

Student Name: _____

Order of Documents for Student Files

- Parent Orientation Checklist
- Policy on Infant Safe Sleep
- Admission Information Packet
- Vaccination Records
- Child Assessment Form
- Child Health Record
- Medical Emergency Statement
- Drop Off and Pick Up policy
- CACFP Participant and Enrollment Form
- CACFP Meal Benefit Income Eligibility
- Publicity Release Agreement
- Student Behavioral Log
- Parent Handbook Agreement



Parent Orientation Checklist

Name Of Child: _____

Name of Parent/Guardian: _____

- Opportunity to tour the facility
- Introduction to Staff
- Parental visit with classroom caregiver
- Overview of the Parent Handbook
- Overview of arrival time Policy
- Opportunity for an extended visit in the classroom by both parent and student to allow both to become comfortable
- Explanation of the Texas Rising Star Program
- Encouragement to share elements of CCS enrollment so that the provider may assist, if applicable
- Explanation of available family support resources and activities in the milestones

Expectations of Families:

- The significance of consistent arrival time, including
 - Arrival Prior to the educational portion of the day begins
 - Impact of disrupting other children's learning
 - The importance of consistent routines in preparation for the transition to kindergarten
- Information of limited technology use on site to improve communication between staff, children, and families
- Statement reflecting the role and influence of families in child development

I acknowledge receipt of the above information.

Parent/Guardian Signature Date

Staff Signature Date

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at _____ and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: <http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>

Safe Sleep Policy

All staff, substitute staff, and volunteers at _____ will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/ animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415(b) and §747.2315(b)]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415(b) and §747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing _____ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415(b) and §747.2315(b)].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2428 and §747.2328].

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>.

Signatures

This policy is effective on: _____ Child's name: _____

Signature — Director/Owner

Date Signed

Signature — Staff member

Date Signed

Signature — Parent

Date Signed



Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information			
Operation's Name		Director's Name	
Child's Full Name	Child's Date of Birth	Child Lives With <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian	
Child's Home Address		Date of Admission	Date of Withdrawal
Name of Parent or Guardian Completing Form	Address of Parent or Guardian (if different from the child's)		
List telephone numbers below where parents/guardian may be reached while child is in care.			
Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File <input type="radio"/> Yes <input type="radio"/> No
Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached			Relationship
I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.			
Name		Phone Number	
Name		Phone Number	
Name		Phone Number	

Consent Information
Check All That Apply:
1. Transportation
I give consent for my child to be transported and supervised by the operation's employees:
<input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school
2. Field Trips
<input type="radio"/> I give consent for my child to participate in field trips.
<input type="radio"/> I do not give consent for my child to participate in field trips.
Comments

3. Water Activities

I give consent for my child to participate in the following water activities:

- water table play
 sprinkler play
 splashing/wading pools
 swimming pools
 aquatic playgrounds

4. Receipt of Written Operational Policies (Check All that Apply)

I acknowledge receipt of the facility's operational policies, including those for:

- | | |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Discipline and guidance | <input type="checkbox"/> Procedures for release of children |
| <input type="checkbox"/> Suspension and expulsion | <input type="checkbox"/> Illness and exclusion criteria |
| <input type="checkbox"/> Emergency plans | <input type="checkbox"/> Procedures for dispensing medications |
| <input type="checkbox"/> Procedures for conducting health checks | <input type="checkbox"/> Immunization requirements for children |
| <input type="checkbox"/> Safe sleep | <input type="checkbox"/> Meals and food service practices |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director | <input type="checkbox"/> Procedures to visit the center without securing prior approval |
| <input type="checkbox"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website |

5. Meals

I understand that the following meals will be served to my child while in care:

- None
 Breakfast
 Morning snack
 Lunch
 Afternoon snack
 Supper
 Evening snack

6. Days and Times in Care

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Authorization For Emergency Medical Attention

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone Number
Name of Emergency Care Facility	Address	Phone Number

I give consent for the facility to secure any and all necessary emergency medical care for my child.

 Signature — Parent or Legal Guardian

Child's Additional Information Section

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? Yes No Plan Submitted on _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian

Date Signed

School Age Children

My child attends the following school

School Phone Number

My child has permission to (check all that apply):

walk to or from school or home ride a bus be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address

Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Check **only one** option:

1. Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Signature — Health Care Professional

Date Signed

2. A signed and dated copy of a health care professional's statement is attached.

3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

4. My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name

Address of Health Care Professional

Signature — Parent or Legal Guardian

Date Signed

Requirements for Exclusion

- I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ Pass Fail

Signature

Date Signed

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

Signature

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

_____ Signature

_____ Date Signed

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

_____ Signature

_____ Date Signed

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If Required)

Positive Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

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Signatures

Child's Parent or Legal Guardian

Date Signed

Center Designee

Date Signed

Purpose:

These questions are designed to give you the information needed to provide the best, most appropriate care for children. This information is confidential and parents must be reassured it will not be shared without their written permission.

Experts in the field recommend completing an assessment form for each child. It can help start mutual trust and respect that will develop into a strong, cooperative partnership between parents and caregivers.

The assessment should be completed prior to enrollment. Give parents an opportunity to review your enrollment forms and parent handbook before you complete the assessment form. The parent handbook or operational policies set forth your program's philosophy and values.

The enrollment interview is the time to obtain critical information about the child and provide information on your program's operational policies, such as health checks (if conducted), procedures for the release of children, and illness and exclusion criteria. It also provides parents an opportunity to assess your program and determine if it is best suited for their child's needs.

Child Name (last, first, middle)		Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)		City	County	Zip
Mailing Address (if different) -- Street or P.O. Box		City	County	Zip
Telephone No. (include A/C)				

* If applicable.

1. Health

Does your child have any allergies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what allergies does your child have?			
How should we respond if he/she has an allergic reaction?			
Does your child have an existing illness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how is the medication administered, and will it need to be administered while he/she is in care?			
Is the medication prescribed for continuous use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. Toileting:

Does your child need assistance with toileting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How can we best help?			
What are your ideas about toilet training?			
How can we best help?			

3. Behavior:

Does your child have any special fears?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child communicate his/her needs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any special words that your child uses that might not be readily recognized?			
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?			
When your child gets upset, what helps him/her calm down?			
What is a good way to distract your child when he/she is having a temper tantrum?			
Are there any particular routines that are particularly helpful at naptime?			

What position is most comfortable for your child when he/she is napping?	
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4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

5. Activities:

What activities do you like to do with your child?			
What activities does your child like to do when playing with other children?			
What does your child like to do when he is playing alone?			

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)			
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I verify that the above assessment was discussed with the parent(s) of _____

Signature of Director

Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

Signature of Parent

Date Signed

Additional Comments:

Child Health Record

Child's Name: _____

Nickname: _____

Birth date: _____

Child's Physician: _____

Is your child currently under the care of a physician? _____

Please describe your child's current physical health Good Fair Poor

Medical Conditions: (Please check all that apply)

Has your child had any of the following?

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hearing
<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Surgeries	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Convulsion/Epilepsy	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Impairment
<input type="checkbox"/> Polio	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney/Liver Problems	

Has your child had any serious medical conditions not listed above?

If yes, please explain: _____

Does your child have any Disabilities?

If yes, please explain: _____

Has your child had more than two ear infections in a year? Yes No

Has your child had tonsillitis? Yes No

Has your child ever had reaction to the Tuberculosis skin test? Yes No

Has your child ever been near anyone suffering from tuberculosis? Yes No

Does your child suffer for any hemophiliac disorders? Yes No

Does he/she have seizures fits or shaking spells? Yes No

Does your child have speech or hearing problems? Yes No

Does your child have trouble with his eyes or seeing? Yes No

Does your child have speech or hearing problems? Yes No

Is your child able to play as hard as other children? Yes No

Does your child have tubes in his/her ears? Yes No

Does your child get along with other children? Yes No

Is he/she usually happy? Yes No

Does your child have herpes? Yes No

Does your child have any special problems not indicated above? Yes No

If yes please explain: _____

When did your child last see a doctor? Month: _____ Year: _____

Has your child ever been in the hospital overnight? Yes No

If yes, why? _____

Has your child had any operations? Yes No

If yes, please explain? _____

Does your child have any medical conditions that the emergency room would need to know about (such as asthma, diabetes, epilepsy, etc.) Yes No

If yes, please explain: _____

Is your child on any medication? Yes No

If yes please list all medication both over-the-counter and prescription:

I understand that the information I have given is correct to the best of my knowledge, That it will be held in the strictest of confidence.

Parent Signature: _____

Date: _____



Medical Emergency Statement

Date of Application: _____ Date of Enrollment: _____ Last Day of Enrollment: _____

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

Child's Address: _____

City: _____ Zip Code: _____

Mother's Name: _____

Address: _____

City: _____ Zip Code: _____

E-mail Address: _____

Home Telephone #: (____) _____ Cell #: (____) _____

Mother's Employer: _____

Work #: (____) _____

Mother's Employer Address: _____

City: _____ Zip Code: _____

Father's Name: _____

Address: _____

City: _____ Zip Code: _____

E-mail Address: _____

Home Telephone #: (____) _____ Cell #: (____) _____

Father's Employer: _____

Work #: (____) _____

Father's Employer Address: _____

City: _____ Zip Code: _____

BREACH EARLY LEARNING CENTER

Known Allergies: _____

Last Tetanus: _____

Insurance Carrier: _____

Insurance ID: _____ Medical Facility: _____

Phone #: (____) _____

Child's Physician

Name: _____ Phone #: (____) _____

Address: _____

City: _____ Zip Code: _____

Child's Dentist

Name: _____ Phone #: (____) _____

Address _____

City: _____ Zip Code: _____

I, _____, give my consent for the day care provider
Parents Name

Breach Early Learning Center and its employees, to contact the above named physician or dentist if my child has a medical emergency. I understand that if my child's physician or dentist is not available, another physician or dentist may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency. I

will be responsible for all medical charges. (hospital or walk-in clinic)

_____, my child care provider, has my permission to
Provider's Name

transport my child if necessary, when my child is in care.

Is your child related to the person providing his/her child care? No Yes

If yes, what is the relationship? _____

(Relationship - grandchild, niece, nephew, sibling, son or daughter by blood, adoption or marriage)

The provisions outlined on this form have been worked out in consultation with me and have my approval.

Signature of Parent or Guardian: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

BREACH EARLY LEARNING CENTER

Drop Off and Pick Up Policy

Release of a Child

Parents are required to indicate the name and phone number of all authorized individuals who are clear to pick up the child. All parents and/or authorized individuals are to sign-in and sign-out on the provided sheet, each day the child is dropped off and picked up from the daycare. Only persons designated to pick up a child will be allowed to do so.

Unauthorized Pick Up

The parent/guardian is required to notify the caregiver in writing if someone else, other than the authorized persons, will pick up the child. Please provide name, phone number, and description of the person. The person will be asked to show photo identification. If necessary, police will be called for assistance.

Custody and Related Court Orders

The day care staff cannot become involved in the marital or custody issues of the families that we serve. If a custody or court order exists, a copy of the order needs to be placed in the child's file. The guardian is responsible for providing up to date and accurate information concerning the legal guardianship of the child. Without a custody or court order on file, the caregiver cannot deny access to the non-enrolling parent. If the non-enrolling parent is not listed on the pick up list, the policy on unauthorized persons will be implemented. The guardian will provide all consents.

BREACH EARLY LEARNING CENTER

Drop Off and Pick Up Policy

Please notify me if an unauthorized person will be picking up your child. Verbal or written permission must be received before we will release a child to anyone who is not authorized on the registration form. We will not allow your child to leave with an unauthorized person without previous permission. This is for the safety and protection of your child.

A parent or guardian must authorize up to 3 individuals to pick up their child from child care. Authorized individuals will be required to present valid identification to pick up any child from the child care.

I authorize the following individuals to pick up my child from the child care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

If an authorized individual without valid identification or an unauthorized individual comes to pick up my child from child care, I can be contacted at this number:

All parents and guardians must make sure that a staff person recognizes that the child has been dropped off or is being picked up from child care.

Parent Name

Date

Child Food Program of Texas CE: 02058 CHILD ENROLLMENT FORM

IMPORTANT NOTICE: Your daycare facility participates in the US Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participants will receive nutritious meals and snacks at no cost to you. This form must be completed by a parent or guardian at the time of enrollment and must be updated yearly. Failure to complete the enrollment form will result in non-payment for this child's meal.

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

Sex Male Female Food Allergies: Yes No If "yes", specify: _____ **A doctor's note must be provided.**

Days Normally in Care: Sunday Monday Tuesday Wednesday Thursday Friday Saturday **Original**

Meals/Snacks Normally Served: Breakfast AM Snack Lunch PM Snack Dinner Evening Snack **Start Date:** _____

Arrival and Departure Times: **Arrive** _____ AM PM **Depart** _____ AM PM **Withdrawn Date:** _____

RACE OF CHILD: You are NOT required to answer this question:
 White Black or African American American Indian/Alaska Native Asian Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question: Hispanic or Latino Not Hispanic or Latino

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

Sex Male Female Food Allergies: Yes No If "yes", specify: _____ **A doctor's note must be provided.**

Days Normally in Care: Sunday Monday Tuesday Wednesday Thursday Friday Saturday **Original**

Meals/Snacks Normally Served: Breakfast AM Snack Lunch PM Snack Dinner Evening Snack **Start Date:** _____

Arrival and Departure Times: **Arrive** _____ AM PM **Depart** _____ AM PM **Withdrawn Date:** _____

RACE OF CHILD: You are NOT required to answer this question:
 White Black or African American American Indian/Alaska Native Asian Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question: Hispanic or Latino Not Hispanic or Latino

Infant Decline Statement

Walmart Parent's Choice Advantage is the formula this facility offers for infants through CACFP. It is your choice whether or not to use this formula based on your infant's needs. Baby foods provided by this facility must be in compliance with the infant meal pattern.
To be completed by facility

<p>Please make your preferences _____ Today's Date</p> <p>I will bring expressed breastmilk for my infant: <input type="checkbox"/> Birth - 5 months <input type="checkbox"/> 6 - 11 months</p> <p>I want the facility to provide the infant formula for my infant: <input type="checkbox"/> Birth - 5 months <input type="checkbox"/> 6 - 11 months</p> <p>I will bring the following for my infant: <input type="checkbox"/> Birth - 5 months <input type="checkbox"/> 6 - 11 months</p>	<p>Please mark your preferences for 6-11 months old _____ Today's Date</p> <p>I want the facility to provide the infant cereal and other foods for my infant: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I will bring the infant cereal and/or other foods for my infant: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Parent Formula Name: _____

I certify that I have received the following: (1) WIC Flyer, (2)"Building for the Future", (3) a Parent Letter, (4) Income Eligibility Guidelines, (5) Income Eligibility Qualifying Form, (6) TDA's Directions on Filling out the Income Eligibility Form, (7) a blank copy of the Child Enrollment Form, (8) CACFP & Civil Rights Complaint Procedures.

_____ _____
Address Phone Number

_____ _____
City State Zipcode

_____ _____
Parent or Guardian's Name - PRINT Parent or Guardian's Signature Date



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**
 NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____
 Check here if no eligibility number

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income) <i>(Example)</i> <i>Jane Smith</i>	B. Gross income and how often it was received Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly _____	\$150/twice a month _____	\$100/monthly _____	\$200/bi-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 4 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 next 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



Parent Handbook Agreement

I, the undersigned, acknowledge that I have received a copy of the Parent Handbook for Breach Early Learning Center. While I understand that the Parent Handbook is neither a contract nor a legal document, I recognize that it is my responsibility to read and understand the policies, provisions, and procedures contained in the Parent Handbook.

In addition, I understand that the contents of the Parent Handbook are subject to change. I acknowledge that the Parent Handbook will be revised in accordance with the rules or regulations of state, federal, and accrediting entities, or with the best practices for child care service providers. I recognize that any such revisions will supersede, modify, or eliminate the current contents of the Parent Handbook.

I acknowledge that it is my responsibility to stay informed of policy and procedure revisions to the Parent Handbook. I understand that I can obtain a hard copy of the updated Parent Handbook upon request.

Moreover, I recognize that it is my responsibility to contact the Breach Early Learning Center Director for any questions I might have about the contents of the Parent Handbook now and in the future.

Guardian Name (Print)

Date

Guardian Signature

Hard copy of Parent Handbook Provided:

Breach Early Learning Center Representative - Signature

Child Registered in Program



Publicity Release Agreement

I hereby consent to the use of my name, photograph or other likeness by Breach Early Learning Center and/or its affiliates Repair the Breach Ministries, their respective employees, agents, licensees, franchisees, and assigns in all marketing and advertising materials, publications, word of mouth programs, Web sites, social media and/or in media interviews without restriction as to manner, frequency or duration of usage.

I further agree that my name and/or photograph or other likeness may be used with whatever visuals, copy or other elements for Breach Early Learning Center's online newsletters, Web sites, social media sites or in electronic/print media and I agree that all such materials produced hereunder are and will remain the sole and exclusive property of Breach Early Learning Center and will not have to be reviewed with me prior to their use.

I further consent to the use of statements, comments, or opinions I have made, whether oral or written, referring or relating to Breach Early Learning Center, its business, the Repair the Breach Ministries system and its programs, and/or my own franchised business.

I hereby warrant and represent that the statements attributable to me, accurately reflect my true and honest belief and my actual experience with Breach Early Learning Center, which I testify to and recommend. I agree to execute whatever documents Breach Early Learning Center requires confirming this warranty and representation.

I represent that I am over the age required by law in this state to enter into binding agreements and that I have no conflicting contractual obligations that would interfere with my performing services hereunder or my granting the rights herein granted. If I am under age, the signature of my parent/guardian below shall constitute the parent/guardian's consent on my behalf to the terms and conditions of the Release Agreement. This consent is irrevocable and is given on the express understanding and condition that no reward or compensation is or shall be due to me or to the undersigned parent/guardian for the giving of this consent or for the grants and licenses provided herein.

I hereby certify and represent that I have read the foregoing and fully understand the meaning and effect thereof.

Signature of Parent/ Guardian: _____

Print Name: _____

Print Child's Name: _____

Telephone: _____