

KIND Care Summer Program Contract 2020

Dates/Hours: The KIND Care summer program will be open Mon-Fri, 6:00 AM – 6:00 PM, **Monday May 25 through Friday August 21. The center will be closed on Friday July 3rd^h.**

Registration: (Check one) Registration fees are non-refundable. (Registration fees are waived for DHS families)

- New families and current drop-in status families:

April 18 through May 1st - \$50.00 _____ After May 1st \$75 _____

- Current all year, full-time KIND Care families:

April 1 through April 17 - \$30 _____ After April 17 \$50 _____ After May 1st \$75 _____

Activity Fee: All Families including DHS - \$65.00 X (Due at time of Registration)

Contracted weeks: (Check all that apply)

<input type="checkbox"/> Week 1, May 25 – May 29	<input type="checkbox"/> Week 2, June 1- June 5	<input type="checkbox"/> Week 3, June 8- June 12
<input type="checkbox"/> Week 4, June 15 - June 19	<input type="checkbox"/> Week 5, June 22 – June 26	<input type="checkbox"/> Week 6, June 29 – July 3
<input type="checkbox"/> Week 6, July 6 - July 10	<input type="checkbox"/> Week 7, July 13 - July 17	<input type="checkbox"/> Week 8, July 20 - July 24
<input type="checkbox"/> Week 9, July 27– July 31	<input type="checkbox"/> Week 10, Aug 3 - Aug 7	<input type="checkbox"/> Week 11, Aug 10 - Aug 14
<input type="checkbox"/> Week 12, Aug 17 - Aug 21		

Check one: 8 or more full weeks _____ 5-7 full weeks _____ 1-4 full weeks _____ Fee -
\$150.00 per week Fee - \$160.00 per week Fee - \$165.00 per week

Contract Changes: Changes may be made to this contract until May 1, 2020. After that date, you must give a paid, written two week notice to make changes.

Fees: You will be responsible for payment of all days and weeks contracted in this agreement regardless if your child does or does not attend. Weekly fees are due in advance on Mondays. A late charge of \$25.00 will be assessed when fees are not paid by 10:00 AM on Monday 10 A.M.

- **How do you plan to pay?** (check one) Weekly _____ Bi-weekly _____ Monthly _____
(Entire summer will be billed out at one time)

Prefer Part-Time Child Care for the Summer?

Drop-In Status: (Check if choosing this option) _____

- You must register your child the same as above.
- The fee for a drop-in day is \$50 whether your child attends all or part of the day.
- You will need to provide a 24 hour advance notice if your child will attend.
- Payments for drop-in days will be due in advance as much as possible. When this is not possible, charges must be paid the following week.

About your Child:

Name _____

Child's Estimated arrival time _____ Estimated departure time _____

Child's T-shirt size: (Circle one) YS YM YL AS AM AL Child's grade (in the fall) _____

Is there anything you would like or need staff to know about your child?

Consent/Liability: I give my consent for (child's name) _____ to participate fully in the W4Cs/KIND Care 2020 Summer Program, including fieldtrips, swimming and off-site visits.

I will not hold W4Cs/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 other activities held at the daycare center.

Parent/Guardian Signature _____

Date _____

All W4C's and K.I.N.D. Care families,

This is just a reminder that all payments are due by **Monday by 10 AM**. Payments are due in advance.

For example:

- If you pay weekly, the payment is due by **Monday 10 Am** of the current week.
- If you pay bi-weekly, payment is due by **Monday 10 Am** of the 1st week, not the second.
- If you pay monthly, payment is due by **Monday 10 AM** of the first week of the month.

The payment box is checked at **10 AM or after each Monday**. If your payment is there, you will not be charged a late fee.

Late fees will be assessed each time there is a late payment. If your payment is short for some reason, I may give you a reminder in your mailbox, but if the payment is short a second time, a late fee will be assessed at that time. If you don't pay the late fee at your next scheduled payment, you may be given a reminder, but if it remains unpaid at the next payment due date, you will be assessed another late fee and they will continue to accrue until paid in full.

You are able to check the balance of your account when you sign your child in or out. When you come to the screen where it says "Welcome" or "Goodbye", you can click on the "Ledger Card" box to see your account charges and credits. I know these can be confusing so if you have any questions, please let myself or Sandy know. If we aren't here when you are, send an email or call.

If you are having problems paying your tuition, please speak with Sandy or Barb. We are willing to try and work with you and your specific situation when you communicate with us.

Barb Blatter
Office Administrator

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 _____

W4C's / K.I.N.D. Care Admission Agreement

ATTENDANCE:

- I will notify the center staff as early as possible when my child will not be participating or arriving late.
- I or an adult I designate, will bring and pick up my child from the center at scheduled times. All legal parent/guardians will be allowed to pick up their child/ren unless there is a legal document on file at the center stating otherwise.
- I will not permit my child to attend the center if he/she is sick or not able to physically participate in the daily activities.
- If my child becomes sick while at the center, I will arrange transportation for him/her to return home. If a medical emergency arises, the center staff will first attempt to contact me. If I cannot be reached or my established emergency contacts cannot be reached, the staff will contact my child's doctor. If necessary an ambulance or emergency vehicle may take my child to the hospital.

FEES:

Registration Fees: (non-refundable) (waived for DHS and Head Start families)

- W4C's - one-time \$60 per child
- KIND Care each School Year: New and Drop-In families - \$50 Full-time Existing families - \$30 (late registration fees may apply \$75, published deadline is determined each year)
-
- KIND Care each Summer: New and Drop-in families - \$50 Full-time Existing families (priority reg.) \$30 (late registration fees may apply \$75, published deadline is determined each year)

Activity Fee: to cover summer fieldtrips.

- KIND Care Summer Families including DHS Families \$65
- Payments of fees are due in advance on Monday's. If fees are not paid by 10:00 A.M. on Monday, a late charge of \$25 will be assessed to my account.
- If my account balance becomes two weeks delinquent, my child/ren must be withdrawn from the center until the entire balance is paid in full.
- Payment is due even if my child is absent during their reserved time slot.
- I will give a two week written notice of withdraw from the program. I will be responsible for regular payments during the two week period. If I do not give a two week notice, I agree to pay the two weeks tuition. Two week notices must begin on a Monday as we bill weekly M-F.
- Contract changes (K.I.N.D. Care only) - I may change my contract at any time with a two week written notice. I will be responsible for regular payments during the two week period. A \$25 fee will apply for **each** contract change.
- The 1 week's tuition is due (W4C's only), when my child's spot is guaranteed and reserved. This will be applied toward the last week of attendance. (non-refundable)

OTHER PARENT RESPONSIBILITIES:

- I agree to ask questions and share concerns with the child care staff.
- I will dress my child properly for outside in play in current weather conditions.
- I will update the center staff of any changes to my child's file information as soon as I am aware of those changes.
- I give my permission for _____ (child's name) to participate fully in the W4C's / K.I.N.D Care programs.

Parent/Guardian Signature / Date

Director Signature / Date

Over →

Please mark the boxes below that apply to you:

- I would like a receipt each time I make a payment.
- I would like a statement for the month at the beginning of each month.
- I would like a statement for the month at the end of each month.
- I would like a receipt only if I pay with cash.
- I will request a receipt or statement, only when I need one.
- I do not need either a receipt or a statement.
- I will need a statement of all charges and payments at the end of the year for my taxes.

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

- | |
|--|
| <ul style="list-style-type: none"><input type="checkbox"/> Skin, hair, fingernails or toenails<input type="checkbox"/> Stomach aches or upset stomach<input type="checkbox"/> Eyes/vision, glasses or contact lenses<input type="checkbox"/> Using toilet, night time wetting<input type="checkbox"/> Ears/hearing, hearing aids or tubes in ears<input type="checkbox"/> Constipation, diarrhea<input type="checkbox"/> Nose problems, nosebleeds, breaths through mouth<input type="checkbox"/> Bones, muscles, pain moving |
|--|

- | |
|---|
| <ul style="list-style-type: none"><input type="checkbox"/> Mobility, uses assistive equipment<input type="checkbox"/> Mouth, teeth, gums, tongue, sores in mouth<input type="checkbox"/> Heart or heart murmur<input type="checkbox"/> Breathing, asthma, or on lips, cough<input type="checkbox"/> Frequent sore throats or tonsillitis<input type="checkbox"/> Nervous system, headaches, seizures or nervous habits like twitches<input type="checkbox"/> 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 _____

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)

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

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 _____



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:

- | | | |
|--|--|--|
| <input type="checkbox"/> school meals | <input type="checkbox"/> children in child care center | <input type="checkbox"/> children in child care home(HP) |
| <input type="checkbox"/> special milk (restrictions apply) | <input type="checkbox"/> Tier I home provider (HP) | Provider name: _____ |
| | <input type="checkbox"/> Head Start/Even Start | |

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		OPTIONAL	
				<i>If ethnicity & race are not completed, the form will be completed based on visual observation</i>					
Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade			ETHNICITY	RACE
1.			<input type="checkbox"/>						
2.			<input type="checkbox"/>						
3.			<input type="checkbox"/>						
4.			<input type="checkbox"/>						
5.			<input type="checkbox"/>						

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 <u>everyone</u> 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.			<input type="checkbox"/>								
2.			<input type="checkbox"/>								
3.			<input type="checkbox"/>								
4.			<input type="checkbox"/>								
5.			<input type="checkbox"/>								

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: <input type="checkbox"/> Income <input type="checkbox"/> Foster Child (free) <input type="checkbox"/> Head Start DOCUMENTATION REQUIRED	<input type="checkbox"/> FIP/Food Assistance <input type="checkbox"/> Homeless/Migrant/Runaway (Schools only)	CACFP HP ONLY: <input type="checkbox"/> Tier 1 Area (Provider's own children) <input type="checkbox"/> Tier 1 Income (All children) <input type="checkbox"/> Tier 1 Child (Tier 2 mixed)
Eligibility Determination: <input type="checkbox"/> Free Meals <input type="checkbox"/> Reduced Price Meals Application Denied: <input type="checkbox"/> Incomplete <input type="checkbox"/> Over income limits	<input type="checkbox"/> Free Milk	

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	

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.

**Iowa Child and Adult Care Food Program
Child Care Enrollment Form**

Last Name, First Name	Birthdate	Times of Care		Regular Days of Care							Meals Served During Care				Ethnicity/Race*			
		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! Yes No 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 infant². 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)
- ¹Ask your center if you can breastfeed on-site.
²The 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.

KIND Care – Williamsburg Public Library

This form MUST be returned BEFORE your child may check out library books when KIND Care visits the Williamsburg Public Library.

KIND Care Parents,

- **Please set up your family library account with the Williamsburg Public Library as soon as possible.**
- If your family does not have an account, your child may still enjoy visiting the library, but will not be allowed to check out any books. A family library account is needed in order for your child to check out books with KIND Care.
- **The library staff will NOT censor or restrict what materials the children check out.** However, KIND Care staff will do our best to be mindful of what materials are being checked out. If you find that your child has checked out something that you aren't ok with, please let us know.
- **KIND Care will allow the children to check out up to 2 books each week.** Please return the books the following week so they may be returned to the library during our next visit. (If your family decides to return the books checked out during our last visit, please let the KIND Care staff know that those books have been returned.)

My signature below implies that I have read and comply with the above points of interest and that I give permission for my child(ren) listed below to check out books at the Williamsburg Public Library with KIND Care:

Name on your Library Account _____

Child's Name _____ Child's Name _____

Child's Name _____ Child's Name _____

Parent Signature _____ Date _____