KinderCollege
Learning Academy

PARENT ORIENTATION

- ☐ Tour of the Facility
- ☐ How to sign in & out
- ☐ Kinder College's Phone, Fax and email
- ☐ Introduced to teaching staff
- ☐ Visit the classroom/teacher
- ☐ Inform the center of any elements/concerns
- ☐ Availability of family support resources
- ☐ Significance of consistent arrival time
- ☐ Policy for arrival and late arrival/pick-up
- ☐ Opportunity for an extended visit in the classroom
- ☐ Who to approach to find out details of your child's progress
- ☐ Who to see if the office is unattended
- ☐ Tuition Fees / How to Avoid $5.00 Per Day Late Fees
- ☐ Vacation Requests / Fees
- ☐ Where to find messages and notices
- ☐ Where the menu's are displayed
- ☐ Rest / Sleep time policy
- ☐ Where and how to complete medication forms and where to put the medication
- ☐ Policy for dispensing medication
- ☐ What is an accident/incident Form
- ☐ Statement of the child's health from a health-care professional
- ☐ Current Immunization record
- ☐ Vision and hearing screening
- ☐ Procedure when you arrange for someone else to pick up your child
- ☐ Withdrawal Policy
- ☐ Limited Cell Phone use to improve communication between Parent, Teacher, and Child
- ☐ Child Development & Developmental Milestones
- ☐ Explanation of Texas Rising Star Quality Certification
- ☐ Overview of Parent Handbook

Center Director: *Cabry Brown*

If you have any questions and or concerns, please do not hesitate to ask.

Parent Signature

Date

KinderCollege Learning Academy

Enrollment Packet

Child's First date of attendance:	Child Resides with: ☐ Mom & Dad ☐ Mother ☐ Dad ☐ Grandparent(s) ☐ Other		
Child's Full Name:		Date of Birth:	Home Phone:
Child's Home Address:	City:	Zip:	Subdivision:
1st Parent/Guardian Name & Relation: Name: Relation:		2nd Parent/Guardian Name & Relation: Name: Relation:	
Previous daycare or preschool: 1.		Previous daycare or preschool: 2.	

I hereby authorize Kinder College Academy to allow my child to leave the childcare facility ONLY with the following persons. Children will only be released to a parent or a person designated below by the parent/guardian after verification of ID.

1st Authorized Person:	Relationship to child:	Phone:
2nd Authorized Person:	Relationship to child:	Phone:
Does your child have permission to be released to the care of a sibling(s) under 18 yrs. of age? ☐ Yes ☐ No ☐ Not Applicable Sibling(s) Name:		

Public School Information (For School Age Children Only):

What type of care will we be providing for your school age child? ☐ Before school ☐ After School ☐ Before & After School ☐ Summer Camp		
Name of Attending Public School:	Telephone:	Grade:
Your child's immunization, vision and hearing records are current and on file at the school? ☐ Yes ☐ No		

Permissions:

Water Activities: I ☐ give ☐ do not give consent for my child to participate in the following water activities. ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ water table play
I acknowledge receipt of the facility's operational policies including those for discipline and guidance and gang free zones. ☐ Yes ☐ No

For Office Use Only

NCI: ☐ Yes ☐ No			
Copy of Mother's TDL on file? ☐		Copy of Father's TDL on file? ☐	
Payment: ☐ Weekly ☐ Bi-Weekly	☐ Semi-Monthly	☐ Monthly	
☐ Immunization records	☐ Vision & Hearing	☐ Food Pro App	☐ Physician's Statement
LOCATION ☐ 6903 Huffmeister	☐ 12511 Steepleway Blvd	☐ 32212 Decker Prairie, Magnolia	

Mother's Signature _____ Father's Signature _____ Date _____

CHILD'S NAME: _____

Parent Contact, Transportation & Emergency Information: Please complete in detail.

1st Parent/Guardian: ☐ Mom ☐ Dad ☐ Other: **Name:**		Email address *(please provide an email address that you check daily)*	
Address: ☐ check here if same as child's	City:	Zip:	Date of Birth:
Employer:	Address:		Last 4 Digits of SS# (for security purposes):
List telephone numbers below where parent/guardian can be reached while child is in care			
Call this number first: ( ) -	This # is: ☐ Work	☐ Cell	☐ Home
Call this number second: ( ) -	This # is: ☐ Work	☐ Cell	☐ Home
For non-emergency matters, how would you like to be contacted?: ☐ Work ☐ Cell ☐ Home ☐ Doesn't Matter			
2nd Parent/Guardian: ☐ Mom ☐ Dad ☐ Other: **Name:**		Email address *(please provide an email address that you check daily)*	
Address: ☐ check here if same as child's	City:	Zip:	Date of Birth:
Employer:	Address:		Last 4 Digits of SS# (for security purposes):
List telephone numbers below where parent/guardian can be reached while child is in care			
Call this number first: ( ) -	This # is: ☐ Work	☐ Cell	☐ Home
Call this number second: ( ) -	This # is: ☐ Work	☐ Cell	☐ Home
For non-emergency matters, how would you like to be contacted?: ☐ Work ☐ Cell ☐ Home ☐ Doesn't Matter			

Secondary Emergency Contact Information: If parent/guardian cannot be reached, please contact the following:

1st Contact Name:		Relationship to child:	
Address:		City:	Zip:
Call this number first: ( ) -	This # is: ☐ Work	☐ Cell	☐ Home
Call this number second: ( ) -	This # is: ☐ Work	☐ Cell	☐ Home

Transportation Permissions: Check all that apply

Transportation: I give consent for my child to be transported and supervised by Kinder College Learning Academy's employees. (check all that apply) ☐ for emergency care ☐ field trips ☐ to / from elementary school.

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Child's Physician:	Address:	Phone:
Name of emergency care facility:	Address:	Phone:

List any special problems that your child may have. Please include allergies, existing illness, previous serious illness and/or injuries, hospitalizations during the past 12 months, any medication prescribed for long term continuous use, health concerns or physical restrictions.

☐ I give my consent for the facility to secure any and all necessary emergency medical care for my child.

_____ _____ _____

Mother's Signature Father's Signature Date

CHILD'S NAME: _____

Marketing Information:

How did you hear about us?

☐ Phone Book ☐ Website ☐ Drive By ☐ Other: _____ ☐ Referral/Friend: _____

Prospective parents may request references; may we give out your first name and telephone number to these prospective parents?

☐ Yes ☐ No

Parent Permissions:

Kinder College Learning Academy has my permission to perform the following (Please mark ALL that apply):

Apply sunscreen ☐ , Apply insect repellent ☐ , Apply anti-itch or antibiotic ointment ☐, remove splinters/stingers ☐,

INFANTS: Apply diaper rash ointment ☐, baby powder ☐, Orajel ☐

I understand that Kinder College Learning Academy takes photographs of center events & classroom activities throughout the year. I give my permission for Kinder College to develop and use these pictures for decorations, projects and post to the center's website or social media accounts. ☐ Yes ☐ No

Health Requirement (Skip this section ONLY if your child attends public school):

If your child DOES NOT attend public school, one of the following must be presented when your child is admitted to Kinder College Learning Academy. Please check the item you will be presenting.

☐ **Physician's Statement** (Physician's statement form on next page) or

☐ **Written Health Statement**: A signed and dated copy of a health care professional's statement or

☐ **Parent Statement**

My child has been examined within the last twelve (12) months by a licensed physician and is able to physically participate in the child care program. I will obtain a physician's statement within the next twelve (12) months and submit it to this child care facility.

Physican Name:_____

(Physican who performed exam in last 12 months)

Phone: _____

Physician's address: _____ City: _____ State_____ Zip: _____

☐ **Immunization Records**: I certify that my child's immunization requirements are current, and **I will provide a copy of these records within 5 days of enrollment (required for Infants thru 5 years).**

☐ **Medication Authorization**: In the event that my child becomes ill I will be contacted. If it is determined that medication such as Tylenol, Benadryl, Anti-Itch cream, etc., could be administered to relieve high fever, pain or itching until I arrive, I authorize Kinder College Learning Academy to administer medication upon my verbal approval.

Enrichment Opportunities: (Check box if interested in receiving more information)

☐ Dance ☐ Gymnastics ☐ Computer Classes ☐ Martial Arts

☐ I decline enrichment opportunities

Release of Liability:

Please note that by enrolling your child (ren) in the enrichment activities offered at Kinder College Learning Academy, you are releasing us of any and all liabilities associated with said enrichments. This includes injuries, account discrepancies, etc. Questions regarding liability and liability insurance should be directed to the company offering the activity (we verify they have liability insurance). Also, note that Kinder College Learning Academy is not responsible for enrichment tuition payments lost or stolen and your child may not participate in an enrichment activity if your account is past due. By enrolling your child (ren) in the enrichment activities offered, you are giving permission for Kinder College Learning Academy to release your child (ren) into the care of the Enrichment Personnel temporarily for the duration of the enrichment exercise.

_____ _____ _____

Mother's Signature Father's Signature Date

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

CHILD'S NAME: _____

(SKIP THIS SECTION IF YOUR CHILD ATTENDS PUBLIC SCHOOL)

Parents,
If you have not obtained a physician's statement or a current copy of your child's immunization records. Please complete the bottom portion of this form.
Thank You!

Physician's Statement & Immunization Records Request

Dr. _____,

I am requesting the following records for my child

Name of Child: _____ **Date of Birth:** _____

☐ Vision & Hearing Screening Records

☐ Immunization Records

Please fax current immunization records for the above-named child.
Immunization record must provide;

1. Child's name
2. Child's birthday
3. The number of doses and vaccine type
4. Signature or stamp of the health care professional

☐ Physician's Statement

I have examined the above-named child within the last twelve (12) months and verify that he/she is physically able to participate in a child care program.

_____ _____
Physician's Signature Date

_____ _____ _____
Mother's Signature Father's Signature Date

CHILD'S NAME: _____

Enrollment condition:

☐ Research shows that a consistent environment is directly related to the healthy development of a child's social-emotional being and that moving a child from center to center is detrimental to his/her social-emotional growth. It is the goal of Kinder College Learning Academy to provide a pleasant, stimulating, healthy and stable environment to all children enrolled. Please acknowledge that you stand behind this belief and agree to do your part in achieving this by;

- ☐ Notifying management of any questionable situation or condition
- ☐ Keeping open lines of communication between my family and Kinder College Learning Academy
- ☐ Communicating my family's needs and desires
- ☐ Advising Kinder College Learning Academy of any illness in my family and keeping sick children home
- ☐ Advising Kinder College Learning Academy of any family issues that may affect my child's behavior
- ☐ Understanding the importance of paying my tuition in a timely manner
- ☐ Understanding and supporting that throughout the day my child will learn about God, pray before meal's and learn The Pledge of Allegiance

☐ I understand that a condition of enrollment is that I volunteer to participate in AT LEAST ONE Parent Advisory Committee (PAC) event per year. I agree that 100% parent participation ensures that my child (along with the other children enrolled) will enjoy successfully planned events throughout the year. PAC event details below.

Parent Advisory Committee (PAC) Events & Volunteer Opportunities

Joining PAC is a great way for you to participate in family activities. The Parent Advisory Committee (PAC) will meet to plan seasonal events for the children enrolled. Participation is extended to extended family members and friends, including but not limited to grandparents, aunts, uncles, etc.

Seasonal Events – Your participation in most is appreciated:

Please check as many events that you would like to participate in (check all that apply):

☐ Parent Advisory Committee Fall Fundraiser – Volunteers are asked to vote on a fundraising event and assist in preparing fundraising products for delivery to participants. Volunteers vote on how the funds are to be spent.
☐ Fall Festival/Carnival –Volunteers are asked to help plan festivities typically including game booths, prizes, food and candy galore. Children are encouraged to dress up in their favorite make-believe costume. No scary costumes please.
☐ Thanksgiving Feast – Volunteers are asked to bring a covered dish to PAC's annual Thanksgiving feast. One free week is given for best side dish and one free week is given for best dessert. Parent & staff vote.
☐ Christmas Party & Feast - Volunteers are asked to bring a covered dish to PAC's annual Christmas feast. One free week is given for best side dish and one free week is given for best dessert. Parent & staff vote.
☐ Valentine's Day Party – Volunteers are asked to assist in planning and carrying out PAC's annual Valentine's Day/Staff Appreciation events.
☐ Spring Kid's Helping Kid's Charity Fundraiser & Easter Egg Hunt – Volunteers are asked to help plan PAC's annual Easter Egg hunt and Choose a Children's Charity to support.
☐ Teacher Appreciation Week – Volunteers are asked to help plan festivities for Teacher Appreciation week

What level of participation are you interested in?

☐ General volunteer: Carries out various tasks as it relates to project, i.e., pick up cookies, bring candy, etc.
☐ Project leader: Leads project and coordinates volunteers.
☐ Project communicator: Ensures that parents are informed of event details. Assists project leader.
☐ Treasurer - ensures PAC fundraiser money is accounted for and used appropriately for each project.

_____ _____ _____

Mother's Signature Father's Signature Date

CHILD'S NAME: _____

Our Contract with You

Center Policies & Procedures Agreement

***Very Important—Read This Entire Form Carefully Before Signing**

Child's Name: _____ Effective Date (First date of care): _____

I elect to pay: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

PAYMENT PROCEDURES:

Your child's tuition fees may be paid on a monthly, semi-monthly, bi-weekly or weekly basis. The following is an explanation of these payment plans:

MONTHLY TUITION FEE PAYMENTS:

Fees are due in **ADVANCE** on the first day of each calendar month. Fees received later than close of business on the second day of any calendar month will incur a late charge of $5.00 per day.

SEMI-MONTHLY TUITION FEE PAYMENTS:

Fees are due in **ADVANCE** on the first and fifteenth day of each calendar month. Fees received later than close of business on the second and sixteenth day of any calendar month will incur a late charge of $5.00 per day.

BI-WEEKLY TUITION FEE PAYMENTS:

Fees are due in **ADVANCE** every other Friday. Fees received later than close of business on Monday following the Friday due date will incur a late charge of $5.00 per day.

WEEKLY TUITION FEE PAYMENTS:

Fees are due in **ADVANCE** every Friday. Fees received later than close of business on Monday following the Friday due date will incur a late charge of $5.00 per day.

In the event that the first, second, fifteenth and/or sixteenth day of any calendar month should fall on a weekend or holiday; or if a Friday or Monday should fall on a holiday, fees are due on the next regularly scheduled business day and are considered late if not paid by close of business on that day.

Daycare service shall be declined if fees and/or late charges are not paid in full by the schedule as outlined above.

OTHER TUITION PROCEDURES & FEES:

A **non-refundable registration and supply fee shall be paid upon enrollment**.

Pre-registration enables us to place your child's name on the roster and reserve placement in our program beginning on the date above. This does require a non-refundable deposit totaling the first week tuition, supply and registration fee. The deposit is forfeited if you withdraw your child's enrollment prior to scheduled start date, as Kinder College Academy held your child's spot and, in turn, turned away prospective enrollees. If you extend the scheduled start date, an additional deposit will be required.

An annual administration/registration fee is due around the first week of August each year for all children who continue in our program along with an annual supply fee.

If your child is enrolled in our Pre-School or Pre-K program you will incur annual workbook and curriculum fees.

_____ _____ _____

Mother's Signature Father's Signature Date

CHILD'S NAME: _____

OTHER TUITION PROCEDURES & FEES Cont'd

For a family of 2 children, a discount of ten percent (10.00%) is given for the lesser priced child. For a family of 3 or more we offer a total rate discount of 10%. These discounts are only available on FULL TIME enrollments.

No credit shall be given for days the Center is officially closed due to electricity, water, inclement weather, etc. We allow for 3 days per enrollment year for inclement weather and 3 days for loss of electricity, water or other environmental issues.

There is a 50% rate reduction when a complete enrollment week (Monday-Friday) is missed. If your child attends 1 day, the full week's tuition is due. This rate reduction is allowable for up to 6 weeks. After 6 weeks of reduced tuition you must pay full price tuition

Personal checks returned from the bank for any reason shall be due and payable within 2 days of presentation. There is a returned check fee of $25 and a $5.00 per day late fee from the date the check was written until the day it is replaced. We will not return your check until it is replaced with another form of payment that includes these fees. 3 or more returned checks within 1 year will result in your account being on a cash basis for 1 year. Should you withdraw prior to paying your NSF check we will proceed to the Harris County Clerk's Office and file criminal charges for "theft by check", leading to a warrant for your arrest.

Should you withdraw with a balance on your account you will be notified immediately. You will be given 30 days to dispute any charges in writing. If payment or payment arrangements are not made on undisputed charges, your account will be referred to a Collection Agency and/or the Harris County Courthouse for small claims court. On the day paperwork is filed with HCC, your account will be charged a collection fee of $200 plus any and all postage fees during the entire process. In addition, you will be responsible for ALL applicable court costs. **Please pay your account.**

OBLIGATIONS OF PARENTS OR GUARDIANS

A parent or guardian shall furnish requested immunization information within FIVE days of enrollment.

A parent, guardian or designated representative shall bring the child into the building upon arrival, sign the child in and hand off the child to a Center staff person.

A parent, guardian or designated representative shall sign the child out before removing the child from the premises.

The parent or guardian shall see the child is appropriately dressed.

The parent or guardian shall notify the Center when someone other than themselves shall be picking up the child.

The parent or guardian shall notify the Center when there is a change to the child's normal schedule at the Center.

The parent or guardian shall notify the Center when there is a change to the child's home and family life.

The parent or guardian shall notify the Center when the child is absent for any reason.

The parent or guardian shall notify the Center when the child has been exposed to a communicable disease.

The parent or guardian shall notify the Center in writing not less than one week prior to withdrawing a child from the Center.

Failure to notify the Center as specified will result in tuition fees being assessed, and due and payable.

_____ _____ _____

Mother's Signature Father's Signature Date

CHILD'S NAME: _____

TERMINATION OF THE AGREEMENT

This agreement shall be terminated if any one or more of the following occurs:

Serious illness of the child, preventing Center attendance.

The parent or guardian of the child allows their account to become delinquent.

Failure of the parents or guardians to honor the obligations listed in this agreement or in any policies promulgated or provided by the Center.

The Center in its sole and unfettered discretion determines that it is unable to meet the needs of the child or family.

The Center in its sole and unfettered discretion determines that it is not in the best interest of the Center or other children enrolled at the Center to have the child in attendance.

PROCEDURE

The child's parents or guardians may request a conference with Center personnel regarding the matters that potentially warrant termination, but the school shall have no obligation to grant any such request.

The Center's Director and/or Owner shall have the sole right and responsibility to determine any disputed factual matters regarding termination of this agreement.

MODIFICATIONS

This agreement may be modified whenever any of the circumstances covered by this agreement changes. Such modifications may only be made in writing and must be signed and dated by the parties involved in order to be binding and effective. Oral modifications are not binding under this agreement and shall not be enforceable under any condition.

OTHER

The parties to this agreement are aware of the Texas Department of Protective and Regulatory Services right to interview the child and the Center staff, and to inspect and audit all records maintained by the Center, without securing the prior consent of anyone. The parties are also aware of the licensing agency's right to observe the physical condition of the child, including conditions indicating neglect and abuse, and to have a licensed medical professional physically examine the child.
The parties to this agreement are aware that the Center staff are required by Texas Law to report any suspected child abuse to the Texas Department of Protective and Regulatory Services, Children's Protective Service and/or any law enforcement agency within the State.

SIGNATURES TO AGREEMENT

For services listed in this Agreement, and in accordance with the terms of this Agreement, I/We agree to perform the obligations of parents or guardians set forth in this agreement, and agree to abide by the rules, policies and procedures set forth in the Parents Handbook provided by the Center and agree to cooperate with the general policies of the Center.

My/our signatures below indicates that I/we have read the terms of this Agreement and that I/we have read the rules, policies and procedures set forth in the Parents Handbook promulgated and provided by the Center. It further indicates that I/we have had this material explained to me/us, if necessary, and that all my/our questions have been satisfactorily answered.

Mother's Signature	Father's Signature	Date

CHILD'S NAME: _____

Credit Card Authorization
Complete and return to center management for automatic payments

CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize **Kinder College Learning Academy** (called "CENTER" in this Authorization) to initiate recurring credit card charges to the below referenced credit card account for the purpose of collecting childcare related payments. I (we) understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction. **I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give CENTER written notice of revocation. A minimum of 5 business days is required to affect revocation.**

WE ACCEPT VISA, MASTERCARD AND DISCOVER

Cardholder Name: _____ Phone # _____

Billing Address: _____

City: _____ State: _____ **ZIP**: _____

Account Number: _____

Expiration Date: _____

SEC Code: _____

Amount $_____

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

*See above payment procedures for specific dates on these payment elections

_____ _____
Cardholder Signature Date

For Office Use Only:

Date Received: _____ Employee Signature: _____

_____ _____ _____
Mother's Signature Father's Signature Date

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth / / **Children under 18 years only.*

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian or managing conservator: _____
Printed Name

_____ _____
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac *– Please enter client information in ImmTrac and* ***affirm*** *that consent has been granted.*
DO NOT fax to ImmTrac. Retain this form in your client's record.

ATTENTION:

THE NEXT PAGE IS REQUIRED!!

Kinder College Learning Academy is a member of the Child Nutrition Program mandated by the U.S. Department of Agriculture. The Child Nutrition Program is a voluntary program. We believe in the importance of proper nutrition and understand the impact that proper nutrition has on learning. Therefore, we strive to comply with the strict requirements set forth by this program. In return for our compliance, the Child Nutrition Program (governed by the U.S.D.A) reimburses our facility for a portion of our food costs thus keeping your childcare cost low.
This facility is inspected regularly by the Texas Department of Agriculture in addition to the State Health Department.

The USDA requires that the following census form be completed

for <u>EVERY</u> family enrolled and updated annually.

It is NOT a form intended solely for low income families.

The purpose of this form is to provide support that our center does not discriminate, and provides care for children of all incomes, racial and ethnic identities.

BEYOND meals
Inspiring Healthy Life, Together!

Child and Adult Care Food Program (CACFP)

I have received the following CACFP Documents:

☐ Enrollment Form ☐ CACFP Letter to Households ☐ Building for Future Flyer ☐ WIC Guidelines

_____

Child(ren) Name

_____ _____

Parent Name **Parent Signature**

Institution Name: Beyond Meals, Inc.	CE ID: 06388

BEYOND MEALS
Inspiring Healthy Life, Together!

Enrollment Form

New ☐	Update ☐	
Center Name _____		Site ID: _____

This Facility participates in the U.S. Dept of Agriculture **Child and Adult Care Food Program (CACFP).** The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the Parent / Guardian section in this form, sign and return to the above Facility / Center. Provide information for one participant per section.

Participant / Child Name _____			**Date of Birth:** _____			**Age** _____
Sex: M ___ F ___	**Date of enrollment** _____		**Class room:** _____			**Withdraw Date:** _____
Circle the days that your child will normally attend the center:			Mon	Tue	Wed	Thu	Fri	Sat	Sun
Circle the meals normally served to your child in the center:			Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack	
List the normal times of Arrival and Departure:	_____ To _____		**Food Allergies:** YES NO			If YES, Please specify:			
Race of Participant (choose one or more):	White ☐	Asian ☐	Black or African American ☐	American Indian / Alaska Native ☐		Native Hawaiian or Other Pacific Islander ☐			
Participant's ethnic Identity	Hispanic or Latino ☐		Not Hispanic or Latino ☐						

If participant is an infant (0 – 11 months), please complete this box, Check all applicable choices below:

This Facility offers _____ formula for infants through CACFP. It is your choice whether or not to use this formula based on your infant's needs. Participation in this program requires centers to follow specific meal patterns according to the age of the infant.

Please mark your preference (choose all that apply)	Today's date Birth – 5 Months	Today's date 6 – 11 Months
I will bring expressed breast milk for my infant:		
I want the center to provide the infant formula for my infant		
I will bring the infant formula for my infant. It is the following brand:		

According to CACFP requirements, in order to claim meals for reimbursement, the center must provide infant cereal and other foods when your infant is developmentally ready to accept them.	Please mark your preference	Today's date 6 – 11 Months
	I want the center to provide the Infant cereal and other foods for my infant	
	I will bring the infant cereal and/or other foods for my infant	

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility form, letter to Household, WIC information, Building for the Future Flyers, Civil Rights Stmt.

Parent / Guardian Signature: _____ **Date:** _____

Print Name: _____ **Contact#:** _____ **Work:** _____

Address: _____ **City:** _____ **State/ Zipcode:** _____

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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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 **only** household members with income)	**B. Gross income and how often it was received** Note: 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
(Example) Jane Smith	$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:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

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, (AD-3027) found online at: 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.

This institution is an equal opportunity provider.