



# Camp Fire

Child Development Center

*A Community Demonstration School*

**2700 Meacham Blvd  
Fort Worth, TX 76137  
817.831.5050  
CampFireFW.org**

# Enrollment Packet





# Camp Fire Child Development Center

## Enrollment Information

This form must be updated every August

Admission Date: _____
Withdrawal Date: _____
Code Word: _____
4-Digit Code: _____
<i>For Office Use Only</i>

### Child Information (Please Print Clearly)

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
First Middle Last

Child's Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Child's Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Ethnicity \_\_\_\_\_

Child's Primary Language \_\_\_\_\_ Parent/Guardian's Primary Language \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Email \_\_\_\_\_

Parent/Guardian Marital Status:  Single  Married  Separated  Divorced  Widowed

Child's Primary Residence:  Mother  Father  Both  Guardian/s

List all of the family members your child lives with, including names and ages of siblings \_\_\_\_\_

The hours of the Child Development Center are 6:30 a.m.-6:00 p.m. Monday-Friday. To ensure that we maintain our standards of teacher to child ratio, please indicate the approximate hours you anticipate dropping off and picking up your child each day. Circle all meals and snacks your child would typically eat on their days of attendance. B = Breakfast L = Lunch S = Snack

Monday	Tuesday	Wednesday	Thursday	Friday
____ to ____	____ to ____	____ to ____	____ to ____	____ to ____
B L S	B L S	B L S	B L S	B L S

### Primary Contact and Release Persons

Parent/Guardian #1 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address \_\_\_\_\_ Driver's License Number/ State \_\_\_\_\_

Employer \_\_\_\_\_ Court Ordered Restrictions? \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address \_\_\_\_\_ Driver's License Number/ State \_\_\_\_\_

Employer \_\_\_\_\_ Court Ordered Restrictions?  Yes  No



Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Emergency Contact and Release Persons

Please list the individuals you would like us to contact if we cannot reach you in case of illness and/or an emergency. By checking the box "Emergency Contact and Release" you are indicating that this person will be contacted and be able to transport your child in case of an emergency. Check the box "Release Only" to indicate that this person is only allowed to pick-up your child under normal circumstances. To ensure the safety of your child, all persons on this list will be required to provide a valid driver's license or other government issued picture ID at the time of pick-up.

Child's Name \_\_\_\_\_

## Required

Name #1 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address \_\_\_\_\_ Driver's License Number/ State \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact and Release

Release Only

## Optional

Name #2 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address \_\_\_\_\_ Driver's License Number/ State \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact and Release

Release Only

## Optional

Name #3 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address \_\_\_\_\_ Driver's License Number/ State \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact and Release

Release Only

## Optional

Name #4 \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address \_\_\_\_\_ Driver's License Number/ State \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact and Release

Release Only

If you need a person other than one identified above to pick up your child, you must notify the Center in writing, in advance. If you cannot submit authorization in writing, you can provide verbal permission for someone to pick up your child once your personal information has been verified by providing the center with the appropriate code word and/or four-digit code

Code Word \_\_\_\_\_ 4-Digit Code \_\_\_\_\_



Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Emergency/Medical Information

Please make certain all information is complete

Child's Name \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Preferred Hospital/Clinic Care/Emergency Care \_\_\_\_\_

Address \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_ Policy Number \_\_\_\_\_

## Please Check All the Following Boxes that Apply:

Food or Medication Allergies (please list) \_\_\_\_\_

Medication is provided in the event of allergy emergency (please list medication type) \_\_\_\_\_

Please list the symptoms to look for when medication is needed \_\_\_\_\_

My child is on medication for long-term continuous use (please list) \_\_\_\_\_

My child has NO known allergies

My child has other health issues/special needs (please list) \_\_\_\_\_

Is your child up-to-date on all immunizations?  YES  NO

Your child's immunizations must be current as required by the Texas Department of State Health Services. A copy of your child's current immunization records is required for admission.

I hereby authorize Camp Fire First Texas to take my child to the above named physician or nearest facility for medical treatment in the event of an emergency in which neither parent can be reached.

I hereby authorize any necessary examination, anesthetic, medical diagnosis, surgery, treatment, and/or hospital care to be rendered to my child, under the general supervision of any licensed medical professional in case the above named physician cannot respond.



Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Authorizations

Child's Name \_\_\_\_\_

## Water Activities

I hereby  give  do not give my consent for my child to participate in water activities. Please note, splash day activities do not include swimming or wading pools.

## Sunscreen

I hereby  give  do not give my consent to have Camp Fire Child Development Center staff apply sunscreen to my child. I understand that I will provide the sunscreen labeled with my child's name. All sunscreen will be in the original bottle, the center does not allow aerosol spray cans.

## Insect Repellent

I hereby  give  do not give my consent to have the Camp Fire Child Development Center staff apply insect repellent to my child. I understand that I will provide the insect repellent. All insect repellent will be in the original spray bottle, the center does not allow aerosol spray cans.

## Photo Release

I give my permission for my child and/or I to be photographed and/or videotaped by Camp Fire and other organizations or individuals approved and/or accompanied by the Director for purposes of advertising, public relations and family enrichment. I agree that any photographs, statements or video becomes the exclusive property of Camp Fire First Texas and I waive all rights thereto. I waive all rights to inspect and/or approve any published matter that may be used in conjunction with the content and the use to which it may be applied.



Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Parent Enrollment Agreement

In order to record my understanding of my rights and responsibilities as a parent/guardian of \_\_\_\_\_, who is enrolled in the Camp Fire Child Development Center, I agree to abide by the requirements written below and all policies set forth in the Parent Handbook.

Please initial each statement and sign and date where required.

## Tuition and Fees

\_\_\_\_ **Registration Fee:** I understand that a non-refundable registration fee of \$75 shall be paid to secure enrollment of my child.

\_\_\_\_ **Annual Re-Enrollment Fee:** I understand that a non-refundable supply fee of \$75 will be due each August and added to my child's tuition (\$125 per family).

\_\_\_\_ **Annual Supply Fee:** I understand that a non-refundable supply fee of \$20 will be due each February and added to my child's tuition (\$40 per family).

\_\_\_\_ **Summer Activity Fee:** I understand that a non-refundable activity fee of \$5 per week will be and added to my child's Summer tuition (\$10 per family).

\_\_\_\_ **Tuition Payment:** I understand that my weekly tuition in the amount of \$\_\_\_\_\_ is due and payable by 6:00pm the Monday of the week of care. I understand that care may not be provided without this advanced payment and that any payments received after this time will be subject to late fees. Tuition payments can be made by check, credit card or automatic draft/electronic funds transfer. Receipts will be given for payments if requested. **CCMS**  **Yes**  **No** **Discounted Tuition**  **Yes**  **No**

\_\_\_\_ **Late or Unpaid Tuition:** If payment is not received when due, I agree to pay a \$25 per week late fee. I understand that if my account is delinquent for more than one week, I may be asked to withdraw my child from care until my fees are paid in full and provided there is still space available for my child. All attempts will be made to collect any unpaid fees upon my child's departure from the center. Any unpaid fees may be sent to a collection agency.

\_\_\_\_ **Late Pick-Up:** The Center is open from 6:30am to 6:00pm Monday through Friday with the exception of holidays and two teacher professional development days. I understand that if I fail to pick-up my child by closing time, I will be charged a late fee of \$1 per minute until my child is picked up. Late fees will be added on to the next week's tuition.

\_\_\_\_ **Fee Reductions:** I understand that there will be no automatic reduction of fees when my child is absent from the Center for any other reason or period of time including illness or inclement weather closings.

\_\_\_\_ **Returned Checks:** I understand that there is a fee of \$25 for all returned checks. After having two returned checks, I understand that future payments will be received on a money order only basis.

## Daily Procedures

\_\_\_\_ **Meals:** I understand that the Child Development Center participates in the USDA Food Program and the following meals will be served to my child while in care: Breakfast (8:00-8:30 am); Lunch (11:00 a.m.-12:00 p.m.); and Afternoon Snack (2:30-3:30 p.m.). I also understand that with the exception of infants I cannot bring in outside food for my child without a signed Doctor's note except on special occasions (with prior approval of the Director). All foods provided for special occasions will be served in addition to the planned menu items and must be store bought.

\_\_\_\_ **Sign In/Sign Out:** I agree to sign my child in and out every day using the Center's two step attendance and sign in/out procedure. I understand that my child is not permitted to be signed out by anyone who is not authorized, in writing, to do so.

\_\_\_\_ **Illness:** I understand that I will be notified should my child become ill while in care and that I will pick my child up promptly or make arrangements for an authorized emergency contact person to pick up my child upon notification of illness within one hour of notification. If my child contracts a contagious disease, I agree to notify the Center and I understand that my child will only be re-admitted according to the criteria stated in the Family Handbook.

\_\_\_\_ **Interviewing Children and Inspecting Records:** I understand that the Texas State Department of Family and Protective Services (TDFPS) has the authority to interview children or staff, to inspect and audit child or facility records, to interview children privately, to observe the physical condition of the children in the Center, to make provisions for the independent medical examination by a licensed physician of any child, and to contact and instruct any other appropriate authority to do the same, without prior notice or consent by the Center.

\_\_\_\_ **Withdrawal from Program:** I understand that I must provide a two-week written notice of intent to withdraw my child from the Center's services. If this notification is not provided, I agree to pay full tuition for two weeks, whether or not my child attends.

**Holidays, Absences and Closures**

\_\_\_\_ **Holidays:** I understand that the Center will be closed on major holidays as well as two additional teacher professional development days. The holiday schedule and teacher professional development days will be announced by September 1 of each year for the following calendar year. If a holiday falls on a Saturday, it will be observed the Friday before. If a holiday falls on a Sunday, it will be observed the Monday following.

\_\_\_\_ **Absences:** I agree to inform the center immediately if my child will be absent on any day. I understand that no allowances, credits, refunds, or make up days shall be made for any absences including illness.

\_\_\_\_ **Vacations:** Each family is given two weeks of vacation per year. The time is available from the first day of enrollment. During vacation weeks, families are only responsible for ½ of their regular tuition per child. Please request to use your vacation at least one week prior to your child's absence. The weeks you take vacation your child should be absent from Camp Fire Child Development Center. Your account must be paid in full before vacation time can be used. Vacation days may not be carried over to the next year.

\_\_\_\_ **Emergency Closing/Inclement Weather:** I understand that it is Camp Fire's intention to be open and provide child care services every weekday of the year, excluding holidays and teacher professional development days, but that inclement weather, natural or national disaster or a major building issue may disrupt services from time to time. I understand that it is my responsibility to contact the Center to ensure that it is open during inclement weather/natural disaster. I realize that in the event the Center is closed for one of the above-mentioned reasons, I am still responsible for my child's tuition.

**Policies and Regulations**

\_\_\_\_ **Policies and State Regulations:** I understand that the policies contained in this document are not all-inclusive and that my child, my family members, authorized agents and I are bound by TDFPS state child care standards, the Family Handbook, and all other Camp Fire policies which may be modified any time without notice.

\_\_\_\_ **Family Conferences:** I understand that it is Camp Fire's intention to provide the best education and care possible for my child. This includes the active participation of the family in the child's learning. Furthermore, I agree to participate in parent conferences which will be of benefit to my child and our family. Family conferences are offered twice yearly and upon families' request.

\_\_\_\_ **Family Handbook:** I have received a copy of the Family Handbook. I have read and understand its contents and policies and agree to be bound by the same.

We do not discriminate based on disability in the admission/enrollment or implementation of our services. Information concerning the provisions of the Americans with Disabilities Act (ADA), including the rights provided hereunder, is available from the Center Director.



**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Mail or Submit Completed Enrollment and Registration Information Packet To:**

**Camp Fire Child Development Center  
2700 Meacham Blvd, Fort Worth, TX 76137**



# Demographics



## Ethnicity

- White/Caucasian
- African American
- Hispanic/Latino
- Asian
- American Indian and Alaska Native
- Hawaii Native and Pacific Islander
- Two or more races

## Household Income

- Below \$17,000
- \$17,000-\$35,000
- \$35,001-\$50,000
- \$50,001-\$75,000
- \$75,001-\$100,000
- \$100,001-\$175,000
- \$175,001-\$250,000
- \$250,001-\$500,000
- Over \$500,001

## County Where You LIVE

- Tarrant County
- Denton County
- Parker County
- Johnson County
- Hood County
- Wise County
- Dallas County
- Other County

## County Where You WORK

- Tarrant County
- Denton County
- Parker County
- Johnson County
- Hood County
- Wise County
- Dallas County
- Other County



# Discipline and Guidance Policy



The Camp Fire Child Development Center follows the required policies set forth by the Texas Department of Family and Protective Services Minimum Standards for Child Care Centers.

Discipline will be:

- Individualized and consistent for each child;
- Appropriate to the child’s level of understanding; and
- Directed toward the teaching the child acceptable behavior and self-control.

A teacher/staff member will only use positive guidance methods of discipline and guidance that encourage self-esteem and self-direction, which include at least the following:

- Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
- Reminding a child of behavior expectations daily by using clear, positive statements;
- Redirecting behavior using positive statements.

There will be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited at all times by staff, family members or any other individual while on Camp Fire premises:

- Corporal punishment or threats of corporal punishment;
- Punishment associated with food, naps or toilet training;
- Pinching, shaking or biting a child;
- Hitting a child with a hand or instrument;
- Putting anything in or on a child’s mouth;
- Humiliating, ridiculing, rejecting or yelling at a child;
- Subjecting a child to harsh, abusive or profane language;
- Placing a child in a locked or dark room, bathroom or closet with the door closed; and
- Requiring a child to remain silent or inactive for in appropriately long periods of time.

***This is part of the Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance***

My signature verifies I have read and received a copy of this discipline and guidance policy.



Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



**SCHOOL AGE CHILDREN:**

My child attends the following school:

\_\_\_\_\_

Name of School and Address School Ph.#

**CHECK ALL THAT APPLY:**

His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

My child has permission to:  walk to or from school or home,  
 ride a bus, and/or  be released to the care of his/her sibling(s) under 18 years old.

Name of sibling(s): \_\_\_\_\_

**IMMUNIZATION RECORD:**

I have provided the childcare operation with a copy of my child's most current immunization record.

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

Please check only one option:

1.  **HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

\_\_\_\_\_

Health Care Professional's Signature Date

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

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

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

Name and address of health care professional:

\_\_\_\_\_

Signature - Parent or Legal Guardian Date

<b>VISION</b>	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	
<b>HEARING</b>	<b>1000 Hz</b>	<b>2000 Hz</b>	<b>4000 Hz</b>
R			
L			
			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	

\_\_\_\_\_  
Signature – Parent or Legal Guardian

\_\_\_\_\_  
Date

# ADMISSION INFORMATION

## HEALTH REQUIREMENTS

Name of Child:

Date of Birth:

Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)

Positive

Negative

Date:

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

Signature

Date

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

Parent's signature

Date

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official  
notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at

[www.dshs.state.tx.us/immunize/public.shtm](http://www.dshs.state.tx.us/immunize/public.shtm)

Signature – Parent or Legal Guardian

Date

**INSTRUCTIONS FOR  
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM  
(CHILD CARE)**

**Follow these instructions, if your household gets SNAP, TANF or FDPIR:**

**Part 1:** List all enrolled children and household members.

**Part 2:** List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC.

**Part 3:** Skip this part.

**Part 4:** Skip this part.

**Part 5:** Sign the form. The last four digits of a Social Security Number are **not** necessary.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

**If you are applying on behalf of a FOSTER CHILD, follow these instructions:**

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

**Part 1:** List all foster children. Check the box indicating that the child is a foster child.

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Skip this part.

**Part 5:** Sign the form. A Social Security Number is **not** necessary.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

If some of the children in the household are foster children.

**Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

**Part 2:** If the household does not have an eligibility number, skip this part.

**Part 3: Applies only to parents/guardians of children in Tier II Day Care Homes.** Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.

**Part 4:** Follow these instructions to report total household income from this month or last month.

**Column A – Name:** List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B – Gross Income and How Often it was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

**Box 1:** List the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and **other deductions**. **You should be able to find it on your stub or your boss can tell you.**

**Box 2:** List the amount each person got from the month from welfare, child support, alimony.

**Box 3:** List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

**Box 4:** List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1.* Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

**Part 5:** Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

**ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:**

**Part 1:** List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Follow these instructions to report total household income from this month or last month.

**Column A – Name:** List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B – Gross Income and How Often it was Received:** For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

**Box 1:** List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

**Box 2:** List the amount each person got from the month from welfare, child support, alimony.

**Box 3:** List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

**Box 4:** List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1.* Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

**Part 5:** Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

**Part 6:** Answer this question if you choose.

**Part 7:** Answer this question if you choose.

**Privacy Act Statement:** This explains how we will use the information you give us.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly.





# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

## Part 1. All Household Members

Name of Enrolled Child(ren):		
Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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

## Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Last four digits of Social Security Number: \* \* \* \* - \* \* \* - \_\_\_\_\_  I do not have a Social Security Number



# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)	
Mark one ethnic identity:	Mark one or more racial identities:
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander

**Part 7. Sharing Information With Other Programs: OPTIONAL**  
 The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

I do elect to allow my household information to be disclosed.

I do not elect to allow my household information to be disclosed.

**Don't fill out this part. This is for official use only.**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_ Reduced \_\_\_ Denied \_\_\_ Tier I \_\_\_ Tier II \_\_\_

Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Non-discrimination Statement:**  
 In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture  
 Office of the Assistant Secretary for Civil Rights  
 1400 Independence Avenue, SW  
 Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

CACFP INFANT FEEDING PREFERENCE

Dear Parent/Guardian,

This child care provider participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires child care providers to follow specific meal patterns according to the age of the infant.

If your child is exclusively breastfed, child care providers participating in the CACFP can feed your infant the breast milk you supply and meet the meal pattern requirements. Breastfeeding is widely recognized as the best source of nutrition for infants.

The Institute of Medicine and the American Academy of Pediatrics recommend that adults/caregivers, who work with infants and their families, promote and support exclusive breastfeeding for the first six months and continuation of breastfeeding in conjunction with complementary foods for 1 year or more, and the Texas Department of Agriculture (TDA) encourages child care provider's to dedicate a space for mothers to breast feed their infants on site.

Child care providers participating in the CACFP **are required** to offer at least one infant formula for infants who are enrolled for child care. You may decline the infant formula offered, and supply breast milk and/or your own preferred infant formula.

Additionally, when you determine in consultation with your physician that your child is developmentally ready, the child care provider will also be **required** to offer infant cereal and other foods. As with infant formula, you can decline the infant cereal and other foods offered and provide those items to your child care provider. It is important to note that your child care provider will not receive reimbursement for meals that contain more than one parent provided component. Speak to your child care provider to understand what components are required for your infant's meal and the exceptions made for infants with disabilities, so that your infant receives the most nutritious meal possible.

This child care provider offers the following infant formula(s): Similac Sensitive

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**It is very important that you indicate your preferences on the form that follows so we can honor the nutrition choices you have made for your family.** Please complete the information below to designate your preference for infant formula, infant cereal and other foods.

Infant's Name \_\_\_\_\_ Infant's Date of Birth \_\_\_\_\_

### Breast milk and/or Formula preference

Please mark your preference (choose all that apply)	Today's Date _____ Birth through 5 months	Today's Date _____ 6 – 11 months
I will bring expressed breast milk for my infant.		
I want the child care provider to provide the infant formula it offers for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring:		

### Preference regarding infant cereal and other foods

Please mark your preference	Today's Date _____ 6 – 11 months
My child is developmentally ready for solid foods. I want the child care provider to provide the infant cereal and other foods for my infant.	
My child is developmentally ready for solids. I will bring the infant cereal and/or other foods for my infant.	
My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.	

Parent's (or guardian's) Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

1. This form must be kept on file for each infant enrolled for child care.
2. This form must be kept current and accurate for each infant enrolled for child care until the infant reaches one year of age.
3. If the parent (or guardian) provides expressed breast milk and the child care provider feeds it to the child, and/or if the mother breast feeds her child on site, the meal may be claimed for reimbursement.
4. If the parent (or guardian) declines the formula and the child care provider provides meal and/or snack components, the meal may be claimed for reimbursement.
5. If the parent (or guardian) declines infant meals/snack, meals and snacks may NOT be claimed for reimbursement.



# All About Me

You know your child better than anyone in the world. We want to get to know them too! Your child is special and unique; please share a few details with us so we can make your child's time with us fun, special and adventurous!

**My Child's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Days spent at school:

Monday

Tuesday

Wednesday

Thursday

Friday

## A few of my child's favorite things:

Foods: \_\_\_\_\_

Colors: \_\_\_\_\_

Activities: \_\_\_\_\_

Books: \_\_\_\_\_

Toys: \_\_\_\_\_

## A few more details about my child:

My child dislikes/is afraid of: \_\_\_\_\_

My child likes to be comforted with/by: \_\_\_\_\_

My child has siblings whose names and ages are: (Leave blank if not applicable)

Name/ Age: \_\_\_\_\_ Name/ Age \_\_\_\_\_

Our pet at home is: \_\_\_\_\_

Special Requests/ suggestions: \_\_\_\_\_