necessary to achieve our mission of providing excellent, loving childcare. Please acknowledge your understanding of the policies below by initialing next to each statement and placing your signature at the end of this document.

_____ I understand that I will be charged the full amount in this agreement even if my child is not in care.

_____ I understand that if I need to make a temporary change in my child's schedule, it requires one week prior written notice submitted to office personnel on the form entitled "Request For Temporary Drop off/Pick up Time" via Brightwheel.

_____ This agreement forms the basis for staff schedules and SonShine's commitments to staff. Early drop off or late pick up affects the day's schedule, staff availability, impacts multiple classrooms and prompts overtime for staff, the fees for which SonShine has had to absorb in the past. Therefore, not adhering to this agreement will result in fees (see *) and could result in possible termination of services.

_____ Dropping off/picking up earlier or later than what is noted on this form on a temporary basis (no more than 10 days total) is permitted with prior approval from office personnel by submitting a "Request For Temporary Drop off/Pick up Time" via Brightwheel. This must be done exactly one week in advance of the starting day of the new temporary schedule. You will receive a decision via Brightwheel no later than three days before the starting day of the new temporary schedule.

_____ Payment is due Monday of week of care. Delinquent account of two weeks could result in termination of services.

* _____ Drop off/pick up times other than those indicated above will result in fees and, possibly, termination of care. Fees consist of the following: \$20 for drop off more than fifteen minutes prior to or later than as stated above, unless approved. SonShine is open Monday-Friday, 6:30am to 5:30pm. A \$30 fee will be assessed for pick up after 5:30pm and \$20 for each five-minute increment after that.

_____ SonShine is closed thirteen days during the year for holidays and staff training. No childcare will be provided those days. These are included in your fee and do not reduce the amount for the week in which a holiday occurs. No childcare will be provided those days.

I have read and understand the terms of the Fee Agreement. I agree to pay the full fee in accordance with the above terms, including late fees when applicable.

(Print Name)_____
(Signature)_____
(Clearly enter your email address)_____
(Today's Date)

If you have any questions please contact Manisha
Phone: 315-399-1813 Email: manishasonshine@gmail.com