



Oak Park YMCA Early Learning Center: Registration 2024-25

Name of Child (Last, First, Middle)			Gender F M		Date of Birth
Address (Number and Street, Building/Apartment Number)			City		State Zip Code
Parent/Legal Guardian's Name		Cell # (required)	Parent/Legal Guardian's Name		Cell # (required)
Parent/Legal Guardian's Date of Birth	Parent/Legal Guardian's Gender M F NB		Parent/Legal Guardian's Date of Birth	Parent/Legal Guardian's Gender M F NB	
Home Address (if not child's address)			Home Address (if not child's address)		
City	State	Zip Code	City	State	Zip Code
Email Address (required)			Email Address (required)		
Desired Start Date			Anticipated drop-off and pick-up times		

Enrollment Options

Ages	Select	Schedule	Weekly Rate	Registration Fee
Infant (6 weeks to 15 months)		Full-time (4-5 days)	\$285	A non-refundable \$100/year registration fee is due at the time of registering for the Child Care Program. Your child is not enrolled or guaranteed a spot until this form and fee are returned.
		Part-time (3 days)	\$214	
		Part-time (2 days)	\$171	
Toddler (16 to 35 months)		Full-time (4-5 days)	\$280	
		Part-time (3 days)	\$210	
		Part-time (2 days)	\$168	
Preschool/Pre-K (36 to 60 months)		Full-time (4-5 days)	\$250	
		Part-time (3 days)	\$188	
		Part-time (2 days)	\$150	
School-age Program (available June 9th – August 15th, 2025; post-kindergarten to age 11)		Full-time (4-5 days)	\$225	A non-refundable \$50/week registration fee is due at the time of registering for the School-age Program.

Credit Card Authorization

In filling out this form, you are providing permission to the Oak Park YMCA Early Learning Center to charge your tuition payment weekly, one week in advance of care.

Circle credit card type:	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	<input type="checkbox"/> Discover
Card Number:	Exp. Date:		CVV:	
Cardholder Name:				
Authorized Signature:				



Oak Park YMCA Early Learning Center: Agreement 2024-25

Please initial each item and sign/date form

_____ I have read the Oak Park YMCA Early Learning Center Handbook and I agree to abide by all the terms stated in the handbook while my child receives care. The handbook included all the following information (R 400.8146 (1-2)):

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided.
- Fee policy
- Discipline policy
- Food service program
- Program philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, incidents, and illnesses.
- Medication policy
- Exclusion policy for child illnesses
- Notice that the center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last five years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at www.michigan.gov/michildcare.

_____ I understand that tuition is due weekly, one week in advance of care.

_____ I understand that I will be assessed a late payment fee if tuition payments fall behind, and a late pick-up fee for any day my child is not picked up on time.

_____ I will pay for my child's enrolled slot even if they are not present due to illness, time off, or vacation.

_____ I understand that I must give two weeks written notice to withdraw my child from the program, and that fees will be due through the end of the two-week period whether or not my child attends.

_____ I understand the Oak Park YMCA Early Learning Center gives priority to full-time enrollment and if necessary I may be asked to rearrange my schedule to meet current vacancies.

_____ I understand the Oak Park YMCA Early Learning Center is mandated to report to the Department of Health & Human Services any suspected case of child abuse or neglect.

Permissions

_____ I give permission to the Oak Park YMCA Early Learning Center program staff to apply (twice daily prior to outdoor time) **sunscreen or bug repellent** that I have provided and labeled for my child.

_____ I give permission to the Oak Park YMCA Early Learning Center program staff to apply (as needed) **lotion** that I have provided and labeled for my child.

_____ I give permission to the Oak Park YMCA Early Learning Center program staff to apply **hand sanitizer** as needed.

_____ I give permission for my child (aged three years and older) to participate in **swimming activities**. I understand that I will be notified in advance to provide appropriate swimwear. I understand that the YMCA will assess each child's swimming ability prior to participation. I understand that non-swimmers and children under three years old will be engaged in supervised non-swimming activities away from the immediate swimming activity area during swim-time.

Parent Signature _____ Date _____

Director Signature _____ Date _____



Oak Park YMCA Early Learning Center: Photo/Media Consent and Release

Taking photographs of children at school is a common method of documenting their activities and development. Classroom staff at the Oak Park YMCA Early Learning Center are trained to be discerning when photographing children, giving thought to its necessity and purpose in such documentation.

Classroom staff are prohibited from using their personal cell phones and other electronic devices for photographing or recording children’s activities. Any photos of children must be taken using only YMCA-issued devices, which are accessible only to center personnel.

Photographs and video of children are intended for educational and communication purposes only. Photographs of an individual child may be shared with that child’s family only. Photographs may be displayed in the classroom, especially to indicate allergies to new staff. Group photographs are sometimes used on the Oak Park YMCA Child Care Center’s *private* Facebook page to convey activities and development, but they are not made public.

On rare occasions, the YMCA of the USA seeks photographs from its association members of people and programs, including children. The Oak Park YMCA Early Learning Center will release to the YMCA of the USA only photographs of children whose family has given explicit consent on this form.

Please initial only those items to which you consent:

- I understand that photographs will be taken of my child by staff at the Oak Park YMCA Early Learning Center to document his/her activities and development.
- I give permission to the Oak Park YMCA Early Learning Center to use my child’s photograph within the classroom.
- I give permission to the Oak Park YMCA Early Learning Center to use my child’s photograph on the center’s private Facebook page.
- I give permission to the Oak Park YMCA Early Learning Center to release my child’s photograph to the YMCA of the USA for their exhibition in promotions, advertising, education, and legitimate business uses. Such use includes reproductions in any form and media, adaptations and/or revisions, throughout the world and forever. I understand and agree there may be no compensation for this, and I will not make any claim for payment of any kind. My child may or may not be identified in such reproductions; however, my child’s name will not be used to endorse any particular commercial products or commercial services.

Parent Signature _____ Date _____

Director Signature _____ Date _____

CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Advancement, and Potential - Child Care Licensing Bureau

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:		Date of Admission	Date of Discharge		
Name of Child (Last, First, Middle Initial)					Child's Date of Birth
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Cell Phone	Parent/Legal Guardian's Name (Optional)		Cell Phone
Home Address (if not child's address)		2 nd Phone (if applicable)	Home Address (if not child's address)		2 nd Phone (if applicable)
City	State	Zip Code	City	State	Zip Code
Email Address (required)			Email Address (optional)		
Employer Name		Work Phone	Employer Name		Work Phone
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number		
Hospital Preferred for Emergency Treatment (optional)					
Allergies, Special Needs and/or Special Instructions? Yes No If yes, explain:					

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.		
2.		
3.		

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.		2.	
3.		4.	

Parent/Legal Guardian Initials:

_____ I give permission to **YMCA Child Care Center**, licensed by the Department of Lifelong Education, Advancement, and Potential, to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian _____ Date Signed _____

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials
MiLEAP is an equal opportunity employer/program.						AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

HEALTH APPRAISAL (due within 30 days of enrollment)

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. **Fill out the information requested in Section I.** Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)	DATE OF BIRTH (mm/dd/yy)
ADDRESS (Number & Street) (City) (ZIP Code) MI	TODAY'S DATE (mm/dd/yy)
PARENT/GUARDIAN (Last, First, Middle)	CELL PHONE
ADDRESS (Number & Street) (City) (ZIP Code) MI	WORK TELEPHONE NUMBER

SECTION I - HEALTH HISTORY (to be completed by parent/guardian)

Yes	No	Resolved	# Is your child having any of the problems listed below?	
			1 Allergies or Reactions (for example, food, medication or other)	Birth History: Are there any current or past diagnosis(es) Yes No If yes, please describe: If yes, list medications: Was the health history reviewed by a health professional? Yes No Examiner's Initials: _____
			2 Hay Fever, Asthma, or Wheezing	
			3 Eczema or Frequent Skin Rashes	
			4 Convulsions/Seizures	
			5 Heart Trouble	
			6 Diabetes	
			7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	
			8 Trouble with Passing Urine or Bowel Movements	
			9 Shortness of Breath	
			10 Speech Problems	
			11 Menstrual Problems	
			12 Dental Problems: Date of Last Exam	
			Other (please describe): _____	
			Does your child take any medication(s) regularly?	
			Reason for Medication	
			_____ Parent/Guardian Signature _____ Date _____	

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: ___/___/___	Visual Acuity Muscle Imbalance Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ___/___/___	Audiometer Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	➔			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ___/___/___	Sugar Albumin Microscopic				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: ___/___/___	Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ___/___/___	Level _____ ug/dl						NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.				

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: ___/___/___

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5			
	3	6	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Tdap	1			2	
<i>Haemophilus Influenzae</i> type b (HIB)	1	3	OTHER Vaccines	Type of Vaccine(s)	Date of Vaccine(s)
	2	4	Specify Date & Type	1	
Polio (IPV/OPV)	1	3		2	
	2	4		3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
	2	4	*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
Rotavirus (RV1/RV5)	1	3	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2				
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:					

I certify that the immunization dates are true to the best of my knowledge

Health Professional's Signature

Title

Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
Other Recommendations		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

Dentist's Signature

_____/_____/_____
Date

PHYSICIAN'S SIGNATURE

Examiner's Signature

_____/_____/_____
Date

Examiner's Name (Print or Type)

Degree or License

Number & Street

City

MI _____
ZIP Code

Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

Oak Park Early Learning Center, Oak Park YMCA, 900 Long Blvd., Lansing 48911

Dear Participant/Parent-Guardian:

This letter is intended for adults/parents or parents/guardians of participants enrolled in a day care center. The Oak Park Early Learning Center offers healthy meals to all enrolled participants as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to participants enrolled in care. Please help us comply with the requirements of the CACFP by completing the attached Household Income Eligibility Statement (HIES). In addition, by filling out this form, we will be able to determine eligibility for free or reduced price meals.

1. Do I need to fill out a HIES for each participant enrolled in care? You may complete and submit one CACFP Household Income Eligibility Statement for all participants enrolled in day care in your household only if those in day care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. Return the completed form to: Oak Park Early Learning Center, Oak Park YMCA, 900 Long Blvd., Lansing 48911.

2. Which adult and childcare institutions can receive free meal reimbursement without providing household income information? Adults receiving Medicaid, Supplemental Security Income (SSI), Food Assistance Program (FAP) Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) are eligible for free meals. Children in households receiving FAP, FIP, or FDPIR can get free meals. Foster children and children enrolled in Head Start Programs are also eligible for free meals.

3. Who can get reduced price meals? You may get low-cost meals if your household's income is within the reduced-price limits on the federal income eligibility guidelines, **effective July 1, 2024, until June 30, 2025**, shown below:

Family Size	Yearly Income	Monthly Income	Weekly Income
1	\$27,861	\$2,322	\$536
2	\$37,814	\$3,152	\$728
3	\$47,767	\$3,981	\$919
4	\$57,720	\$4,810	\$1,110
For each additional family member add:	\$9,953	\$830	\$192

Refer to the Instructions for Participants/Parents/Guardians Household Income Eligibility Statement on how to complete the HIES. Find the category that most closely defines your household and follow the directions for completing each part of the HIES. If your household income is greater than the levels shown on the above CACFP income guidelines, it is not necessary for you to complete the HIES form.

Families with Children:

Your family may be eligible to receive health insurance, called MIChild, through the State of Michigan. MIChild is a health insurance program for uninsured children of Michigan's working families. To determine if your family is eligible, call 1-888-988-6300 for an application or access an online application at the [MI Child website](http://www.michigan.gov/michild) (www.michigan.gov/michild). You can also access the MIChild brochure that briefly explains the insurance program.

Your family may be eligible to receive Women, Infants & Children (WIC), a health and nutrition program, that has demonstrated a positive effect on pregnancy outcomes, child growth and development. To determine eligibility, call 1-800-26-BIRTH or access online information at [Women, Infants, & Children \(WIC\) website](http://www.michigan.gov/wic) (http://www.michigan.gov/wic) to learn about WIC and locate a local WIC agency.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. Participants and family members do not have to be U.S. citizens to qualify for meal benefits offered at the center.

5. Who should I include as members of my household? You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member and the frequency the income is received. If recent income does not accurately reflect your circumstances, you may provide a projection of your income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the federal income eligibility guidelines listed above, the family day care home will receive a higher level of reimbursement. Once properly approved for the higher reimbursement rate, whether through income or by providing a current FAP, FIP, FDPIR case number, or listing the name of other categorically eligible programs, you will remain eligible for those benefits for 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income unemployment causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally receive. For example, if you normally receive \$1,000 every two weeks, but you missed some work in the last two weeks and only received \$900, put down that you receive \$1,000 per every two weeks. If you normally receive overtime, include it, but not if you only receive it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the HIES but are not required to include payments received for the foster child as income.

9. We are in the military. Do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, regarding deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP), is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income. In the operation of child feeding programs, the U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you have other questions or need help, call 517-827-9696.

Sincerely,
Oak Park Early Learning Center

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: [USDA Program Discrimination Complaint Form](#), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:

<https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>

Return this completed form to: Oak Park Early Learning Center, Oak Park YMCA, 900 Long Blvd., Lansing 48911

Participant Enrollment Form

Required

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity (see instructions, #5)	Race (see instructions, #6)
	Mon Tues Wed Thu Fri	7:30 a.m.-5:30 p.m.	Breakfast Lunch PM Snack		
	Mon Tues Wed Thu Fri	7:30 a.m.-5:30 p.m.	Breakfast Lunch PM Snack		
	Mon Tues Wed Thu Fri	7:30 a.m.-5:30 p.m.	Breakfast Lunch PM Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address _____

Adult/Parent/Guardian's Phone Number _____

Signature of Adult/Parent/Guardian _____

Date Signed _____

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: [USDA Program Discrimination Complaint Form](https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov. This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>

**Instructions for Parents/Participants/Guardians
Household Income Eligibility Statement - Child Care Institutions**

If you are applying for foster child(ren) only, follow these instructions:

Part 1: Do not complete.

Part 2: List name, age, and birth date of foster child(ren); check the box for foster child.

Part 3: Sign and date the form. The last four digits of a social security number are not necessary.

If your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR) benefits, follow these instructions:

Part 1: List the name and case number for any household member (including adults) receiving FAP, FIP, or FDPIR.

Part 2: List the name, age, and birth date for all children enrolled in day care.

Part 3: Sign and date the form. A Social Security Number is not necessary.

Note: Benefits received under WIC, Medicaid, or Department of Health and Human Services (DHHS) Child Care Assistance Program (where DHHS pays a portion of your child care expense) does not automatically qualify for Category A (free) meals.

All other households, including households where some of the children are foster children, follow these instructions (not required if household is over the income limits and don't have any foster children):

Part 1: Do not complete.

Part 2: List the names and ages of everyone (related or not related) living in your household, including you, other adults and children (If you need more space, use a separate sheet of paper.)

Place a ✓ in the column for all children enrolled in child care

List household members' ages and dates of birth

Place a ✓ in the next column if children in the household are foster children

If no case number is indicated in Part 1, list (by person) the amount and source of income received last month. List monthly earnings **before** deductions, monthly welfare, child support or alimony or any other income including retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits, Worker's Compensation, unemployment, strike benefits, regular contributions of people who do not live in your household or any other income

Place a ✓ in the box for those listed who do not have income

If you are in the Military Housing Privatization Initiative or receive Combat Pay, do not include the housing allowance as income

Foster child payments received by the family from the placement agency are not considered income and do not have to be reported. The presence of a foster child in a family does not make all children in the household automatically eligible for free meals

If you are a farmer or self-employed, monthly income is gross farm or business income received in the month prior to application minus farm or business expenses. Gross wages from other jobs or income from other sources must also be listed as income. A loss from self-employment must be listed as zero income and cannot reduce other income

Part 3: Sign and date the form and list the last four digits of your Social Security Number or check the box indicating "I do not have a Social Security Number."

Help With Income To determine annualized income:

If paid every week, multiply the total gross income by 52.

If paid every two weeks, multiply the total gross income by 26.

If paid once a month, use the total gross monthly income.

If paid twice a month, multiply the total gross income by 24.

If paid once a year, use the total gross yearly income.

Return the completed application to the child care center.

Privacy Act Statement

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPPIR) case number for the participant or other FDPPIR identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: [USDA Program Discrimination Complaint Form](https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: **mail**: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or **fax**: (833) 256-1665 or (202) 690-7442; or **email**: program.intake@usda.gov

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>

Rev 7/2024



Family Structure and Child Development

The purpose of this questionnaire is to allow the teaching staff a better understanding of your child and your family. All information is confidential.

GENERAL INFORMATION

Child's full name _____ Nickname _____ DOB _____

Race/ethnicity _____ Nationality _____ Religion _____

Person providing this information: _____ Relationship to child _____

Is child your: biological child adopted child foster child other: _____

FAMILY STRUCTURE & LIVING SITUATION

Father's Name _____ Occupation _____ Highest education: _____

Mother's Name _____ Occupation _____ Highest education: _____

Guardian's Name _____ Occupation _____ Highest education: _____

With whom does child live *at least half* the time? (Check all that apply)

- both parents in the same home
- mother's home
- father's home
- other's home (specify) _____

List all people living in household (indicate which household if child lives in multiple homes):

Name	Age	Relationship to child	Which home? (Leave blank if N/A)

Any pets? (Indicate type, name, household) _____

Language(s) spoken at home _____ Primary language at home _____

List all locations (city, state, and/or country) that your child has lived:

1. Birthplace _____ Moved at age _____
2. _____ Moved at age _____
3. _____ Moved at age _____



REQUIRED

Learn, Grow, Thrive

Are parents of child currently:

- unmarried, living together
- divorced
- married
- never married, not living together
- separated

If separated, divorced, or never married and not living together, who has *legal* custody?

- mother
- father
- both
- other (specify): _____

If separated or divorced, how do you feel your child has adjusted to separation/divorce?

Are the other adults who have a *significant* part in raising your child? Yes No If so, please indicate name & relationship (i.e., step-parent, grandparent, etc.) _____

SOCIAL-EMOTIONAL DEVELOPMENT

Has your child had previous experience with a fulltime babysitter/nanny, child care home/center, or other care outside your home? Yes No If so, when, with whom, and how often? _____

Have there been any significant changes in the home over the last few years? (i.e., new marriages, deaths, births, address changes, family separation/divorce, parent dating, money problems, etc.) _____

What do you feel are your child's...

Strengths _____ Weaknesses _____

Reaction to strangers: _____ Able to play alone? _____

How much time each day does your child typically spend on the following electronic media?

Watching TV: _____ Playing video/computer/phone games: _____ Other _____

Does anyone read aloud to your child at home? Yes No If so, how often? _____

At what age did your child begin playing with other children? _____

What are your child's favorite activities? _____

Is your child affectionate? _____

Does your child celebrate holidays or special occasions? _____



REQUIRED

Learn, Grow, Thrive

Are there occasions in which you would rather your child not participate? _____

What are the things your child seems to fear? _____

Has your child had any frightening experiences? If so, describe briefly: _____

What is the method of behavior management/discipline at home? _____

HEALTH AND DEVELOPMENT

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Is your child currently taking any medication? Yes No If yes, please list medication and uses: _____

Has your child ever been identified as having a disability? Yes No If so, by whom, what age, & what disability? _____

Has your child ever received psychological counseling? Yes No If yes, by whom (professional/ agency) and when: _____

During your child's first few years of life, were any of the following significantly present?

- | | |
|---|---|
| <input type="checkbox"/> Difficult to comfort | <input type="checkbox"/> Difficult nursing |
| <input type="checkbox"/> Was not easily calmed by being held or stroked | <input type="checkbox"/> Poor eye contact |
| <input type="checkbox"/> Colicky | <input type="checkbox"/> Did not respond to their name |
| <input type="checkbox"/> Excessive irritability | <input type="checkbox"/> Fascination with certain objects |
| <input type="checkbox"/> Diminished sleep | <input type="checkbox"/> Constantly head banging |

* If you checked any of the above, please describe _____

PARENTING

Which adult would your child prefer to talk with about a problem? _____

Who is the family member with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? _____



REQUIRED

Learn, Grow, Thrive

How does your child respond to discipline at home? _____

List any responsibilities your child has at home: _____

Does your child do these regularly? Yes No

Does your child need frequent reminders? Yes No

SLEEPING HABITS

Indicate your child's... Bed time? _____ Wake time? _____ Do they sleep well? _____

Does your child sleep in a... Crib? _____ Bed? _____ Other? _____

Does your child sleep *in a room* alone? Yes No If not, with whom do they share? _____

Does your child sleep *in a bed* alone? Yes No If not, with whom and how often? _____

Does your child become tired or nap during the day (include when and how long)? _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking, etc.) _____

How does your child fall asleep? (Check all that apply)

Rocking chair

Laying with someone

On their own

Other _____

EATING HABITS & NUTRITION

Is your child usually hungry at mealtime? Yes No Between meals? Yes No

Is your child able to eat with a...

Spoon? Yes No

Fork? Yes No

Hands? Yes No

At home, what time does your child eat breakfast? _____ Lunch? _____ Dinner? _____

Favorite foods: _____

Foods refused: _____

Eating problems or difficulties: _____



REQUIRED

Learn, Grow, Thrive

List foods your child may not eat: _____

TOILETING HABITS

Has toilet learning been attempted? Yes No

How does your child indicate toileting needs (include special words): _____

Please describe any particular toileting procedure(s) to be used for your child at the center: _____

What is used at home?

Pottychair? Yes No

Special child seat? Yes No

Regular seat? Yes No

Is your child ever reluctant to use the toilet? Yes No If yes, what are the circumstances? _____

Does your child have accidents? Yes No If yes, what are the circumstances? _____

Are bowel movements regular? Yes No How many per day? _____

Is there a problem with diarrhea? Yes No If yes, what are the circumstances? _____

Is there a problem with constipation? Yes No If yes, what are the circumstances? _____

ADDITIONAL INFORMATION

Please provide us with any additional information that will help us care for your child.