PARENTAL EMERGENCY MEDICAL CONSENT
This form must be presented upon admission for treatment.

Child's Full Name _____ Date of Birth _____

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at _____(phone number) or _____ (phone number) have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by below listed physician and/or dentist or in the event the designated practitioners are not available, then by another licensed physician or dentist. If it is necessary to transport my child to a hospital, the preferred hospital is _____ (preferred hospital).

1. Parents/Guardians/Custodians with Whom the Child Resides:

Name _____ Relationship to Child _____

Address _____ Home Phone _____ Cell Phone _____

Employer _____ Email Address _____

Work Phone _____ Work Hours _____

Name _____ Relationship to Child _____

Address _____ Home Phone _____ Cell Phone _____

Employer _____ Email Address _____

Work Phone _____ Work Hours _____

2. Persons to Contact In Case of Emergency if Parents Are Unavailable, and are Authorized to Pick Up Child:

Name _____ Relationship to Child _____

Address _____ Home Phone _____ Cell Phone _____

Employer _____ Email Address _____

Work Phone _____ Work Hours _____

Name _____ Relationship to Child _____

Address _____ Home Phone _____ Cell Phone _____

Employer _____ Email Address _____

Work Phone _____ Work Hours _____

3. Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

- Name _____
- Name _____

4. Information:

Physician name _____ Dentist name _____

Street address _____ Street address _____

City, State _____ City, State _____

Phone # _____ Phone # _____

Date of Last Tetanus _____ Known Allergies _____

Present Medication _____

Insurance Company _____ Policy Holder's I.D. _____

This consent **will be in effect for one year** beginning (date) _____.

Signature Parent/Guardian _____ Date _____ Signature Parent/Guardian _____ Date _____

(Revised 1/18/17)

Pick-Up Authorization Form

My child, _____(child's name) may leave W4C's / K.I.N.D Care into the following persons care:

Authorization for Child Pick Up

"Do not release a child to anyone for whom you do not have a written authorization from the parent."
-Department of Human Services (DHS), Rule Citation 441 IAC 109.9(2)

To assist us in keeping every child safe while in our care, please list upon registration, any person you wish to give authorization to pick up your child.

If, at any time, you wish for someone who is NOT listed to pick up your child, you must submit written authorization in person to the center **PRIOR** to when the child is to be picked up. (According to the DHS citation, email and phone calls are not valid methods of "written" authorization).

For safety reasons, please advise any person you have authorized, to be prepared to show our staff their ID before your child can be released to them.

A **4 digit code** for each person authorized to log your child in/out is optional, however they must know a code to clock your child in or out. Please include your emergency contact person(s) as they may be picking up your child in case we cannot reach you in an emergency situation Update as necessary.

1. Name _____ Phone _____ Relationship _____ Code _____
2. Name _____ Phone _____ Relationship _____ Code _____
3. Name _____ Phone _____ Relationship _____ Code _____
4. Name _____ Phone _____ Relationship _____ Code _____
5. Name _____ Phone _____ Relationship _____ Code _____
6. Name _____ Phone _____ Relationship _____ Code _____
7. Name _____ Phone _____ Relationship _____ Code _____
8. Name _____ Phone _____ Relationship _____ Code _____
9. Name _____ Phone _____ Relationship _____ Code _____
10. Name _____ Phone _____ Relationship _____ Code _____

Is there any **court order prohibiting** contact of your child with any person? __Yes ___No, if 'Yes' **please provide a photocopy or order.**

Name of person(s) who **may not** pick up child

_____

_____

Signature of Parent/Guardian _____ Date_____

(Revised 1/18/17)

PERMISSION STATEMENTS

Liability

I _____ parent/guardian of _____ will not hold W4C's / KIND Care in Williamsburg, IA liable for any injury or accident related to water activities held in conjunction with the daycare. This includes, but is not limited to, trips to the public or private pools, or for any activities held at the daycare center.

Records Release Authorization

I hereby authorize and request (name of school)_____ to release to W4C's / K.I.N.D. CARE, a copy of the most recent immunization certificate and physical examination record of (name of child) _____present in their school file.

Transportation Authorization

In the event of an emergency evacuation or evacuation drills, I allow permission for my child to be transported to an alternate site (Williamsburg Recreation Center) via Williamsburg Community School bus or Iowa County Transportation. If we are evacuated to somewhere other than the Rec Center, parents will be notified.

Picture Release

I Do, I Do Not (circle one) give permission to have my child appear in any media coverage approved by W4C's / K.I.N.D. CARE.

Facebook

I Do, I Do Not (circle one) give my permission for my child's photo or video to be posted to their classroom's PRIVATE Facebook page. Classroom Facebook pages privacy settings are set to SECRET and are only shared with other classroom parents and W4C's administrative staff.

Field Trips

I Do I Do Not (circle one) give permission to have my child participate in center sponsored field trips, swimming, and off site activities.

Signature of Parent/Guardian/Custodian Date

(Revised 3/30/18)

Over-The-Counter Medications Release

Name of child_____

I give my permission for appointed staff of W4C's / K.I.N.D. Care to apply or administer: (check all that apply)

_____ Apply sunscreen I have provided UVB and UVA protection of SPF 45-50 or higher (on children 6 months or older), to exposed skin as needed when there is sun exposure. NOTE: It is mandatory for children to have sunscreen on before they go outside.

_____Apply lotion or Vaseline W4C's / K.I.N.D. Care has provided to my child's dry or itchy skin as needed.

_____Apply cream I have provided to my child's dry or irritated skin as needed for itching or wounds and diaper rash. NOTE: Certain creams such as hydrocortisone, require a doctor's order.

____ Administer Acetaminophen W4C's / K.I.N.D. Care has provided for fever or pain, under my direction, according to instructions provided by manufacturer. NOTE: For children under 2 years old, a doctor's order is required.

Any medicine administered to the child will be recorded and kept on file. A copy of the record will also be given to the parent/guardian.

_____ _____

Signature of parent /guardian Date (valid for 1 year)

(revised 2/20/17)

Annual Health Status –Parent Statement

(Kind Care Only Health statement to be completed by parent or guardian)

_____

Child's full name Date of birth

1. Significant illness and or surgeries my child has had (give age at time)

   _____

2. Is this child subject to any conditions which limit classroom activities or physical education?

   _____

3. Is this child subject to any condition which may result in an emergency situation?

   _____

Please ✔ in the box if the statement applies to your child

Plays with friends well – My child

- ☐ Plays well in groups with other children
- ☐ Will play only with one or two other children
- ☐ Prefers to play alone
- ☐ Fights with other children
- ☐ I am concerned about my child's play activity with other children

Body Health – My child has problems with

- ☐ Skin, hair, fingernails or toenails
- ☐ Stomach aches or upset stomach
- ☐ Eyes/vision, glasses or contact lenses
- ☐ Using toilet, night time wetting
- ☐ Ears/hearing, hearing aids or tubes in ears
- ☐ Constipation, diarrhea
- ☐ Nose problems, nosebleeds, breaths through mouth
- ☐ Bones, muscles, pain moving
- ☐ Mobility, uses assistive equipment
- ☐ Mouth, teeth, gums, tongue, sores in mouth
- ☐ Heart or heart murmur
- ☐ Breathing, asthma, or on lips, cough
- ☐ Frequent sore throats or tonsillitis
- ☐ Nervous system, headaches, seizures or nervous habits like twitches
- ☐ Female monthly periods

Medication – My child takes medication

List medications taken at home, school or in child care. List the name, time taken and reason medication is prescribed.

_____

Allergy – My child has the following allergies (food, medication, latex, inhalants, insects, animals etc)

_____

Parent Signature_____Date_____

Williamsburg Child Development Center
802 Franklin St.
Williamsburg, IA 52361
319-668-9515 phone
319-668-9513 fax
wburg4cs@gmail.com
kindcare@windstream.net

Dear Parents,

Please fill out and return the Iowa Eligibility Application regardless of whether or not you believe you may qualify for free or reduced price meals.

If you do not believe you qualify and do not wish to fill out income information, you do not need to provide that information. Please only fill out the names in parts 4 and 5 and sign and date the form.

This form assists us with paperwork we have to submit as part of our participation in the CACFP program. This information is only used for that purpose.

Note: We do not charge extra fees for meals; these forms help us determine what reimbursement we are eligible for under the CACFP program.

Thank you,

W4C's and K.I.N.D. Care

Iowa Eligibility Application

FFY 19-20

Complete one application per household. Fiscal Year 2019-2020

Part 1. Check all applicable boxes:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home(HP) Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.
Name of household member with Case Number _____ **List Case Number** _ _ _ _ _ _ _ _ _ _

Part 4. Children enrolled: REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino
Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White
If ethnicity & race are not completed, the form will be completed based on visual observation

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income: DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3.
Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Gross Income: Report income by how often the household member is paid.

Other Monthly Payments or Income Received.

Last Name	First Name	Age	Check if NO Income	Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: **X XX - X X -** ___ ___ ___ ___ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form_____

Signature of Adult Completing Form | Printed Name of Adult Completing Form | Date Signed

Address of Adult Completing Form | Town | ZIP Code | Work Phone | Home Phone | Cell Phone

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.
Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $_____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _____

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)

Eligibility Determination:
☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk

Application Denied:
☐ Incomplete ☐ Over income limits

☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature | **Effective Date**

Self-Employment Income Worksheet: This worksheet will help you calculate the amount to report if you farm, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. **The least self employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 5 of the application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return - Form 1040 (including Schedule 1). Use the lines from the 1040, Schedule 1 identified below:

Line 12 - Business income or (loss) $ _____

Line 13 - Capital gain or (loss) $ _____

Line 14 - Other gains or (losses) $ _____

Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc. $ _____

Line 18 - Farm income or (loss) $ _____

Total $ _____

The least income possible is zero (a negative number cannot be reported) Total ÷12* = _____

*Enter amount in the "Other Monthly Payments or Income Received" column in Part 5 on the front of the Iowa Eligibility Application.

Income Eligibility Guidelines (IEGs) for Free and Reduced Price Meals
Effective 7-1-2019 through 6-30-2020

(For internal use only—do not distribute to families)

Household Size	Reduced Price Meals					Free Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$23,107	$1,926	$963	$889	$ 445	$16,237	$1,354	$ 677	$ 625	$ 313
2	$31,284	$2,607	$1,304	$1,204	$ 602	$21,983	$1,832	$ 916	$ 846	$ 423
3	$39,461	$3,289	$1,645	$1,518	$ 759	$27,729	$2,311	$1,156	$1,067	$ 534
4	$47,638	$3,970	$1,985	$1,833	$ 917	$33,475	$2,790	$1,395	$1,288	$ 644
5	$55,815	$4,652	$2,326	$2,147	$1,074	$39,221	$3,269	$1,635	$1,509	$ 755
6	$63,992	$5,333	$2,667	$2,462	$1,231	$44,967	$3,748	$1,874	$1,730	$ 865
7	$72,169	$6,015	$3,008	$2,776	$1,388	$50,713	$4,227	$2,114	$1,951	$ 976
8	$80,346	$6,696	$3,348	$3,091	$1,546	$56,459	$4,705	$2,353	$2,172	$1,086
For each additional family member add:	+ $8,177	+ $682	+ $341	+ $315	+ $158	+$5,746	+$479	+$240	+$221	+$111

CHILD & ADULT CARE FOOD PROGRAM

Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

May 2019

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Birthdate	Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, the center's Program representative is required to note race/ethnicity on the basis of visual observation.

Infants only (0 to 12 months): ☐ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

☐ I will provide breastmilk for my infant. ☐ Yes ☐ No Center formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

☐ I would like to breastfeed on site, if this option is available[1]. ☐ Yes ☐ No If yes, time(s)_____

☐ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____

☐ I accept the center's formula for my infant. Name of iron-fortified formula: _____

☐ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____

☐ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

☐ I will provide solid foods for my infant[2]. The center may supplement with additional solid foods when my infant needs them: ☐ Yes ☐ No

Parent Signature_____ Date:_____

Parent Signature_____ Date:_____ (Make any needed changes above, sign and date)

Parent Signature_____ Date:_____ (Make any needed changes above, sign and date)

[1]Ask your center if you can breastfeed on-site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

This institution is an equal opportunity provider.