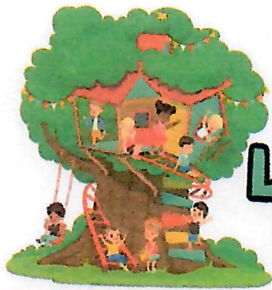
Brandie's Little Bear Learning Center

Child Enrollment Form



Thank you for your interest in Brandie's Little Bear Learning Center. Choosing a quality child care program is one of the most important decisions you will make. We take your decision seriously and are committed to living up to the important responsibility of caring for your child.

To register, please return this completed form and the non-refundable registration fee of $50.00 per child made payable to Brandie's Little Bear Learning Center.

When your registration form and fee are received, you may be placed on a waiting list and will be contacted regarding the availability of space and the enrollment process.

Child's Name: ______________________ Date of Birth: ____/____/____

Parent/Guardians Information

Mother's Name: ______________________ Father's Name: ______________________

Relationship: ______________________ Relationship: ______________________

Address: ______________________ Address: ______________________

E-Mail: ______________________ E-Mail: ______________________

Cell Phone: ______________________ Cell Phone: ______________________

Work/Home Phone: ______________________ Work/Home Phone: ______________________

Place of Employment: ______________________ Place of Employment: ______________________

Instructions on best way to reach Parent/Guardian: Text ☐ Phone ☐ E-Mail ☐

Which option (s) best suits the care you will need?

3 days a week ☐ 4 days a week ☐ Full week ☐ Before School Care ☐ After School Care ☐

Days and Hours Desired:

MON __________ TUE __________ WED __________ THU __________ FRI __________

What date would you like enrollment to begin? ______________________

Payments: ☐ Private ☐ County/child Care Assistance ☐ Early Learning Scholarship

______________________________ ______________

Parent/Guardian's Signature Date

Brandie's Little Bear Learning Center

1250 Industrial Park Drive, Eveleth, MN 55734

Phone: (218)288-1200

For Administration Use Only:

Registration Paid: ________ County Approved: ________ Tour Date: ________ Start Date: ________

REQUIRED PRIOR TO CHILD ATTENDING

Forms

☐ **Immunization Records (on our form).** If parent objects to immunizations, a signed and notarized statement of parental objection on the specified State of Minnesota form.

☐ **Health Care Summary Form** – must be compled by child's medical provider

☐ **Additional Forms (as they pertain)**

- Special Diet Statement (completed by Physician)
- Individual Child Care Program Plan (ICCPP)
- Consent for Swaddling an Infant
- Physician directive for alternative infant sleep position
- Infant rolling before six months parent statement

Items

☐ **Infant:** Formula or breast milk, bottle, pacifier, diapers, wipes, diaper rash cream, 2 sets of *extra clothes, and written or typed daily routine schedule w/ a description of the child's eating, sleeping, toileting, and communication habits, and effective methods for comforting

☐ **Toddler:** Diapers/pull ups, wipes, diaper rash cream, 1 set of extra clothes, and nap blanket

☐ **Preschooler:** Diapers/pull ups, wipes, 1 set of extra clothes and nap blanket

☐ **School Ager:** 1 set of extra clothes (shirt, pants/shorts, underwear and socks in a labeled gallon storage bag).

*** Items should be labeled with child's first and last name**

Child Information Form

Child's Name: ______________________ Child's DOB: ______________

Siblings: ____________________Age____ ____________________Age____

____________________Age____ ____________________Age____

____________________Age____ ____________________Age____

Please note if they live at home with child. If applicable, use reverse side to describe special family dynamics, custody, interactions with step/half siblings, etc.

Allergies ______________________________

Specific allergy triggers______________________________

Avoidance techniques______________________________

____

Allergy Symptoms______________________________

Procedures for allergic reaction______________________________

____

Dietary restrictions ______________________________

____

Daily Medications______________________________

____

Health Care Information

Physician Name: ______________________________

Clinic/Hospital:____________________Address:____________________Phone______________

Dental Provider______________________________

Address______________________________Phone______________

____

To insure prompt medical attention in case of an emergency, please list:

Insurance Policy Number (s)______________________________

Medical assistance Number(s)______________________________

If possible, for emergency treatment, I would prefer my child be taken to:

____

____

____

Emergency Contact Information

Please list a minimum of 3 authorized people to pick up your child from the center. These authorized below will be contacted to take responsibility of your child if you cannot be reached or in case of emergency. Some instances are if your child becomes ill or if there is an emergency. Please list people who can be reached during the day and live within 1 hour of the centers location. Do not list yourself.

Name____________________ Cell Phone : ______________Work/Home Phone: __________

Relationship to Child:______________Address______________________________

Name____________________ Cell Phone : ______________Work/Home Phone: __________

Relationship to Child:______________ Address______________________________

Name____________________ Cell Phone : ______________Work/Home Phone: __________

Relationship to Child:______________Address______________________________

Child's Developmental History:

1. Does your child know any other children at this center? ____________________
2. Do you feel your child will adjust easily to the center? ____________________
____
3. How well does your child get along with other children? ____________________
4. ☐ Left handed ☐ Right handed ☐ Unknown ____________________
5. Favorite play activity? ____________________
6. Favorite toy/toys? ____________________
7. Does your child have a pet? ____________________
8. Does your child take a nap? ____________ How long? ____________
9. Is your child hungry at meal times? ____________ Food dislikes? ____________
10. Usual characteristic behavior: (check all that apply) ☐Calm ☐Excited ☐Whiny ☐Easily angered ☐Cries often ☐Happy ☐Cheerful ☐Stubborn ☐Easily scared ☐Cooperative ☐Quiet ☐Active ☐Independent ☐Fights often ☐Wants own way ☐Temper tantrums ☐Easy going ☐Clingy ☐Sad ☐Helpful ☐Shy ☐Friendly
11. What type of behavior do you find most difficult to deal with?
____
12. Types of home discipline by mother ____________________
by father ____________________
13. Fears (history and how child shows fear) ____________________
14. What frustrates or upsets your child? ____________________
15. Primary language spoken in the home? ____________________
16. Does your child have any difficulties speaking? ____________________
17. Special words child uses to describe his/her needs? ____________________
18. What word is used for urination? ____________ Bowl movements? ____________
19. Has child had experience with: ☐Clay ☐Scissors ☐Blocks ☐Coloring ☐Easel painting ☐Water play ☐ Story hour
20. Does your child have any needs requiring special attention?
____
21. Does either parent have any special requests?
____

Activity Consent

I hereby grant permission for my child:

- to use all the playground and gym equipment.
- to participate in all the activities of the center.
- to be included in evaluations and pictures connected with the centers program.
- to be included in approved university educational resources.
- to participate in walking trips, field trips, public activities or other activities sponsored by the center.
- to have sunscreen and/or insect repellent applied, in which I will provide, to their class room teacher when needed and sign a form each year

Parent/Guardian Signature: ______________________________ Date______________

Emergency Consent

I give Brandie's Little Bear Learning Center permission to make whatever emergency measures as judged necessary for the care and protection of my child while under supervision. In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by local emergency unit for treatment, if the local emergency resource deems it necessary.

It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician and/or other adult acting on the parent's behalf. In case of emergency involving my child, I authorize Brandie's Little Bear Learning Center to use Essentia Health Hospital of Virginia for emergency medical treatment, if I or my own source of medical care listed prior, cannot be reached.
I hereby grant permission for the Directors or acting Director to take whatever steps that may be necessary to obtain emergency medical care for my child if warranted. These steps may include, but are not limited to the following:

1. Attempt to contact parent or guardian
2. Attempt to contact child's physician
3. Attempt to contact the parent through any of the persons listed on the emergency medical form.
4. If #1-3 are unsuccessful, A) call another physician, B) call the paramedics, C) have the child taken to the emergency hospital.

I understand that any expenses incurred under #4 above will be accepted by the child's family.

Mother/Guardian Signature______________________________ Date______________

Father/Guardian Signature______________________________ Date______________

Immunization Form

Name________________________ Birthdate____________

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B					
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)					
Haemophilus influenzae type b (Hib)					
Pneumococcal (PCV)					
Polio					
Measles, Mumps, Rubella (MMR)					
Chickenpox (varicella)					
Hepatitis A					
Tetanus, Diphtheria, Pertussis (Tdap)					
Meningococcal (MCV4)					

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name ______________________________

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: ______________________________ Date: __________
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: ______________________________ Date: __________
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on ______________ (date)

by ______________________________
(name of parent or guardian)

Notary Signature:

____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF

____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year ______________

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: ______________________________ Date: __________
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: ______________________________ Date: __________
(of parent/guardian)

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: ____________

NAME OF CHILD ______________________________ Birth Date ____________

ADDRESS ______________________________ Telephone ____________

PARENT(S) OR GUARDIAN ______________________________

Date of last physical examination ____________ How long have you been seeing this child? ____________

How frequently do you see this child when he/she is not ill? ______________________________

Does this child have any allergies (including allergies to medications)? ______________________________

Is a modified diet necessary? ______________________________

Is any condition present that might result in an emergency? ______________________________

____

What is the status of the child's. . .

Vision ______________________________

Hearing ______________________________

Speech ______________________________

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program ______________________________

____

____

Phone ____________

Signature of Health Source ______________________________ Address ______________________________

Date ______________________________ ______________________________

Swaddling Consent for an Infant

Placing a swaddled infant down to sleep in a licensed setting is *not* recommended for an infant of any age* and is prohibited for any infant who has begun to roll over independently.

However, with written consent of a parent or guardian, a license holder may place the infant who has NOT YET BEGUN to ROLL OVER ON ITS OWN down to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system that fastens securely ONLY across the upper torso, with no constriction of the hips or legs, to create a swaddle.

Any other type of swaddle, including with a blanket, is prohibited.

Prior to any use of swaddling for sleep by a licensed provider, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant. The parent or guardian must demonstrate to the provider how to safely place baby in the swaddle so it is not too tight or too loose.

I ______________________, the parent/guardian of ____________________ DOB __________
(Parent) (Infant)
give written consent to ____
(Provider)
to place my infant to sleep in a crib, on their back, in a one-piece sleeper equipped with an attached system ("wings") that fastens securely ONLY across the upper torso to create a swaddle.

_____I verify that my infant has NOT yet begun to roll over.
_____I verify that the provider will only use the one-piece sleeper to swaddle my infant
_____I verify that the provider has a one-piece sleeper with attached "wings" OR
_____I verify that I have provided the one-piece sleeper with attached "wings"
_____I verify that I have demonstrated to the provider how to place baby in the swaddle.
_____I verify that I will immediately notify the provider when my infant has begun to roll over.

Signature of Parent ____________________________________ Date __________

Signature of Provider ____________________________________ Date __________

At the time that the parent or provider observes that this infant has begun to roll over, this parental consent is no longer valid.

Infant has begun to roll over. Swaddling has been discontinued.

Date: __________ Provider Initials: ____________________ Parent Initials: ______________

*Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition 2012.

Daily Infant Intake Form

Name: ____________________ Date: ____________

Breast Milk: _________ How Many Ounces: _______ How Often: ________ Formula: ____________

My baby can have:

Iron fortified infant cereal ☐ Puffs ☐

Baby Food/Fruit:

Apple/Applesauce ☐ Bananas ☐ Prunes ☐ Pineapple ☐ Pears ☐ Peaches ☐

Strawberry ☐ Blueberry ☐ Mixed Berry ☐ Other: ____________________

Baby Food/Vegetables:

Peas ☐ Carrots ☐ Squash ☐ Sweet Potato's☐ Green Beans ☐ Mixed Vegetable ☐

Garden Vegetables ☐ Other: ____________________

My baby is on table foods: Yes ☐ No ☐

Which foods: ____________________

Tell us about naptime: ____________________

Other Notes: ____________________

REQUIRED FORM FOR INFANTS 6 WKS-12 MO

Dear Parent/Guardian:

We provide nutritious meals every day to the children at our center.

The Child and Adult Care Food Program (CACFP) helps our center to pay for meals. The amount of help we get depends on the incomes of households with children in care. **Please complete the enclosed CACFP Household Income Statement form** following the instructions. **If your household income is higher than the guidelines shown on the instructions page, please write "over income" on the Household Income Statement, include your children's names, and return the form.**

Return your completed Household Income Statement form to:
Brandie's Little Bear Learning Center
1250 Industrial Park Drive, Eveleth, MN 55734

Commonly Asked Questions:

I already get MFIP or SNAP benefits. Do I meet CACFP income guidelines? Yes. You should provide your case number on the form instead of income information if anyone in your household is approved for one of these programs: Minnesota Family Investment Program (MFIP), Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservations (FDPIR).

In addition, foster children meet CACFP guidelines without providing income information.

Your household may meet CACFP income guidelines if you are approved for the *Women, Infants, and Children* program (WIC) or *Medical Assistance* program (MA). Please fill out a Household Income Statement form.

Who should I include as members of my household? Include yourself and all other people living in your household, related or not (such as grandparents, other relatives or friends). Include anyone who is temporarily away, for example a college student.

What if my income is not always the same? List the amount that you normally get. Include overtime pay if you regularly work overtime. For fluctuating income like seasonal work, list the average monthly income.

Do I need to provide my Social Security number? If household incomes are reported on the form, the person signing the form must write in just the last four digits of their Social Security number. If you don't have a Social Security number, indicate that on the form.

May I fill out a Household Income Statement if someone in my household is not a U.S. citizen? Yes. You or your children or other household members do not have to be U.S. citizens for you to fill out a CACFP Household Income Statement.

How will my information be kept? We will keep your information on file as private data. The back page of the form has more information about data privacy.

If I don't qualify now, may I apply later? Yes. Please complete a Household Income Statement form at any time if your income goes down, your household size goes up, or you start getting SNAP, MFIP or FDPIR benefits.

If you have other questions or need help, please call (218) 780-5459.

Sincerely,

Brandie Folken and Brandie Peterson
Owners

HELPFUL TIPS - Annual Family CACFP Enrollment Form

** **Please review each form** to make sure all areas are complete before mailing to Providers Choice **

- Complete the form with a **pen**, not a pencil.
- Do **not** use white-out. Use a new form if needed.
- Draw **one line through an error** and initial. Legibly write the correct information next to the error.

STEP 1:

- If a family has more than 6 children, attach a second form with the additional children listed in Step 1.

STEP 2:

- Complete the breastmilk/formula preference information for each infant in the family *(if applicable)*.

STEP 3: Complete to Qualify by Case Number

- **Programs that Qualify:**
  - **Minnesota Family Investment Program** (MFIP)
  - **Supplemental Nutrition Assistance Program** (SNAP)
  - **Food Distribution Program on Indian Reservations** (FDPIR)

(1) Record **name of household member** currently participating in program,
(2) **Case Number,**
(3) **Select the program box(es).**

- ***Programs that do NOT qualify:*** WIC, Child Care Assistance, Medical Assistance.

STEP 4: Complete to Qualify by Income

- Income information is not needed in Step 4 if a household member completes Step 3.
- If the household income is higher than the guidelines on the Qualifying Incomes Sheet, please write "**over-income**" in Step 4.
- If listing income, make sure each household member lists **Gross Income** (if not Self Employed) and how often they are paid. Do **not** write an Hourly Wage.
- If the adult filling out the form doesn't have a Social Security Number, select the **"I don't have a SSN"** box.

STEP 5:

- Make sure an adult household member **signs** and **dates** the form.
- Only include the last 4-digits of Social Security Number if Step 4 is complete.

Updated 12/11/19

This institution is an equal opportunity provider.

Child Care Center

Qualifying Incomes for Reduced Priced Meals

(Effective July 1, 2021– June 30, 2022)

Category B - Reduced

Household Size	$ per Week	$ per 2 Weeks	$ Twice per Month	$ Per Month	$ Per Year
1	459	917	993	1,986	23,828
2	620	1,240	1,343	2,686	32,227
3	782	1,563	1,693	3,386	40,626
4	943	1,886	2,043	4,086	49,025
5	1,105	2,209	2,393	4,786	57,424
6	1,266	2,532	2,743	5,486	65,823
7	1,428	2,855	3,093	6,186	74,222
8	1,589	3,178	3,443	6,886	82,621
Add'l member	162	324	350	700	8,399

- If your household income is at or below the level listed above, please complete **Section 2** or **Section 3** of the Household Income Statement. Add the last 4 digits of your social security number, sign, and date the form.

- If your family income exceeds this amount, record **OVER INCOME** in Section 3 of the Household Income Statement, sign, and date the form.

PO Box 390813, Minneapolis, MN 55439
TE: 952.944.7010 : 800.356.5983 : FAX 952.944.7011
providerschoice.com
Revised 6/8/21

PROVIDERS CHOICE

PROVIDERS CHOICE

Annual Family CACFP Enrollment Form

Center Name: Brandie's Little Bear Learning Center #251

First Day in Care:

STEP 1 — List all children in the household

First Name	Last Name	Date of Birth	Enrolled in center?	Foster child?	Hours in Care		Normal Days in Care							Normal Meals Received						Ethnicity*	Race**
					Arrive	Leave	M	Tu	W	Th	F	Sa	Su	B	AM	L	PM	D	EV		

Ethnicity**Optional to complete **H**: Hispanic or Latino -OR- **N**: Not Hispanic or Latino

Race**Optional to complete **I**: American Indian or Alaskan Native, **A**: Asian, **B**: Black or African American, **P**: Native Hawaiian or other Pacific Islander, **W**: White

STEP 2 — Infants

Infant's Name:

☐ Parent will provide more than 1 food item per meal/snack and decline the CACFP

☐ Center will provide formula — The type of iron-fortified infant formula this center offers:

☐ Parent will provide breastmilk — ☐ Parent will provide iron-fortified infant formula. *Specify brand & type*:

STEP 3 Do any household members currently participate in: ☐ **SNAP**? ☐ **MFIP**? ☐ **FDPIR**? If YES, **Case Number:**

STEP 4 Complete if you do not have a case number

Adults – Full Name List all adult household members even if they don't receive income.	Gross Pay		Farm or Self-Employment		Public Assistance, Child Support, Alimony		All Other Incomes	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
	$		$		$		$	
	$		$		$		$	
	$		$		$		$	
					Child Income		$	

How Often — **W**: Weekly, **B**: Bi-Weekly (every other week), **2**: Twice a month, **M**: Monthly, **Y**: Yearly

STEP 5

I certify (promise) that all information on this form is true and that all income is reported. I understand this information is given in connection with receipt of federal funds and that officials may check the information. I understand that if I purposely give false information, I may be prosecuted under applicable federal and state laws.

Print Name

Signature — Date — Last 4-digits of Social Security Number SSN (if STEP 4 is completed): — No SSN ☐

Address — City, State, Zip Code — Phone

Email

SPONSOR USE ONLY

☐ Free (A) – Foster ☐ Free (A) – Case Number ☐ Free (A) - Income ☐ Reduced (B) - Income ☐ Paid (C) **Income:** How Much ______ How Often ______ HH Size ______

6/29/22 Effective Dates ______ TO ______ Signature ______ Date ______ 2nd Approval ______

ProvidersChoice
Supporting the Child Care Professional

CACFP: ANNUAL Child Enrollment & Household Income Statement

FARMER OR SELF-EMPLOYED

Income is your NET income (after deducting business expenses) from farm or self-employment during the year, which is generally shown on Schedule C or F from the federal tax return. A loss from farm or self-employment must be listed as zero income and does not reduce other household income for the purpose of completing this form.

SEASONAL WORKER

Income is your expected AVERAGE GROSS INCOME before deductions (NOT take-home pay) from seasonal work during the year. List your AVERAGE GROSS INCOME from seasonal work per month or other frequency.

PRIVACY ACT STATEMENT / HOW INFORMATION IS USED

The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give this information but if you do not, we cannot approve your child for free or reduced-price school meals. You must include the last four digits of the Social Security number of the adult household member who signs the application. The last four digits of the Social Security number are not required when you apply on behalf of a foster child, or you provide a Minnesota Family Investment Program (MFIP), Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservation (FDPIR) assistance number, or you indicate that the adult household member signing the application does not have a Social Security number.

Only authorized officials will have access to the information you provide on this form. We will use your information to determine if your child qualifies for free or reduced- price meals, and for administration and enforcement of the program. We may share your information with other education, health, and nutrition programs to help them evaluate, fund or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules. We require written consent from you before sharing information for other purposes.

While listing your children's race and ethnicity is voluntary, CACFP uses the percentages of participants in each racial and ethnic category to make sure CACFP is operated in a nondiscriminatory manner and in compliance with federal and civil rights laws. The information is not required and will not affect approval of benefits.

NONDISCRIMINATION 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: (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.

ABBREVIATIONS

B = Breakfast **AM** = AM Snack **L** = Lunch **PM** = PM Snack **D** = Dinner **EV**= Evening Snack

SNAP = Supplemental Nutrition Assistance Program
MFIP = Minnesota Family Investment Program
FDPIR = Food Distribution Program on Indian Reservations

11/1/19

ProvidersChoice
Supporting the Child Care Professional
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PERMISSION TO ADMINISTER OVER-THE-COUNTER PRODUCTS

I HEREBY GIVE MY CHILD CARE PROVIDER PERMISSION TO ADMINISTER THE FOLLOWING PRODUCTS ACCORDING TO THE MANUFACTURER'S INSTRUCTIONS OR AS SPECIFIED IN WRITING BY MY CHILD'S PHYSICIAN

CHILD'S NAME: ______________________________

NO	YES	PRODUCTS	BRANDS
☐	☐	Acetaminophen (e.g. Tylenol) (following telephone permission from parent or a physician)	______
☐	☐	Adhesive Tape	______
☐	☐	Antiseptic	______
☐	☐	Baby Lotion	______
☐	☐	Baby Oil	______
☐	☐	Baby Powder	______
☐	☐	Bandages	______
☐	☐	Bar Soap	______
☐	☐	Burn/Sunburn Remedy	______
☐	☐	Conditioner	______
☐	☐	Diaper Ointment	______
☐	☐	Diaper Wipes	______
☐	☐	First Aid Cream	______
☐	☐	Hydrogen Peroxide	______
☐	☐	Insect Repellent	______
☐	☐	Itching Cream	______
☐	☐	Lip Balm	______

NO	YES	PRODUCTS	BRANDS
☐	☐	Liquid Soap	______
☐	☐	Menthol Rubs	______
☐	☐	Moisturizing Lotion	______
☐	☐	Nail Polish	______
☐	☐	Petroleum Gel	______
☐	☐	Rash Ointment	______
☐	☐	Shampoo	______
☐	☐	Sunscreen	______
☐	☐	Teething Ointment	______
☐	☐	Toothpaste	______
☐	☐	______	
☐	☐	______	
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☐	☐	______	

SEPARATE PERMISSION FORMS ARE REQUIRED FOR ALL OVER-THE-COUNTER MEDICATIONS (e.g. cough syrup, cold medications), AND FOR ALL PRESCRIPTIONS.

****THIS FORM MUST BE UPDATED ANNUALLY****

____
Parent's Signature Date

____
Provider's Signature Date

Individual Child Care Program Plan for Allergies

Licensed Child Care Centers

The child care center can use this form to document 1) allergy information, 2) medication to respond to an allergic reaction, and 3) emergency contact information for allergy prevention and response. Complete the Individual Child Care Program Plan for Allergies (ICCPP-A) from the allergy information obtained from parents. Documentation of any known allergy must be obtained before the center cares for the child. The ICCPP-A must be available at all times on site, when on field trips, or during transportation. Food allergy information must be readily available to staff in the area where food is prepared and served to the child. All staff who interact with this child must review and follow this plan. **Use a separate form for each allergy, even if the same child has more than one identified allergy.**

Allergy prevention and response requirements are found in MN Statutes, section 245A.41, subdivision 1.

Child Information

Child's Full Name | Child's Date of Birth

Date ICCPP-A was developed

Initial Date | Print Name of Center Representative that developed this ICCPP-A | Signature of Center Representative that developed this ICCPP-A

Allergy Information

1. Describe the allergy. **Use a separate form for each known allergy.**

2. What triggers the allergy?

3. What symptoms may the child display when exposed to an allergen or trigger? (Check all that apply)

- ☐ No history of symptoms or unknown
- ☐ Mouth: Itching; tingling; swelling of lips, tongue or mouth ("mouth feels funny")
- ☐ Skin: Hives; itchy rash; swelling of face or extremities
- ☐ Gut: Nausea; abdominal cramps; vomiting; diarrhea
- ☐ Throat: Difficulty swallowing; hoarseness; hacking cough
- ☐ Lung: Shortness of breath; repetitive coughing; wheezing
- ☐ Heart: Weak or fast pulse, low blood pressure; fainting; pale; blueness
- ☐ Other:
- ☐ Other:
- ☐ Other:

What techniques are used to avoid an allergic reaction?

What procedures will be taken to respond to an allergic reaction for this child?

Medications for Responding to an Allergic Reaction- Call 911 if Epinephrine is administered

What medication(s), if applicable, are required for response to an allergic reaction for this child? *Note: If medication provided, refer to Minnesota Rules, chapter 9503.0140, subpart 7 for administration of medication requirements.*

Medication | Dosage

Medication | Dosage

Medication | Dosage

Doctor Information - Call 911 for EMERGENCIES

Doctor's Name | Doctor's Phone Number

Individual Child Care Program Plan (ICCPP) Special needs/Diagnosis and non-food Allergy Prevention and Response

Child's Name: ____ Date of Birth: ___/___/___

Parent/Guardian #1 Name: ____

Home # ________________ Work # ________________ Cell # ________________

Parent/Guardian #2 Name: ____

Home # ________________ Work # ________________ Cell # ________________

Primary health Provider's Name: ______________________ Phone: ____________________

Other Specialist's Name/Title (If Applicable): __________________ Phone: ________________

Specialist's Clinic: ________________________________ Phone: ____________________

If child has allergies, please fill out the following so staff can be trained and informed.

Description of allergies: ____

Specific Triggers: ____

Procedure for responding to allergic reaction: ____

Avoidance Techniques: ____

Symptoms of an allergic reaction: ____

OPTIONAL FORM FOR CHILD WITH SPECIAL NEEDS

Individual Child Care Program Plan (ICCPP) Special needs/Diagnosis and non-food Allergy Prevention and Response

Current Medication/Dosages:

____

If a child has special needs, care or diagnosis you would like staff to be aware of please fill out this section. Ex.- Speech delay, hearing impairment, etc.

Diagnosis (es):

____

Areas of developmental delay/concern:

____

Parent/Guardian #1 Signature: ________________________ Date: ________________

Parent/Guardian #2 Signature: ________________________ Date: ________________

ProvidersChoice
Supporting the Child Care Professional

Special Diet Statement to Request Dietary Accommodations

Participant Information:

Name of Child Participant: ______________________ Date of Birth: ____________

Name of Parent or Guardian: ____

Parent or Guardian Phone #: ________________ Email: ______________________

Child Care Provider or Center Name: ___________________ PCI Provider #: _________

Child Care Provider Phone #: ____

REQUIRED: Participant Medical Information

List the medical condition, disability or food allergies:

REQUIRED: Dietary Accommodation

List specific foods to be omitted and specific foods to be substituted. (You may attach a sheet with additional information as needed).

Foods to be Omitted	Foods to be Substituted

Exempt Infant Formula: ☐ Nutramigen ☐ NeoSure ☐ Alimentum ☐ Other: __________

Texture Modifications: ☐ Bite Size Pieces ☐ Ground ☐ Pureed ☐ Other: __________

Tube Feeding: Formula Name: ______________________________

Administering Instructions: ______________________________

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: ____________

REQUIRED: Signature

Licensed physician, physician assistant, or nurse practitioner must sign and retain a copy of this document.

Signature of Medical Authority: ______________________ **Credentials:** ________

Printed Name: ____

Clinic Name ____

Phone Number: ______________________ **Date:** ________________

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Rev 7/19

Voluntary Authorization

Note to Parent(s)/Guardian(s): You may authorize Providers Choice, Inc. to clarify this Special Diet Statement with the physician by signing the following Voluntary Authorization section: In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _______________ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to Providers Choice, Inc. and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning _______________ **(child participant's name)**, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet. I understand that permission to release this information may be rescinded at any time except when the information has already been released.

Parent/ Guardian Signature _______________________________ Date _______________

Optional: My permission to release this information will expire on ___________ (date). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

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:

(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.

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REQUIRED

Tuition® Express

Automated Payment 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 (business name) ______________________________ 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

John Sample
Mary Sample
123 Nice Street
Anytown, USA

BANK OF THE WEST
555-555-5555

00226

Pay to the order of: Attach Voided Check Here $

Deposit slips not accepted ______________ Dollars

⑆123456789⑆ 1000338⑈ 0226
Routing Number Account Number Check Number

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