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)

W4C'S / KIND CARE ENROLLMENT APPLICATION

I. Child's Identification Information		
Name		Nickname
Sex	Birth Date	Parents Email

II. Family Information: Parents or Guardians			
Name	Address & Phone	Place of Employment	Work Phone

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Foster Parent

Names and ages of other children in the home:

Name	Age	Name	Age

III. Parental Sign in/out code			
Name	Relationship	4 digit Code	

IV. Special Needs
Child's Allergies & Dietary Restrictions
Child's special needs
Is your child receiving daily long-term medications? ☐ Yes ☐ No
Will W4C's or Kind Care need to administer medications during program hours? ☐ Yes ☐ No If yes, a Medication Authorization Form will need to be signed to give permission to administer medication.
Other (Specify):

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, age, disability, religion, sex, and familial status. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD)

W4C'S CHILDREN

A. Play and Sociability:

1. How does your child get along with other children?_____
2. His/her usual playmates are: Girls Boys Older Younger
3. What is the usual size of your child's playgroup?_____
4. Previous group experience other than school: Preschool Playgroup Sunday school
5. Other (specify)_____

B. Personality and Emotional Development:

1. Is your child affectionate? Yes No To Whom?
2. Does she/he accept new people easily? Yes No
3. What are your child's fears?_____
4. Is your child usually happy? Yes No
5. What nervous habits does your child have?_____

C. Discipline:

When you find it necessary to discipline your child, which parent usually does this and how?

_____

D. Infants and Toddlers:

1. Has your baby had any feeding problems? Yes No

If yes, please explain:_____

2. Is your baby breast fed bottle fed
3. What food is your baby eating now?

Fruits:_____ Juices:_____

Vegetables:_____ Meats:_____

Cereals:_____ Milk(formula):_____

4. Sleeping habits during the day:_____
5. Does your child have a "fussy" time? Yes No When?_____
6. How do you handle this "fussy" time?_____
7. Do you have special ways of helping your baby to go to sleep? If yes, how?_____
8. Does your child use a pacifier or suck thumb/fingers? Yes No
9. Has toilet training been attempted? Yes No
10. Is baby's skin highly sensitive? Yes No
11. How does your child relate to strangers?_____
12. Is your child frightened by anything?_____

W4C'S AND KIND CARE CHILDREN

Favorite:

Snacks and Drinks:_____

Games:_____

Activities:_____

Talents: Instruments Dance Gymnastics Other:_____

Please give any other information you believe will be helpful to us in understanding your child:

_____

_____

_____ _____ _____ _____

Parent Signature Date Director Signature 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_____

(Revised 1/18/17)

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.

_____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. 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. 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 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.

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 1/18/17)

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

ATTENDANCE:

- ☐ I will notify the center staff as early as possible each day 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:

- ☐ Payments of fees are due in advance on Monday's. If fees are not paid by 10:00 A.M. on Wednesday, a late charge of $25.00 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.
- ☐ 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 $25.00 fee will apply for **each** contract change.
- ☐ The 1st weeks tuition is due (W4C's only), when my child's spot is guaranteed and reserved. This will be applied toward the first week of attendance. (non-refundable)
- ☐ Registration Fees: (non-refundable) (waived for DHS and Head Start families)
  - ☐ W4C's - $60.00 per child
  - ☐ W4C's - $30 annual re-registration fee per family (due in October)
  - ☐ K.I.N.D. Care - $50 per child for 1st year – If using school year only or summer only, $50 fee applies each year.
  - ☐ K.I.N.D. Care $30 per child year-round (fall spring summer) beginning 2nd year

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 have read and understand all of the policies and procedures in the Parent Handbook and agree to follow them.
- ☐ 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

K.I.N.D. CARE Fees

Schedule AM Only:

My child will attend (circle all that apply) Monday Tuesday Wednesday Thursday Friday

My child will arrive approximately _____A.M.

_____Weekly Fee $35.00 $6.00 per A.M. delayed start / $20.00 per day on no-school days

_____ Drop-In status $14.00 per A.M. $17.00 per A.M. delayed start / $35.00 per day on no-school days

Schedule PM Only:

My child will attend (circle all that apply) Monday Tuesday Wednesday Thursday Friday

My child will arrive approximately _____P.M.

_____Weekly Fee $55.00 $6.00 per early release / $20.00 per day on no-school days

_____ Drop-In status $14.00 per P.M. $17.00 per early release / $35.00 per day on no-school days

Schedule AM and PM:

My child will attend (circle all that apply) Monday Tuesday Wednesday Thursday Friday

My child will arrive approximately _____A.M. and depart approximately _____P.M.

_____Weekly Fee $85.00 $6.00 per delayed start or early release / $20.00 per no-school day

I agree to pay tuition of _____ in advance. I will pay this

____Weekly ____Bi-Weekly ____Monthly

NOTE: Parents will have the option to sign their child up for all day care, on scheduled no school days. There will be a sign-up sheet located near the sign in/out computer. You must mark whether or not your child will be attending on these days. There will be a deadline to sign up that will be noted on the sign-up sheet; typically one week before the no school day. Using a scheduled no school day will have an extra fee in addition to the normal weekly tuition (see above).

If you sign up after the deadline or you don't sign up and your child does attend on the no school day, you will be charged an additional $10 fee. If you have signed up for a no school day and your child does not attend, you will still be charged for the day unless you give a full 2 business day notice. Example: a Friday no school day begins at 6am so cancellation needs to be given by 6 am on Wednesday. Crossing your child's name off the list is not enough, you must communicate with staff. An email is preferred as it would be dated and trackable.

Child's Grade_____ Teacher _____

Routinely expect my child for early releases ____yes ____no (we will call each time)

_____ _____

Parent Signature Date

_____

Director Signature Date

(Revised 1/18/17)

PHYSICAL EXAM FORM

To be filled out by physician/health care provider:

Child's Name: _____ Age:_____ Date of physical:_____

Weight:	Height:	Blood Pressure:	Urinalysis:
Lead:	Hemoglobin	Vision Screen L R	Developmental Screen

Does the examination reveal any abnormality?	Normal	Abnormal	Not Examined	Describe any abnormal findings
General appearance, posture and gait				
Speech/Language Development				
Behavior during exam				
Skin				
Eyes: Extraocular movements				
Ears: Canal, Tympanic Membrane				
Noe, Mouth, Pharynx & Tonsils				
Teeth				
Heart				
Lungs				
Abdomen (includes hernias)				
Genitalia				
Extremities & Feet				
Neurological				
Other:				

Disability (diagnosed):	Treatment:

Summary of findings and recommendations: _____

_____

_____ _____

Signature of Physician or Health Care Provider Date Signed

Stamp Here

Annual Health Status –Parent Statement

(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_____

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (___) _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis *DTaP/DTP/DT/ Td/Tdap*			
Polio *IPV/OPV*			
Measles, Mumps, Rubella *MMR*			
***Haemophilus influenzae* type b** *Hib*			
Hepatitis B			
Varicella Chicken Pox If applicant has a history of natural disease write "Immune to Varicella"			
Pneumococcal *PCV/PPV*			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal *MCV4/MPSV4*			
Hepatitis A			
Rotavirus			
Human Papilloma Virus *HPV*			
Other			

Licensed Child Care Requirements

4 through 6 months
1 dose Diphtheria/Tetanus/Pertussis
1 dose Polio
1 dose Hib
1 dose Pneumococcal

6 through 11 months
2 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib
2 doses Pneumococcal

12 through 18 months
3 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib or 1 dose received at ≥ 15 months of age.
3 doses Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

19 through 23 months
4 doses Diphtheria/Tetanus/Pertussis
3 doses Polio
3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age.
1 dose Measles/Rubella ≥ 12 months of age.
1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease.
4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

24 months and older
Same requirements as the 19-23 months except 4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses < 12 months of age; or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.

Elementary/Secondary School Requirements

4 years of age and older
5 doses Diphtheria/Tetanus/Pertussis with at least 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥ 4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
4 doses Polio with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2003.
2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
3 doses Hepatitis B if born on or after July 1, 1994.
2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but before September 15, 2003, unless the applicant has a reliable history of natural disease.

Rev. 12/2008

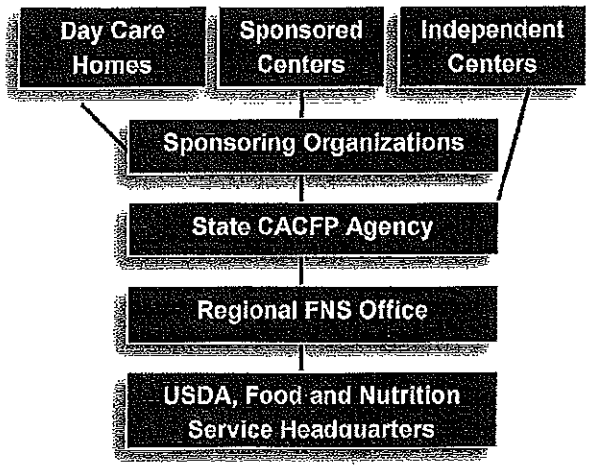
How Does CACFP work?

CACFP reimburses participating centers and day care homes for serving nutritious meals. It is administered at the Federal level by the Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA).

The **Iowa Department of Education** administers CACFP in Iowa. The State agency approves sponsoring organizations and independent centers to operate the Program at the local level. The State also monitors the Program and provides guidance and assistance to ensure requirements are met.

Sponsoring organizations play a critical role in supporting day care home providers and/or centers through training, technical assistance, and monitoring. Several types of organizations are approved by the State agency to serve as home or center sponsors, including community action agencies, nonprofit organizations, public agencies, and churches. Centers may operate independently, but all day care homes must come into the Program under a sponsoring organization.

CACFP Partners



Nondiscrimination Policies

USDA Nondiscrimination Statement:

USDA is an equal opportunity employer and provider

Iowa Nondiscrimination Statement:

It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14th St. Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: https://icrc.iowa.gov/.

Revised 6-22-2015

Child and Adult Care Food Program (CACFP)

Building FOR THE Future

Iowa Department of Education
Bureau of Nutrition and Health Services
Grimes State Office Building
400 E. 14th St.
Des Moines, IA 50319
Phone: (515) 281-5356

What is CACFP?

CACFP is the Child and Adult Care Food Program, a Federal program that provides reimbursement for serving healthy meals and snacks to children and adults receiving day care.

Each day more than 3.2 million children and almost 112,000 older adults participate in CACFP. Through CACFP, participants' nutritional needs are supported on a daily basis. The Program plays a vital role in improving the quality of day care and making it more affordable for many low-income families.

In addition to day care, CACFP helps make afterschool programs more appealing to at-risk children and youth. Afterschool centers that serve meals and snacks draw students into constructive activities that are safe, fun, and filled with learning opportunities.

Children who are homeless or from temporarily displaced families can also receive up to three meals each day through emergency shelters that operate the Program.

Who is eligible for CACFP meals?

- Children age 12 and under,
- Migrant children age 15 and younger,
- Children and youths through age 18 in afterschool programs in low-income areas,
- Children and youths age 18 and under residing in emergency shelters, and
- Adults age 60 and older enrolled in an adult day care center, and functionally impaired adult participants in day care or emergency shelters.

What kinds of meals are served?

CACFP facilities follow the meal patterns established by USDA.

- Breakfast requires of a serving of milk, fruit or vegetable, and grains or bread.
- Lunch and Supper require milk, grains or bread, meat or meat alternate, and two different servings of fruits and/or vegetables.
- Snacks require two different servings of the four components: milk, fruits or vegetables, grains or bread, or meat or meat alternate.

Infants follow a separate meal pattern.

CACFP Facilities

Many different facilities operate CACFP, all sharing the common goal of serving nutritious meals and snacks to participants.

- **Child Care Centers**
  Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers serving meals to large numbers of low-income children.
- **Day Care Homes**
  Small groups of children receive nonresidential day care in DHS registered private homes.
- **"At-Risk" Afterschool Care Programs**
  Centers in low-income areas provide free meals and snacks to school-age children and youth.
- **Homeless Shelters**
  Emergency shelters provide temporary shelter and food services to homeless children.
- **Adult Day Care Centers**
  Public, private nonprofit, and some for-profit adult day care facilities provide structured, comprehensive services to functionally impaired nonresident adults.

Your child is enrolled for care in a child care center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center is meeting Federal meal pattern requirements and receiving reimbursement to

Revised 6/2014

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

Last Name, First Name	Date of Birth	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=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 a program recipient may neither discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, under Federal regulations, this program representative is required to note race/ethnicity on the basis of visual observation or surname.

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. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select (X) your choice(s) of the following options that will fulfill your infant's food needs.

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

☐ I will provide infant formula for my infant. Name of formula: _____

☐ I accept the center's formula for my infant. Name of formula: Parent's Choice

☐ I will provide a statement from a medical authority 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*. The center may supplement with additional solid foods when my infant needs them: ☐ Yes ☐ No

*Meals cannot be reimbursed by the CACFP when parents provide solid foods except for medical reasons. DHS licensed centers are required to 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.

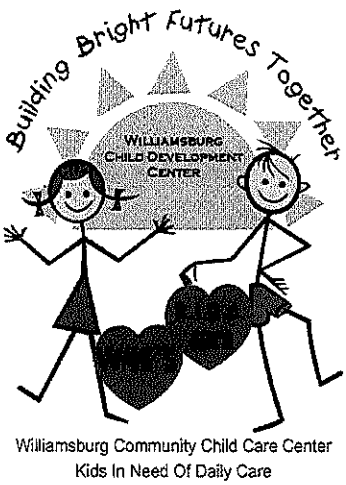
Parent Signature_____ Date:_____

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

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

USDA is an equal opportunity provider and employer.

This form is available in Spanish in "Form Download" (on the website where claims are submitted)



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 16-17

Complete one application per household. School Year 2016-2017

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. 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.

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

Last Name	First Name	Age	Check if NO income	**Gross Income: Report income by how often the household member is paid.** Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. 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**

Name of Adult Completing Form:_____ page 2/2

hawk-i /Medicaid Information Form: Read this information and sign if you do not want your name released to hawk-i or Medicaid.

If your children do not have health insurance, many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law requires schools to share your free and reduced price meal eligibility information with Medicaid and *hawk-i*, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and *hawk-i* can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

Childcare organizations may share this information at their option.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the *hawk-i* program. It will not affect your children's eligibility for free and reduced price meals. If you do NOT want your information shared with Medicaid or *hawk-i*, you must tell us by completing the information below at the time you complete this eligibility application. If you want further information, you may call *hawk-i* at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or *hawk-i*. Also, if you are already receiving Medicaid or *hawk-i*, please sign below. This will avoid another contact.

Child's Name: _____ School/Child Care/Head Start Center:_____

Child's Name: _____ School/Child Care/Head Start Center:_____

Child's Name: _____ School/Child Care/Head Start Center:_____

Parent/Guardian Name (Printed)_____ **Signature**_____ **Date**_____

Self-Employment Income Worksheet: This worksheet will assist you in calculating the amount to report if you engage in farming, 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. Use the lines from the 1040 that are identified.

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 "All Other Income Last Month" column in Part 5 on the front of the Iowa Eligibility Application.

Optional Waiver Information (for Schools only)

Instructions for Completing Iowa Eligibility Application

Complete both sides of an application for each household.

All applicants should complete Part 1. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

FIP OR FOOD ASSISTANCE HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start, follow these instructions.
Part 3. List one FIP or Food Assistance **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.
Part 5. Skip this section.
Part 6. Read the certification and complete this section.

HOMELESS, MIGRANT OR RUNAWAY, follow these instructions.
Part 2. For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.
Part 5. Skip this section.
Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.
Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.
Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.
Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income.
Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.
Part 5. Follow these instructions to report total household income from last month.

- **Name:** List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- **Age:** List the age of each household member.
- **Check if No Income:** Put a mark in the box if the household member **does not** have an income.
- **Gross Income last month and how it was received:** Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, or monthly). List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.
- **Other Monthly Payments or Income:** Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report**: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.
- **Social Security Number:** If the application is being made on the basis of income, 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. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.

ALERT Iowa- Emergency Announcement Communication (See form below)

The center has the ability to use the Iowa County Emergency Information System to contact families via (text message and or email) when the center has an emergency (lockdown, closings, evacuation etc.). Please fill out the requested information below so we can add your preferred contact information into the Emergency System.

Thank you,

Child Name:_____

ALERT Iowa- Emergency Announcement Communication Family Preference

Please return to Sandy or Dani's mailbox ASAP

Please mark your preference on receiving center-wide emergency notifications. It's okay to choose both email and text.

___Email

_____

Email address (print clearly)

___Text Message:

_____

Parent Phone Number (Father)

_____

Parent Phone Number (Mother)

Parent Name (print clearly) Date

(Revised 1/18/17)

Receipt and Statement Survey

Child's Name:_____

Please mark the boxes below that will apply to you and turn back in to office mailbox.

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

Thank you!!

Dani Jones

TO: New Families

RE: Front Door Entry Cards

You will receive 2 cards that will gain you entry to the Williamsburg Child Development Center when your child starts attending W4C's or KIND Care. You will not be charged for the cards unless you lose them or do not turn them in when your child is no longer attending. The cost is $5.00 per card.

DO NOT write on the cards. You will be charged the $5.00 if you write on the card because we will not be able to give that card out to someone else at a later date.

We understand that occasionally you may forget your card and need to be buzzed in. This is not a problem unless it happens on a regular basis as it does disrupt the classrooms and takes the teacher's attention away from the children.

If you have other people picking up your child, please make sure you include them on the Pick-Up Authorization sheet. If they are not listed as an authorized person, they will not be allowed to pick up your child. They will need to push the button and be buzzed in once they give their name and are verified to be on your pick up list. They may also be asked to show identification.

You may lend your card to an authorized person when they are coming to pick up your child, but you will still be responsible for the card if it is damaged or lost.

Thank you in advance for your cooperation. As always, if you have any questions, please don't hesitate to ask.

EARN FREE MONEY FOR THE CENTER WITHOUT ANY EFFORT!

You may or may not know that Williamsburg Community Child Care Center - W4Cs participates in fundraising opportunities with Goodsearch.com. You can help without doing anything that you don't already do. Just start using Yahoo! powered Goodsearch.com as your search engine and Goodsearch donates money to your favorite cause when you search the Internet, shop online or dine out at local restaurants!

1. Use *Goodsearch.com* to search the Internet and they donate a penny per (new) search to your cause.

2. Use *Goodshop.com* when you shop online and they donate a percentage of every purchase and offer over 100,000 coupons to help you save money too! You can shop at more than 2,600 top online retailers and a percentage of your purchases will go to the charity or school of your choice. You pay the same price as you normally would, but a donation goes to your cause!

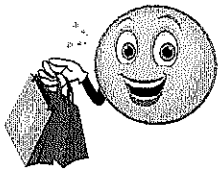
3. Sign up for their Gooddining program and they'll donate a percentage of your restaurant bill when you eat at any one of thousands of participating restaurants. Eat at over 10,000 participating restaurants nationwide and you can earn up to 6% of every dollar spent on the meal as a donation for your charity or school.

It's really easy; it's free and turns simple everyday actions into a way to make the world a better place. Please sign up today to help support Williamsburg Community Child Care Center - W4Cs.

Go to www.goodsearch.com to get started.

Search their 100,000 charities and choose to donate to Williamsburg Community Child Care Center – W4Cs. Then use Goodsearch.com for all of your internet searching and shopping and you will be automatically donating to your child care center!

Thank you for your support!



You can also read about Goodsearch in the NY Times, Oprah Magazine, CNN, ABC News and the Wall Street Journal.

Williamsburg Child Development Center
W4C's and K.I.N.D. Care

Parent Handbook Acknowledgement

I, the undersigned, acknowledge that I have received a copy of the Parent Handbook for the Williamsburg Child Development Center (W4C's and K.I.N.D. Care). I recognize that it is my responsibility to read and understand the policies and procedures contained in the Parent Handbook. If I have any questions regarding the policies or procedures contained within the handbook, I will ask the Director for clarification.

In addition, I understand the contents of the handbook are subject to change. I acknowledge the Parent Handbook will be revised in accordance with the rules and regulations of State, Federal and accrediting entities for child care service providers or at the discretion of the Board of Directors for W4C's. I recognize that any such revisions will supersede, modify or eliminate the current contents of the Parent Handbook.

I acknowledge that it is my responsibility to stay informed of policy and procedure revisions to the Parent Handbook, which will be posted on the center website at www.williamsburgchildcare.com. In the event that I do not have internet access, I understand that I can obtain a hard copy of the updated Parent Handbook upon request to the Director.

_____	_____	_____
Parent/Guardian Printed Name	Date	Parent/Guardian Signature
_____	_____	_____
Parent/Guardian Printed Name	Date	Parent/Guardian Signature

If requested, hard copy of Parent Handbook Provided on _____

_____

Center Director Signature