TEXAS
Health and Human Services

Form 2935
October 2023

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name:		Director's Name:	
Child's Full Name:		Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian *(if different from the child's)*:	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			

I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.

Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance?	Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?
○ Yes ○ No	○ Yes ○ No
Do you want your child to wear a life jacket while in or near a swimming pool?	
○ Yes ○ No	

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

- ☐ Discipline and guidance
- ☐ Suspension and expulsion
- ☐ Emergency plans
- ☐ Procedures for conducting health checks
- ☐ Safe sleep
- ☐ Procedures for parents to discuss concerns with the director
- ☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
- ☐ Procedures for parents to participate in operation activities
- ☐ Procedures for release of children
- ☐ Illness and exclusion criteria
- ☐ Procedures for dispensing medications
- ☐ Immunization requirements for children
- ☐ Meals and food service practices
- ☐ Procedures to visit the center without securing prior approval
- ☐ Procedures for supporting inclusive services
- ☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signature — Parent or Legal Guardian **Date Signed**

8. Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯Yes ◯No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title II, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian **Date Signed**

9. School Age Children

My child attends the following school:	School Area Code and Phone No.:

My child has permission to *(check all that apply)*:

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

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

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

- ◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- ◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

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. *(Select **only one** option.)*

- ◯ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.
- ◯ A signed and dated copy of a health care professional's statement is attached.
- ◯ 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.
- ◯ 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 submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

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.

Signature **Date Signed**

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx us/immunize/public.shtm.

TB Test (If required)

◯Positive ◯Negative Date:

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

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

Signature **Date Signed**

TEXAS
Health and Human Services

Form 2987
October 2023

Parent's Rights

This form provides the required information per Chapter 42 of the Human Resource Code (HRC) Section 42.04271.

Directions: Parents will review these rights upon enrolling their child.

Rights of Parent or Guardian

A parent or guardian of a child at a child care facility has the right to:

(1) enter and examine the child care facility during the facility's hours of operation without advanced notice;

(2) review the child care facility's publicly accessible records;

(3) receive inspection reports for the child care facility and information about how to access the facility's online compliance history;

(4) obtain a copy of the child care facility's policies and procedures;

(5) review, at the request of the parent or guardian, the facility's:

(A) staff training records; and

(B) any in-house staff training curriculum used by the facility;

(6) review the child care facility's written records concerning the parent's or guardian's child;

(7) inspect any video recordings of an alleged incident of abuse or neglect involving the parent's or guardian's child, provided that:

(A) video recordings of the alleged incident are available;

(B) the parent or guardian of the child does not retain any part of the video recording depicting a child that is not their own; and

(C) the parent or guardian of any other child captured in the video recording receives written notice from the facility before allowing a parent to inspect a recording;

(8) have the child care facility comply with a court order preventing another parent or guardian from visiting or removing the parent's or guardian's child;

(9) be provided the contact information for the child care facility's local Child Care Regulation office;

(10) file a complaint against the child care facility by contacting the local Child Care Regulation office; and

(11) be free from any retaliatory action by the child care facility for exercising any of the parent's or guardian's rights.

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signature of Parent or Guardian **Date**

Resources

Facility Information and Online Compliance History: http://txchildcaresearch.org

Child Care Regulation Contact Information: https://www.hhs.texas.gov/services/safety/child-care/contact-child-care-regulation

Enrollment Application for

Kids 'R' Kids of _____

Childs First Name: _____ Last Name: _____

Age: _____ Grade: _____ Gender: _____ Birth date: _____ Today's Date: _____

Home Address: Street: _____ Preferred Enrollment Date: _____

City: _____ Zip: _____ Actual Enrollment Date: _____

Home Phone #: _____ Child's SSN: _____

Days in Care (Check all that apply): ☐ M ☐ Tu ☐ W ☐ Th ☐ F

Child's Legal Guardian: ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Parents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Child Lives With: _____

Mother's First Name: _____ Last Name: _____

Mother's Address: Street: _____ Mother's Home Phone #: _____

City: _____ Zip Code: _____ Mother's Work Phone #: _____

Mother's email address: _____ Mother's Cell Phone #: _____

Mother's Employer: _____ Other Phone # for Mother: _____

Employer's Address: Street: _____ Suite: _____ City: _____ Zip: _____

Mother's SSN: _____ Mother's Driver's License #: _____ State: _____

Father's First Name: _____ Last Name: _____

Father's Address: Street: _____ Father's Home Phone #: _____

City: _____ Zip Code: _____ Father's Work Phone #: _____

Father's email address: _____ Father's Cell Phone #: _____

Father's Employer: _____ Other Phone # for Father: _____

Employer's Address: Street: _____ Suite: _____ City: _____ Zip: _____

Father's SSN: _____ Father's Driver's License #: _____ State: _____

The Following person(s) may be contacted in the event of an emergency and the parents cannot be contacted. My child has my permission to leave the facility with them.

Name: _____ Phone #: _____ Relationship: _____

Address: _____

Name: _____ Phone #: _____ Relationship: _____

Address: _____

Acknowledgement and Receipt of Family Handbook

The registration of your child is considered an acceptance, on his/her part and on the part of his/her families or guardians, of the terms and conditions of the Family Handbook and all of our School's rules and regulations, including the School's judgment on disciplinary sanctions or dismissal of a child.

The rules and regulations contained in this Handbook are not meant to be comprehensive. Rather, they presuppose the good will and judgment of a child in all circumstances in which he/she may find himself/herself and are subject to the School's ultimate discretion, judgment and interpretation.

Children and families or guardians are asked to familiarize themselves with all of the information contained in this Family Handbook, ask questions and then sign this form.

We have read and understood all statements and provisions set forth in the Family Handbook or as they may be changed from time to time by the School.

_____	_____	_____
Child	Age	Date
_____	_____	_____
Family Member or Guardian	Relationship	Date

(School File Copy)

Acknowledgement and Receipt of Family Handbook

The registration of your child is considered an acceptance, on his/her part and on the part of his/her families or guardians, of the terms and conditions of the Family Handbook and all of our School's rules and regulations, including the School's judgment on disciplinary sanctions or dismissal of a child.

The rules and regulations contained in this Handbook are not meant to be comprehensive. Rather, they presuppose the good will and judgment of a child in all circumstances in which he/she may find himself/herself and are subject to the School's ultimate discretion, judgment and interpretation.

Children and families or guardians are asked to familiarize themselves with all of the information contained in this Family Handbook, ask questions and then sign this form.

We have read and understood all statements and provisions set forth in the Family Handbook or as they may be changed from time to time by the School.

_____	_____	_____
Child	Age	Date
_____	_____	_____
Family Member or Guardian	Relationship	Date

(Family Copy)

Kids 'R' Kids Learning Academy

Distribution
- *Child's File*

Parental/Guardian Agreement with Kids 'R' Kids #_____

1. Kids 'R' Kids #_____ agrees to provide child care for_____ on M – Tu – W – Th – F from _____am to _____pm.
   Child's Full Name
2. I agree to pay the tuition fee of $_____ as designated by the school as well as a registration fee of $_____ that will be due annually. Payment will be due on _____.
3. My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: _____
   _____.
   I agree to provide the school with all necessary information pertaining to the administering of medication (date, prescription #, Allergy Action Plan, doctor's notes, direction, medication in original pharmaceutical container, etc.).
4. I agree to follow all requirements of the school's medical policy.
5. My child has the following special needs that may affect participation in school activities: _____
   _____.
6. The following special accommodation(s) may be required to most effectively meet my child's needs while at this school: _____.
7. I understand my child will be provided with all snacks and lunch served daily during his/her hours of attendance.
8. I understand I am responsible for any special diet required by my child and will provide a doctor's note indicating so. If my child's diet consists of breast milk or formula taken from a bottle, I understand I will provide Kids 'R' Kids with the appropriate number of bottles containing formula/ breast milk necessary for my child each day. Each bottle will be clearly labeled with my child's full name and current date.
9. If my child wears diapers, I understand I will provide whatever disposable diapers are necessary for my child. I understand that only disposable diapers are permitted in the school and that they will be changed every two hours, or as needed.
10. If child is of school age, what school does he/she attend: _____.
11. Transportation is provided to and from school and on planned field trips with parental/guardian permission. A separate form and signature are required for this service. A School-Age Transportation Agreement form must be signed each school year. A field trip agreement form must be signed before each fieldtrip.
12. I give consent for my child to participate in the following water activities: ☐ water table play, ☐ sprinklers, ☐ slip and slide.
13. Should my child become ill during the time he or she is in the care of Kids 'R' Kids or suffers an accident of any nature, the school will contact me immediately and is authorized to secure such medical attention and care for my child as necessary. (The parent/guardian will assume responsibility for payment).
14. I understand that if my child is ill, including, but not limited to, a severe cough or sore throat, undetermined rash or spots, temperature over _____ degrees, severe headaches, upset stomach or diarrhea, he or she cannot be accepted into the school until well (24 hours well without symptoms or medication). In the event my child has a notifiable disease, a release form from a medical source may be required before my child can re-enter the school. Kids 'R' Kids will notify parents if a notifiable disease has been introduced into the school and guidelines will be followed per the CDC Chart/Health Dept.
15. I understand that Kids 'R' Kids # _____ a Kids 'R' Kids franchise, is independently owned and operated and that neither Kids 'R' Kids International, Inc. nor any other Kids 'R' Kids is responsible for the actions or obligations of this school.
16. I understand that it is my responsibility to escort my child into and out of the school. And to sign my child in and out of the school. I understand that a staff member will escort my child into the school when being transported from school by county or Kids 'R' Kids transportation.
17. If I have not picked up my child 30 minutes after closing, and all attempts to contact my emergency contacts and me fail, Kids 'R' Kids will call the proper authorities.
18. I understand that it is my responsibility to keep the school advised of any changes to the information provided in this application.

I agree to abide by the policies and procedures of Kids 'R' Kids as outlined in this agreement and the Parent Handbook. I have read and understand the above statements.

_____ ___/___/____
Parent/Guardian Signature Date

_____ ___/___/____
Owner/Director Signature Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

Kids R Kids Learning Academy

Distribution
- *Child's File*
- *Infant/Toddler Classroom Forms*

Infant Child Profile

For children ages 6 weeks-12 months

A new form is required with each classroom transition and should be updated as information changes.

This profile will help your child's teacher get to know your child better. Your input will also help with your child's adjustment to the new classroom.

Child's Full Name: _____ Date of Birth: ___/___/___

Parent/Guardian's Name: _____
(Please Print)

1. Has your child had previous group care experiences? □ Yes □ No
2. What language(s) is spoken in your home? _____
3. List the names and ages of siblings.

   _____

   _____
4. Do you have pets at home? □Yes □ No If yes, please list type of pet and name.

   _____
5. What milestone(s) has your child reached? (I.e. rolling over or crawling)

   _____

   _____
6. Does your child take a pacifier? □ Yes □ No When? _____
7. How often and how long does your child nap? _____
8. How many hours does your child sleep at night? _____
9. List any additional care plan instructions, i.e. diapering or sleeping _____

   _____

   _____

_____ ___/___/___
Parent/Guardian Signature Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

KRK/REV/12/2013

Kids 'R' Kids Learning Academy

Distribution
- *Infant/Toddler Classroom Forms*
- *Front Desk Forms*

_____
(Month)

Infant Feeding Plan

For children ages 6 weeks-12 months

Child's Full Name: _____ Date of Birth: ____/____/____

Instructions to Parents/Guardians:

- Bottles must be pre-mixed (if applicable), labeled with child's full name, current day's date and ready to be served.
- Breast milk must be prepared and stored in a bottle ready for use with the amount of milk for one feeding, labeled with the child's full name, and date of collection. *frozen storage bags are not permitted.
- Update diet information as needed or every 30 days. Use a new form or initial/date changes on this form.

Does child feed self? □Yes □ No

Child's diet includes (check all that apply):

Formula	□	Juice	□
Breast Milk	□	Baby Foods	□
Whole Milk	□	Strained Foods	□
Water	□	Table Foods	□

Formula type: _____
Bottle's Formula Amount: _____

Breast Milk Storage: □ Bottles
Bottle's Breast Milk Amount: _____

Food Likes: _____
Food Dislikes: _____
Allergies: _____
Restrictions: _____

Feeding	Time of Day	Type and Approximate Amount of Food

Additional Instructions (i.e. for the introduction of solid foods, dietary changes): _____

I understand it is my responsibility to keep Kids 'R' Kids # _____ updated, In writing, as my child's needs change or ***every 30 days,*** and that it is Kids 'R' Kids policy that bottles are held, not propped, during feeding & that bottles are discarded within an hour after warmed. Unused breast milk will be sent home. Not discarded.

_____ ____/____/____
Parent/Guardian Signature Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

KRK/REV/12/2019

Kids R Kids Learning Academy

Distribution
- *Infant/Toddler Classroom Forms*
- *Preschool/School-Age Classroom Forms*
- *Kitchen Log*
- *Child's File*

Child Allergy Profile

Update annually or as child's information changes

(place child's picture here)

Child's Full Name: _____ Suite: _____

Allergy To:

_____

Symptoms of Allergic Reaction:

_____

_____

_____

_____

Emergency Care Plan:

_____

_____

_____

_____

_____ ___/___/___

Parent/Guardian Signature Date

_____ ___/___/___

Owner/Director Signature Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

KRK/REV/12/2019

Kids R Kids Learning Academy

Child Profile

Child's Name: _____ Birthday: _____

This profile will stay with your child. As your child grows and develops, changes should be noted or added to this form to keep your child's teachers in touch with the growth and development your child has made. We need your input on any changes taking place outside of school that may have an affect on your child while in our care. Thank you for helping us make our school the best we can be.

1. Has your child had previous preschool experience? ☐ Yes ☐ No
   If so, please elaborate:

_____

2. What would you like most for your child to experience with us?

_____

3. What does your child most enjoy doing?

_____

4. Does your child have any fears?

_____

5. Do you consider your child shy or outgoing?

_____

6. What are your child's favorite toys?

_____

7. About what things does your child express the most curiosity?

_____

8. Does your child play well with other children? ☐ Yes ☐ No

9. List the names and ages of other children in your family.

_____

10. What words are spoke in your home for toileting?

_____

11. Does your child take a nap? ☐ Yes ☐ No

12. Does your child need a favorite item (such as a blanket or stuffed animal) for nap?
☐ Yes ☐ No

13. How many hours of sleep does your child usually receive at night?

_____

14. Do you have a special interest or hobby you would like to share with your child?

_____

15. Are you available to help us with the field trips or other special events?

☐ Yes ☐ No

16. Who, besides the immediate family, resides in the home?

_____

17. Does anyone else care for your children? ☐ Yes ☐ No

If so, then whom? _____

18. What language is spoken in your home?

_____

_____

Parent'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

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

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

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

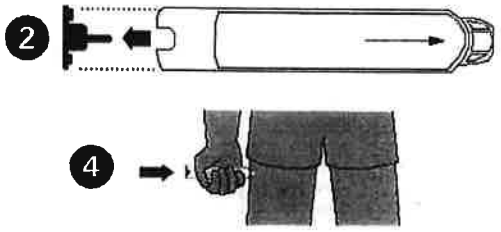
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

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

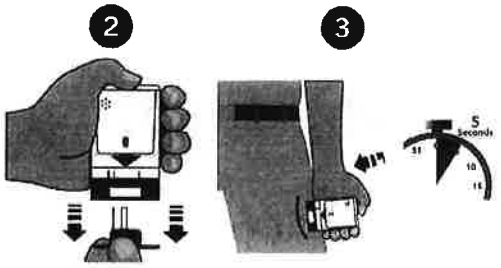
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

Kids R Kids Learning Academy

Distribution
- *Front Desk Forms*
- *Infant/Toddler Classroom Log*
- *Preschool/School-Age Classroom Log*

Topical Ointment and Cream Authorization

All topical ointments and creams must be current, in its original container and labeled with the child's full name. Follow state guidelines for new authorization.

Child's Full Name: _____ D.O.B. __/__/__

Classroom: _____

Dates: Start ____/____/____ End ____/____/____

_____ Sunscreen
Product Name: _____ Expiration Date: _____

_____ Insect Repellent
Product Name: _____ Expiration Date: _____

_____ Non-Prescription ointment (such as Diaper Cream)
Product Name: _____ Expiration Date: _____

_____ Other (Please specify)
Product Name: _____ Expiration Date: _____
Product Name: _____ Expiration Date: _____

Specific Terms of Use: _____
_____
_____

_____ ____/____/____
Parent/Guardian Signature Date

Center Use Only:

Disposal of Leftover Topical Ointment/Cream:

□ Returned to Child's Parent/Guardian
□ Discarded

_____ ____/____/____
Authorized Person's Signature Date

KRK/322/REV/C4/13

NO MEDS

Distribution
- *Front Desk Forms*

Medication Authorization

All long and short-term medications must be current, in its original container and labeled with the child's full name. Over the counter medication must be accompanied by written authorization from the child's physician indicating dosage. Follow state guidelines for new authorization. If guidelines are not stipulated for short term medications, all authorizations must be updated every 2 weeks. If guidelines are not stipulated for long-term medications, **all authorizations must be updated every month when medication is changed and when child transitions to the next classroom.**

Child's Full Name: _____ D.O.B. ____/____/____

Classroom: _____

Physician Name: _____ Physician Phone: _____

Authorization Instructions:

Name of Medication: _____

Prescription #: _____ Expiration Date: ____/____/____

Dates to administer (***not to exceed 2 weeks***): Start ____/____/____ End ____/____/____

Dispense medication at: 11 am 3 pm Dosage Amount: _____

Other Directions: _____

Does medication require refrigeration? ☐ Yes ☐ No

For over-the-counter medication, was a copy of physician's authorization provided to the school? ☐ Yes ☐ No

_____ ____/____/____

Parent/Guardian Signature Date

Center Use Only:

Authorized Person reviewed information above for completeness ☐ Yes ☐ No

_____ ____/____/____

Authorized Person's Signature Date

Record of Dispensation

Date	Time	Dosage	*Adverse Reactions/ reason not given	Administered By (Full Signature)

*If noticeable adverse reaction to medication occurs, parents must be notified immediately.
*If child is not given medication at the exact time indicated, list reason here.

Disposal of Leftover Medication: ☐ Returned to Child's Parent/Guardian ☐ Disposed

Date: ____/____/____ Admin Signature: _____

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

KRK/REV/04/2022

Distribution
- *Child's File*
- *Front Desk Forms*

Safe Sleep Policy

In accordance with the Texas Health and Human Services Commission and Caring for Our Children 4th Edition, National Health and Safety Performances

Child's Name: _____ Date of Enrollment: ___/___/___

We believe that a safe sleep environment for infants helps lower the chances of an infant dying from SIDS, and that parents and childcare providers can work together to provide a safe sleep environment. According to the Texas Health and Human Services Commission rule number 746.501(9) and 747.501(6) childcare providers caring for infants 12 months of age or younger than 18 months of age, not walking and sleeping in a crib, are required to implement safe sleep practices. Kids 'R' Kids of *Insert your school's name here* will implement the following Safe Sleep practices.

Safe Sleep: Sleeping & Resting Requirements

1. Center staff shall place an infant to sleep on the infants back in a crib unless the center has been provided a physician's written statement authorizing another sleep position for that particular infant; that includes how the infant shall be placed to sleep and a timeframe that the instructions are to be followed.

2. When infants can easily turn over from back to front and back again, center staff shall continue to put the infant to sleep initially on the infant's back but allow the infant to roll over into his or her preferred position and not reposition the infant.

3. Wedges, other infant positioning devices and monitors shall not be used unless the parent or guardian provides a physician's written statement authorizing its use that includes how to use the device and a timeframe for using the device is provided for that particular infant.

4. Infants shall not sleep in equipment other than safety-approved cribs, such as, but not limited to a car seat, bouncy seat, highchair, or swing. Infants who arrive at the center asleep in such equipment, or on the floor or elsewhere, shall be transferred to safety approved crib.

5. Kids 'R' Kids require sleeping infants will to be visually check on daily, every 15 minutes, by assigned staff. The sleep information will be recorded on a Sleep Chart. Assigned caregiver will check the infant for:
- Normal skin color
- Normal breathing by watching the rise and fall of the chest
- Signs of overheating: flushed skin color, increase in body and restlessness.

6. All parents/guardians of infants care for in the facility will receive a written copy of our infant/toddler Safe Sleep policy before enrollment and sign a statement saying they received and reviewed the policy.

7. Center shall maintain the infant sleeping area to be comfortable. Kids 'R' Kids mandates that the lights remain on at all times in the infant classrooms.

Safe Sleep Environment

8. All cribs must be safety approved in compliance with Consumer Product Safety Commission (CPSC) and American Society of Testing and Materials (ASTM) safety standards.

9. Mattress shall be provided for each crib and shall be firm, tight fitting without gaps at least two" thick and covered, waterproof, washable material, and a tight-fitting sheet.

10. Staff shall not place objects or allow objects to be placed in or on the crib with an infant such as, but not limited to, toys, pillows, quilts, comforters, blankets, sheep skins, stuffed toys, bumper pads, mobiles, crib gyms, mirrors, bibs, or pacifiers.

Safe pacifier practices
- Pacifiers are permitted but attachments of any type are not allowed
- We do not reinsert the pacifier in the infant's mouth if it falls out
- We remove the pacifier from the crib once it has fallen from the infant's mouth.

11. All cribs shall be arranged to avoid obstructing access to exit doors and to prevent children's access to cords hanging from the window treatments and other hazardous objects. Crib spacing should be far enough apart so that one infant may not reach into another crib with enough space for caregivers to walk and work between cribs.

12. Each infant will have his or her own crib. Only one infant will be in a crib at a time unless we are evacuating.

13. If an infant needs extra warmth, use sleep clothing _____ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternate to blankets (746.2415(b) and 747.2315(b)

14. Do not swaddle an infant or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional (746.2428 and 747.2328)

15. Awake infants will have supervised "tummy time" several times daily.

Kids R Kids Learning Academy

Distribution
- *Child's File*
- *Front Desk Forms*

I, the parent/guardian of _____ (child's name), received a copy of the facility's Safe Sleep Policy. I have read the policy and discussed it with the facility director/operator or other designated staff member.

Director/Owner Signature: _____ Date: _____

Staff Member Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

This form was developed by Kids 'R' Kids International, Inc. It is important to review State Guidelines regularly to ensure compliance.

KRK/REV/01/2023

Distribution
- *Child's File*
- *Transportation Log*

Transportation Agreement

The following information is required to be updated by Kids 'R' Kids annually and when transportation situation changes

Child's Full Name: _____ Date of Birth ___/___/___

Kids 'R' Kids_____ emergency transportation/medical procedure:

1. Call emergency medical team, if necessary
2. Contact parent/guardian (phone, email, text)
3. Contact alternate emergency contact, if necessary
4. Emergency medical team transports child to hospital.
5. Kids 'R' Kids representative will accompany child to hospital.

Emergency Medical Facility the center uses: _____

Address_____ Phone _____

I, _____give permission for Kids 'R' Kids _____ to seek medical attention and /or transport my child_____, in the event of any emergency. I further agree to hold harmless and release Kids 'R' Kids _____and Kids 'R' Kids International, Inc. from all liability. I further agree to keep the facility informed of any changes in the information below.

For School Age Use Only: *If the child relocates to another school or the hours change, this form must be updated immediately*

Name of School: _____

School Address: _____

School Phone: _____

- In the event the designated location is unable to receive children they will be returned to Kids 'R' Kids_____.
- It is vital that Kids 'R' Kids_____ be notified of any changes in the above scheduled transportation.
- Kids 'R' Kids_____ will assume the above schedule of transportation will be followed unless we receive different instructions from parents in writing. Instructions should be received at Kids 'R' Kids_____ by the earliest possible time before scheduled pickup or drop off.

I, _____ agree for my child to be transported by Kids 'R' Kids_____

☐ **To school at _____ (am/pm)**
☐ **From school at _____ (am/pm)**

On the following days: Monday Tuesday Wednesday Thursday Friday

_____ _____/_____/_____
Parent/Guardian Signature Date

_____ _____/_____/_____
Owner/Director Signature Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

KRK/REV/02/2020

Distribution
- *Child's File*

Photo and Social Media Release

For and in consideration of the opportunity to have my minor child's name, voice, picture, portrait, artwork and/or likeness published and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the undersigned, on behalf of myself and my minor child, hereby agree as follows:

1. I hereby grant Kids 'R' Kids International, Inc., Kids 'R' Kids # _____, and its affiliates, franchisees, nominees, licensees, successors and assigns and those acting under their permission (hereinafter "KRK"), the unrestricted, absolute, perpetual, worldwide right to:

a. use my and my minor child's name, voice, picture, portrait, artwork and/or likeness, however obtained;

b. reproduce, copy, modify, alter, edit, publish, use, create derivatives in whole or in part, without limitation, my and my minor child's image, picture, portrait, artwork and/or likeness in still and/or video photography, film or tape taken of me or my minor child by or on behalf of KRK.

c. display, exhibit, distribute, transmit or broadcast the above or any part thereof; in any project or medium, whether now or hereafter existing, including, without limitation printed publications, television, radio, the internet, any online service or website, blog or social media, including, without limitation: Twitter, Facebook, Instagram, any number of times and for any purpose, including, without limitation, promotional, advertising and marketing purposes.

2. I agree that any picture, portrait, artwork or other product or material derived there from is wholly owned by KRK and that KRK may copyright any product or material containing same. If I receive any copy thereof, I shall not use it for any purpose nor authorize its use by anyone else.

3. I hereby waive my right to inspect and/or approve the finished product or material, or to the eventual use that it might be applied.

4. I hereby release and discharge KRK from and against any claim or liability arising out of invasion of privacy, right of publicity, defamation, portrayal in a false light, misappropriation, and copyright infringement arising out of or in connection with the use of materials referenced hereunder, including without limitation the use of my or my minor child's name, voice, picture, portrait, artwork and/or likeness in any manner authorized by this Release, whether now known or arising in the future.

5. I hereby warrant that I am eighteen years old or older and am the parent and/or legal guardian of the minor child named below and am competent to contract for the minor child named herein as the above is concerned. I have read the foregoing release and warrant that I fully understand the contents hereof. I agree that this Release is intended to be as broad and inclusive as permitted under the laws of the State of Georgia, and that if any portion thereof is held to be invalid, that the balance shall continue in full force and effect.

6. This Release constitutes an Agreement between myself and KRK and contains the entire understanding between myself and KRK regarding the subject matter hereof. This Release cannot be modified except in a writing signed by all parties hereto and shall be governed in accordance with the laws of the State of Georgia.

_____	_____
Child's Full Name	Parent/Guardian Printed Name
_____	___/___/___
Parent/Guardian Signature	Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

Kids R Kids Learning Academy

Distribution
- *Child's File*
- *Transportation Log*
- *Field Trip Log (School-Age Only)*

Health and Emergency Permission

This form must be completed for all enrolled children annually and as changes occur

Child

Child's Full Name _____ Age _____ Gender_____ Date of Birth ___/___/____

Child's Home Address _____ Home Phone _____

Parent/Guardian(s)

Parent/Guardian Name_____ Phone 1: _____ Phone 2: _____

Parent/Guardian Name_____ Phone 1: _____ Phone 2: _____

Medical Information

Doctor to be contacted when parents cannot be reached:
Name Full Address Telephone

_____

Dentist:
Name Full Address Telephone

_____

Health Insurance Provider:
Name Full Address Telephone

_____

Does your child have special needs affecting participation in school activities? □ Yes □ No
Specify: _____

Does your child have allergies? □ Yes □ No
Is your child on prescribed medication for Illness/Allergies? □ Yes □ No
Specify: _____

Actions Taken: _____

_____

Weight of Child: _____

Emergency Contacts

The child may be released to the person(s) signing this agreement or to the following with photo ID:
Name Address Telephone Relationship

_____

_____

_____

Emergency contact(s) when parents cannot be reached:
Name Address Telephone Relationship

_____

_____

_____ _____/_____/_____
Parent/Guardian Signature Date

_____ _____/_____/_____
Owner/Director Signature Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.

KRK/REV/02/2020

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT

I hereby authorize (business name) _____ to initiate charges to the below-referenced checking or savings account indicated below.

To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

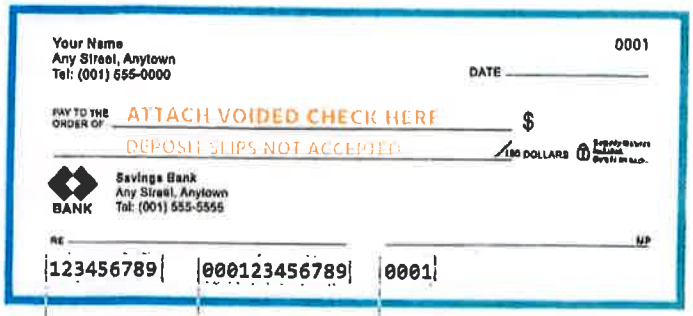
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received _____

Employee Signature _____

800.338.3884 • procaresoftware.com

Kids R Kids

☐ **Kings River Campus**
6262 Upper Lake Dr.
Humble, TX 77346
Phone: 281-812-2882
Fax: 281-812-3286

☐ **Eagle Springs Campus**
18410 Timber Forest Dr.
Humble, TX 77346
Phone: 281-812-3770
Fax: 281-812-6906

Child's Name: _____ Birthdate: _____

HEALTH INFORMATION

INFANTS THROUGH PRE-K ONLY*

To be completed by child's physician:
I have examined the above named within the past year and find that he/she is physically able to take part in the child care program.

Physician's Name: _____

Street: _____

City: _____ Zip: _____

Phone Number: _____

Physician's Signature: _____

Status Of:

Vision: _____

Hearing: _____

Date: _____

Please check box below if the above information is not completed by physician:

☐ My child has been examined within the past year by a health professional and is able to participate in the child care program. Within one (1) week of admission, I will obtain a health care professional's signed statement and will submit it to the school my child attends.

I understand that Kids R Kids is required to have a copy of my child's updated shot records and a copy must be turned in with enrollment package (or within 48 hours of my child's start date). I also understand that if my child's shot records are not up to date, I will be sure my child receives the appropriate immunizations within the time frame set by the school my child attends.

Parent's/Guardian's Signature: _____ Date: _____

***SCHOOL AGE CHILDREN PLEASE COMPLETE "SCHOOL RECORD SIGN-OFF" FORM**

School Record Sign-off
Kids 'R' Kids of Humble

Eagle Springs Campus
18410 Timber Forest Dr.
Humble, TX 77346
(281) 812-3770

Kings River Campus
6262 Upper Lake Dr
Humble, TX 77346
(281) 812-2882

My school-age child _____ is enrolled at one of the schools
(child's name)
listed below, where his/her records are current. These records include immunizations, hearing, and vision screening.

Humble ISD

- ☐ Atascocita Springs Elementary
- ☐ Eagle Springs Elementary
- ☐ Whispering Pines Elementary
- ☐ Timbers Elementary
- ☐ Oaks Elementary
- ☐ Oak Forest Elementary
- ☐ Pine Forest Elementary
- ☐ Groves Elementary
- ☐ Green Tree Elementary
- ☐ Deerwood Elementary
- ☐ Elm Grove Elementary
- ☐ Maplebrook Elementary

☐ Other school not listed above: _____
(school's name)

_____ _____
Parent signature Date

Updated 12/10/2021

Emergency Contact Card

Child's Name: _____ Date of Birth: _____

Home Address: _____ Primary Phone: _____

City: _____ Zip: _____

Allergies to medicine: _____

Allergies to food: _____

Emergency contacts other than parents:* 1st Parent Name: _____

1st Contact Name: _____ Cell Phone: _____

Home Address: _____ Work Phone: _____

Relation: _____ Primary Phone: _____

2nd Contact Name: _____ 2nd Parent Name: _____

Home Address: _____ Cell Phone: _____

Relation: _____ Primary Phone: _____ Work Phone: _____

Kids 'R' Kids of _____ has permission to transport my child in case of emergency

_____

Parent's Signature Date

Kids R Kids Learning Academy

**TDFPS Licensing expects the parent to list someone other than themselves as an emergency contact and authorized to pick up their child from care. If the parent chooses to not designate anyone else, they will need to indicate this in writing.*

Child and Adult Care Food Program (CACFP)

I have received the following CACFP Documents:

- ☐ CACFP Letter to Households
- ☐ Enrollment Form (Must be entirely filled out by parents)
- ☐ WIC Guidelines
- ☐ Building for the Future Flyer

_____

Child(ren) Name(s)

_____ _____

Parent Name **Parent Signature**

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at **[Name of Center].** This center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP reimburses centers for healthy meals and snacks served to children enrolled in child care based on their eligibility for free or reduced-price meals. Higher reimbursement is received for meals served to enrolled participants who are eligible for free or reduced-price meals, and this reimbursement is then used to purchase healthy food to prepare nutritious meals. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form so that we can determine your child(ren)'s eligibility for free or reduced-price meals.

1. Am I required to complete a Meal Benefit Income Eligibility Form in order to receive meals? No, but if you choose to do so, this center may receive a higher reimbursement for the meals you receive, which is used to buy nutritious food for meals.

2. Do I need to fill out a Meal Benefit Form for each of my children in day care? If all children enrolled for care at this center live in the same home, you only need to complete and submit one CACFP Meal Benefit Income Eligibility Form for these children. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [(Name of Center, address, phone number].**

3. Who is eligible for free or reduced-price meals? While this center does not charge for meals served, children in households receiving benefits in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR); foster children (reference question #7 for more information on foster children); or children designated as homeless are automatically eligible for free meals, and no additional income information needs to be provided.

Children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) (must not have yet entered kindergarten) are also eligible for free meals. Households with children enrolled in an HSP, EHSP, or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form. **Note that only the child or children enrolled in these programs will qualify for benefits.**

All other children living in households with a combined income that does not exceed the household income thresholds attached to this letter and as documented on the Meal Benefit Income Eligibility Form are eligible for reduced-price meals and may be eligible for free meals based on the determination of this center.

4. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you, including foster children or homeless children who temporarily live with you.

5. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income, providing a current SNAP, TANF, FDPIR case number, or by providing a certification letter establishing participation in an HSP, EHSP, or ESP, your child will remain eligible for those benefits for 12 full months. You should notify us, however, if you or someone in your household becomes unemployed, and the loss of income causes your household income to be within the eligibility standards.

6. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

7. What if I have foster children? Foster children who are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

8. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **[281-325-0365].**

Sincerely,

[signature]

Effective July 1, 2025 – June 30, 2026

Household Size	Total Income									
	Annual		Monthly		Twice-Monthly		Bi-Weekly		Weekly	
No. of Household Members	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	$20,345	$28,953	$1,696	$2,413	$848	$1,207	$783	$1,114	$392	$557
2	$27,495	$39,128	$2,292	$3,261	$1,146	$1,631	$1,058	$1,505	$529	$753
3	$34,645	$49,303	$2,888	$4,109	$1,444	$2,055	$1,333	$1,897	$667	$949
4	$41,795	$59,478	$3,483	$4,957	$1,742	$2,479	$1,608	$2,288	$804	$1,144
5	$48,945	$69,653	$4,079	$5,805	$2,040	$2,903	$1,883	$2,679	$942	$1,340
6	$56,095	$79,828	$4,675	$6,653	$2,338	$3,327	$2,158	$3,071	$1,079	$1,536
7	$63,245	$90,003	$5,271	$7,501	$2,636	$3,751	$2,433	$3,462	$1,217	$1,731
8	$70,395	$100,178	$5,867	$8,349	$2,934	$4,175	$2,708	$3,853	$1,354	$1,927
For each additional family member, add	+$7,150	+$10,175	+$596	+$848	+$298	+$424	+$275	+$392	+$138	+$196

These guidelines are based on 130% (free) and 185% (reduced) of the federal poverty guidelines and are effective July 1, 2025 – June 30, 2026.

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: Healthy Plate Solutions Agreement Number: 05001

Facility/Provider Name: _____

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) 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 of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** _____ ☐ am ☐ pm **Depart:** _____ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ America Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box. Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date / Birth - 5 months	Today's Date / 6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimbursement, the provider 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 provider to provide the infant cereal and other foods for my infant.	
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.	

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

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, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date Dropped:

Work Telephone Number: _____ Emergency Telephone Number: _____ _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Name of Child Care Facility or Day Care Home Provider:

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) OR A HOMELESS CHILD * IF ALL CHILDREN LISTED BELOW ARE FOSTER OR HOMELESS 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 benefits, 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 or day care home provider households) 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 ☐

ADDITONALLY, PLEASE ATTACH OFFICIAL EVIDENCE OF ENROLLMENT IN THE LISTED PROGRAM. If you are not a day care home provider, do not have a child enrolled at a day care, and/or are not participating in a qualifying program, **skip to Part 4.**

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 ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American	☐ American Indian or Alaska Native ☐ 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 meal benefits. You must include the last four digits of the Social Security Number of the adult household member who signs the application; however, 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), or other qualifying program eligibility 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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Join Texas WIC

We're here for you

"Thanks to WIC, I now have the tools I need to make sure my family stays on the path to a healthy lifestyle."

—Roxie, WIC Client

As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	$ 3,261	$ 39,128
3	$ 4,109	$ 49,303
4	$ 4,957	$ 59,478
5	$ 5,805	$ 69,653
6	$ 6,653	$ 79,828

Effective May 1, 2025

* A pregnant woman's household can be increased by the number of infants she is expecting. For more than 6 household members, call your local WIC office.

** Income can also be determined on a weekly or biweekly basis.

Start now. Call 1-800-942-3678 or visit TexasWIC.org

TEXAS Health and Human Services | TEXAS WIC

This institution is an equal opportunity provider.

Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program

Questions? Concerns?

Call USDA at
1-866-873-2263

OR

Food and Nutrition at
1-800-TELL-TDA
(835-5832)

Your child care at

Contact Information:
Address
Phone Number
Email Address
Other Necessary Information

Fraud Hotline: 1-866-5-FRAUD or 1-866-537-2834
P.O. Box 12847 Austin TX 78711
www.SquareMeals.org
USDA is an equal opportunity provider and employer.

El Programa de Atención Alimenticia para Niños y Adultos (CACFP)

He recibido los siguientes documentos CACFP:

☐ CACFP Carta para el hogar

☐ CACFP Ingresos Máximos

☐ Inscripción de participantes (Debe ser completado en su totalidad por los padres)

☐ Directrices de WIC

☐ Volantes Construyendo para el Futuro

_____

Niño(s) Nombre(s)

_____ _____

Nombre del padre **Firma de los padres**

Estimado(a) padre (madre) o tutor:

Esta carta está dirigida a los padres o tutores de los niños inscritos en **[Name of Center]**. Este centro ofrece comidas saludables a todos los niños inscritos como parte de nuestra participación en el Programa de Alimentos para el Cuidado Infantil y de Adultos (CACFP) del Departamento de Agricultura de los Estados Unidos (USDA). El Programa CACFP reembolsa a los centros las comidas y refrigerios saludables que se sirven a los niños inscritos en guarderías infantiles de conformidad con su elegibilidad para recibir comidas gratuitas o a precio reducido. Se recibe un reembolso mayor por comidas servidas a participantes inscritos que sean elegibles para obtener comidas gratuitas o a precio reducido. Este reembolso se utiliza posteriormente para comprar alimentos saludables destinados a la preparación de comidas nutritivas. Ayúdenos a cumplir con los requisitos del Programa CACFP completando el "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas" adjunto con el fin de que podamos determinar la elegibilidad de su(s) niño(s) para recibir comidas gratuitas o a precio reducido.

1. ¿Debo completar un "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas" para poder recibir comidas? No, pero si decide hacerlo, este centro puede recibir un reembolso mayor por las comidas que usted recibe, que se utiliza para comprar alimentos nutritivos destinados a la preparación de comidas.

2. ¿Necesito completar un "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas" para cada uno de mis niños en la guardería? Si todos los niños inscritos para recibir cuidado en este centro viven en la misma vivienda, usted solo necesita completar y enviar un "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas" del Programa CACFP para estos niños. No podemos aprobar un formulario que no esté completo, así que asegúrese de leer las instrucciones cuidadosamente y de incluir toda la información requerida. **Devuelva el formulario completado al siguiente destinatario: [(Name of Center, address, phone number].**

3. ¿Quién es elegible para recibir comidas gratuitas o a precio reducido? Si bien este centro no cobra por las comidas servidas, son automáticamente elegibles para la recepción de comidas gratuitas (y no es necesario facilitar información adicional sobre ingresos) aquellos niños en grupos familiares que reciben beneficios del Programa de Asistencia Nutricional Suplementaria (SNAP), del Programa de Asistencia Temporal para Familias Necesitadas (TANF) o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR); también niños bajo crianza temporal (consulte la pregunta núm. 7 para obtener más información sobre niños en este regimen) o bien niños denominados como sin hogar.

Los niños inscritos en un programa de Head Start (HSP), de Early Head Start (EHSP) o de Even Start (ESP) también son elegibles para recibir comidas gratuitas (no deben haber ingresado aún a kínder). Los grupos familiares con niños inscritos en un programa de HSP, EHSP o ESP pueden brindar una carta de certificación del programa respecto a la inscripción del niño y no necesitan completar el "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas" del Programa CACFP. **Tenga en cuenta que solo el (los) niño(s) inscrito(s) en estos programas calificará(n) para recibir beneficios.**

Todos los otros niños que vivan en grupos familiares con ingresos combinados que no excedan los umbrales de los ingresos familiares adjuntos a esta carta y como se documenta en el "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas" son elegibles para recibir comidas a precio reducido y pueden serlo respecto a comidas gratuitas, según lo decida este centro.

4. ¿A quiénes debo incluir como integrantes de mi grupo familiar? Usted debe incluir a todas las personas de su grupo familiar que compartan ingresos y gastos (tales como abuelos, otros parientes o amigos que vivan con usted). Debe incluirse a sí mismo y a todos los niños que vivan con usted, incluyendo niños bajo crianza temporal o sin hogar que vivan de manera provisional con usted.

5. ¿Cómo declaro información sobre ingresos y cambios en la situación laboral? Los ingresos que declare deben ser los ingresos brutos totales indicados por fuente de cada integrante del grupo familiar devengados el último mes. Si los ingresos del último mes no reflejan con exactitud sus circunstancias, puede facilitar una proyección de sus ingresos mensuales. Si no se ha producido ningún cambio significativo, puede utilizar los ingresos del último mes como base para elaborar esta proyección. Si sus ingresos de su grupo familiar son iguales o menores que los montos señalados para el tamaño de su grupo familiar en la tabla de ingresos adjunta, el centro recibirá un nivel de reembolso más elevado. Una vez se reciba la aprobación correspondiente para recibir beneficios de comidas gratuitas o a precio reducido, ya sea mediante ingresos o facilitando un número de caso actual de los programas SNAP, TANF o FDPIR o una carta de certificación que confirme la participación en un programa de HSP, EHSP o ESP, sus niños seguirán siendo elegibles para la recepción de esos beneficios durante 12 meses completos. Sin embargo, debe notificarnos si usted o alguien de su grupo familiar queda desempleado y la pérdida de ingresos hace que los ingresos de su grupo familiar estén dentro de los estándares de elegibilidad.

6. ¿Qué pasa si mis ingresos no son siempre los mismos? Indique el monto que recibe normalmente. Por ejemplo, si recibe con regularidad $1000 cada mes, pero faltó al trabajo algunas veces el mes pasado y solo recibió $900, escriba que recibe $1000 por mes. Si suele recibe remuneración por horas extras, inclúyala, pero no lo haga si solo la recibe en ocasiones.

7. ¿Qué pasa si tengo niños bajo crianza temporal? Son elegibles para la recepción de comidas gratuitas aquellos niños bajo crianza temporal que estén bajo la responsabilidad legal de una agencia de cuidado de crianza temporal o de un tribunal. Cualquier niño bajo crianza temporal en el grupo familiar es elegible para recibir comidas gratuitas, independientemente de sus ingresos. Los grupos familiares pueden incluir a niños bajo crianza temporal en el "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas", pero no están obligados a incluir pagos recibidos por el niño bajo crianza temporal como ingresos. Los grupos familiares que deseen solicitar dichos beneficios para niños bajo crianza temporal deben facilitar al cuidador de su niño el documento Form 2085FC, *Placement Authorization Foster Care/Residential Care* (del Departamento de Servicios Familiares y de Protección de Texas) y no necesitan completar un "Formulario de elegibilidad según ingresos para beneficios de recepción de comidas" del Programa CACFP.

8. Estamos en las Fuerzas Armadas. ¿Incluimos nuestras asignaciones para vivienda y complementarias como ingresos? Si su vivienda es parte de la Iniciativa de Privatización de Viviendas para Militares y usted recibe beneficios del Programa de Asignación Complementaria para Sustento Familiar, no incluya estas asignaciones como ingresos. Además, en lo que respecta a miembros del servicio desplegados, solo la parte de los ingresos de dichos miembros que se pone a disposición por estos o en su nombre al grupo familiar se contabilizará como ingresos para dicho grupo. La remuneración por combate (incluyendo la remuneración de incentivo por ampliación del despliegue) también se excluye y no se contabilizará como ingresos para el grupo familiar. Todas las demás asignaciones deben incluirse en sus ingresos brutos.

En el funcionamiento de programas de alimentación infantil, ninguna persona será discriminada por motivos de raza, color, origen nacional, sexo, edad o discapacidad.

Si tiene otras preguntas o necesita ayuda, llame al **281-325-0365**.

Atentamente,

[signature]

Effective July 1, 2025 – June 30, 2026

Household Size	Total Income									
	Annual		Monthly		Twice-Monthly		Bi-Weekly		Weekly	
No. of Household Members	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced	Free	Reduced
1	$20,345	$28,953	$1,696	$2,413	$848	$1,207	$783	$1,114	$392	$557
2	$27,495	$39,128	$2,292	$3,261	$1,146	$1,631	$1,058	$1,505	$529	$753
3	$34,645	$49,303	$2,888	$4,109	$1,444	$2,055	$1,333	$1,897	$667	$949
4	$41,795	$59,478	$3,483	$4,957	$1,742	$2,479	$1,608	$2,288	$804	$1,144
5	$48,945	$69,653	$4,079	$5,805	$2,040	$2,903	$1,883	$2,679	$942	$1,340
6	$56,095	$79,828	$4,675	$6,653	$2,338	$3,327	$2,158	$3,071	$1,079	$1,536
7	$63,245	$90,003	$5,271	$7,501	$2,636	$3,751	$2,433	$3,462	$1,217	$1,731
8	$70,395	$100,178	$5,867	$8,349	$2,934	$4,175	$2,708	$3,853	$1,354	$1,927
For each additional family member, add	+$7,150	+$10,175	+$596	+$848	+$298	+$424	+$275	+$392	+$138	+$196

These guidelines are based on 130% (free) and 185% (reduced) of the federal poverty guidelines and are effective July 1, 2025 – June 30, 2026.

Nombre de la Institución: Healthy Plate Solutions Número del acuerdo: 05001

Nombre Proveedor/Centro: _____

Programa de comida en el cuidado de niños y adultos (CACFP)
Formulario para inscripción de participantes

Estimado Padres/Tutor/Curador,

Su centro de cuidado diurno participa en el Programa de comida en el cuidado de niños y adultos (CACFP por sus siglas en Inglés) del Departamento de Argricultura de Estados Unidos (USDA). El participante inscrito recibirá comidas y refrigerios nutritivos sin costo alguno para usted. CACFP necisita que se verifique la inscripción de cada participante en este centro. Sírvase llenar la sección de padres/tutor/curador de este formulario, fírmelo y devuélvalo al Proveedor/Centro arriba indicado. Suministre información sobre sólo un (1) participante por formulario. **(Para que la institución sea reembolsada por las comidas que sirven/solicitan, se deberá llenar un formulario para cada participante inscrito todos los años.)**

Padres/Tutor/Curador:

Nombre del participante: _____ Feche de nacimiento: _____ Edad: _____

Sexo: ☐ Masculino ☐ Femenino Fecha en que participante se inscribió en el centro: _____

Alergias a alementos: ☐ Si ☐ No Si contestó "Si", especifique: _____

(Si el participante no puede recibir el Plan de Comidas CACFP, suministre una declarción del Proveedor de atención a la salud del participante.)

Indique los días de cuidado normal en el centro: ☐ domingo ☐ lunes ☐ martes ☐ miércoles ☐ jueves ☐ viernes ☐ sábado

Indique comidas que normalmente se comen en el centro: ☐ Desayuno ☐ Refrigerio a.m ☐ Almuerzo ☐ Refrigerio p.m ☐ Cena ☐ Refrigerio nocturn

Sírvase indicar horas normales de llegada y salla (marque a.m. o p.m.) **Llegada:** _____ ☐ am ☐ pm **Salida:** _____ ☐ am ☐ pm

Horario Escolar **Salida:** _____ ☐ am ☐ pm **Regreso:** _____ ☐ am ☐ pm

Si el participante es un bebé (0 a 11 meses de edad), sírvase llenar este cuadro. Marque todas las selecciones que corresponden a continuación:

Esta institución/centro ofrece _____ fórmula para bebés a través de CACFP. Es opción suya
(Proveedor/centro llena esta información)

usar esta fórmula o no segun las necesidades de su bebé. Las comidas para bebés provistas por la institución/centro deben cumplir con el plan de comidas para bebés, tal como lo exige 7CFR 226.20.

☐ Usaré la fórmula ofrecida por este centro. Doy permiso para que el personal del centro mezcle la fórmula o prepare los biberones para mi bebé.

☐ No usaré la fórmula ofrecida por este centro.
Do ser así ¿qué fórmula enviará usted para que su bebé la use? _____
Si la fórmula que usted proporciona es una fórmula especial, deberá presentar un declaración médica.

☐ Proporcionaré leche materna para mi bebé.

☐ Mi bebé tiene cuatro (4) meses de edad o más, y debido a su desarrollo, está listo para comidas para bebé. Yo quiero que la institución/centro le dé las siguientes comidas para bebé, las cuales se permiten conforme a 7CFR 226.20 (b)(2)(3)(4).

_____

Nota a los padres que reciben fórmula a través del Programa WIC: Su bebé tiene derecho a recibir fórmula de esta institución/centro de cuidado de niños, así como del Programa WIC. Es decisión suya decidir qué fórmula su bebé recibirá cuando esté en el centro. Si usted encuentra que está recibiendo más fórmula de la que su bebé necesita, hable con la nutrióloga de WIC o con el proveedor de atención a la salud de su bebé.

Firma Padres/Tutor/Curador: _____ Fecha: _____

Nombre en letra de imprenta: _____

Dirección: _____ Cuidad: _____ Etado: _____ C.P.: _____

Teléphono del hogar: _____

Teléphono del trabajo: _____ Indique turno de trabajo: ☐ 1° ☐ 2° ☐ 3° ☐ Otro (especifique) _____

Para uso exclusivo del Proveedor/Centro:

Firma del Proveedor/Representante del Centro: _____ Fecha: _____

Fecha en que el participant se retiró del Centro: _____

De acuerdo con la ley federal y la política del Departamento de Agricultura de Estados Unidos , se le prohíbe a la Institución discriminar debido a raza, origen nacional, sexo, edad o discapacidad. Para iniciar una reclamatión por discriminación, sírvase escribir al USDA Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 o llame al (202) 720-5964 (voz y TDD). El USDA es un proveedor y empleador de igualdad de oportunidades."

FORMULARIO DE ELEGIBILIDAD SEGÚN INGRESOS PARA BENEFICIOS DE RECEPCIÓN DE COMIDAS DEL PROGRAMA CACFP (guarderías infantiles)

Nombre de la guardería infantil o proveedor de guardería:

Parte 1. Todos los integrantes del grupo familiar

Nombre del (de los) niño(s) inscrito(s):

Nombres de todos los integrantes del grupo familiar (Primer nombre, segundo nombre, apellido)	MARQUE SI SE TRATA DE UN NIÑO BAJO CRIANZA TEMPORAL (RESPONSABILIDAD LEGAL DE UNA AGENCIA DE BIENESTAR O UN TRIBUNAL) O DE UN NIÑO SIN HOGAR. * SI TODOS LOS NIÑOS INDICADOS A CONTINUACIÓN SON NIÑOS BAJO CRIANZA TEMPORAL O SIN HOGAR, PASE A LA PARTE 5 PARA FIRMAR ESTE FORMULARIO.	MARQUE SI NO HAY INGRESOS
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Parte 2. Beneficios. Si algún integrante de su grupo familiar recibe beneficios de los programas SNAP, TANF o FDPIR, facilite el nombre y el número de elegibilidad de dicha persona. **Si nadie recibe estos beneficios, pase a la parte 3.**
NOMBRE:_____ NÚMERO DE ELEGIBILIDAD: _____

Parte 3. (Se aplica solo a padres o tutores con niños inscritos en una guardería o en grupos familiares proveedores de guarderías). Si algún integrante de su grupo familiar recibe beneficios indicados en el formulario adjunto "Lista de programas elegibles financiados con fondos federales o estatales" (*H1660*), facilite el nombre del programa y el número de elegibilidad:
NOMBRE: _____ NÚMERO DE ELEGIBILIDAD: _____
Marque aquí si no tiene número de elegibilidad ☐

ADEMÁS, SÍRVASE ADJUNTAR PRUEBAS OFICIALES DE INSCRIPCIÓN EN EL PROGRAMA MENCIONADO. Pase a la parte 4 si usted no es proveedor de guardería, no tiene un niño inscrito en una guardería o no participa en un programa calificado.

Parte 4. Ingresos brutos familiares totales: debe notificarnos su monto y su frecuencia

A. Nombre (Indique **únicamente** los integrantes del grupo familiar que devengan ingresos)	**B. Ingresos brutos y frecuencia con la que se recibieron.** **NOTE:** Los trabajadores por cuenta propia declaran los ingresos después de gastos en la casilla 1.			
	1. Ganancias del trabajo antes de deducciones	2. Bienestar, manutención infantil, pensión alimenticia	3. Pensiones, jubilación, Seguridad Social, Programa SSI, beneficios para veteranos	4. Todos los demás ingresos
(Ejemplo) *Jane Smith*	$200/semana	$ 150/dos veces al mes	$100/mes	$200/dos veces al mes
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____
	$____/____	$____/____	$____/____	$____/____

Parte 5. Firma y últimos cuatro dígitos del número de Seguro Social (debe firmar un adulto)
Un integrante adulto del grupo familiar debe firmar este formulario. **Si se completa la parte 4, el adulto que firma el formulario también debe incluir los últimos cuatro dígitos de su número de Seguro Social o marcar la casilla "No tengo un número de Seguro Social".** (Consulte la "Declaración de la Ley de Privacidad" en la página siguiente).

Certifico que toda la información incluida en este formulario es verdadera y que se declaran todos los ingresos. Entiendo que el centro o la guardería recibirá fondos federales en función de la información que facilite. Entiendo que los funcionarios del Programa CACFP pueden verificar la información. Entiendo que, si doy información falsa a sabiendas, el participante que recibe las comidas puede perder dichos beneficios y que se me puede someter a enjuiciamiento.

Firme aquí: _____ Nombre en letra de imprenta: _____

Fecha: _____

Dirección: _____ Número de teléfono: _____

Ciudad: _____ Estado: _____ Código postal: _____

Últimos cuatro dígitos del número de Seguro Social: _ _ _ _ _-_ _ _-_ _ _ _ ☐ No tengo un número de Seguro Social

FORMULARIO DE ELEGIBILIDAD SEGÚN INGRESOS PARA BENEFICIOS DE RECEPCIÓN DE COMIDAS DEL PROGRAMA CACFP (guarderías infantiles)

Parte 6. Identidades étnicas y raciales del participante (opcional)

Marque una identidad étnica:	Marque una o más identidades raciales:	
☐ Hispano o latino ☐ No hispano o latino	☐ Asiático ☐ Blanco ☐ Afroamericano	☐ Indio americano o nativo de Alaska ☐ Nativo de Hawái u otro isleño del Pacífico

Parte 7. Compartir información con otros programas (OPCIONAL)

La información anterior puede divulgarse con la finalidad de inscribir a los niños en el Programa de Seguro Médico para Niños (CHIP). Los padres o tutores no están obligados a dar su consentimiento para dicha divulgación y escoger no permitirla no afectará de manera negativa la elegibilidad del niño.

☐ **Opto por permitir que se divulgue la información de mi grupo familiar.**

☐ **No opto por permitir que se divulgue la información de mi grupo familiar.**

No complete esta parte. Es solo para uso oficial.

Conversión a ingresos anuales: semanal x 52, cada 2 semanas x 26, dos veces al mes x 24, mensual x 12

Ingresos totales: _____ Frecuencia: ☐ Semanal ☐ Cada dos (2) semanas ☐ Dos veces al mes ☐Mensual ☐ Anual
Tamaño del grupo familiar: _____

Elegibilidad categórica: ___ Fecha de retiro: _____ Elegibilidad: Gratuitas___ A precio reducido___ Rechazado___ Nivel I_____
Nivel II____

Motivo: _____

Firma del funcionario encargado de la toma de decisiones: _____ Fecha: _____

Firma del funcionario encargado de confirmaciones: _____ Fecha: _____

Firma del funcionario de seguimiento: _____ Fecha: _____

Declaración de la Ley de Privacidad.

La Ley Nacional de Almuerzos Escolares Richard B. Russell exige la información contenida en esta solicitud. No es obligatorio que facilite la información. Sin embargo, si no lo hace, no podremos otorgar aprobación al participante para recibir beneficios de comidas gratuitas o a precio reducido. Debe incluir los últimos cuatro dígitos del número de Seguro Social del integrante adulto del grupo familiar que firma la solicitud. Sin embargo, el número de Seguro Social no es obligatorio cuando usted presenta la solicitud en nombre de un niño bajo crianza temporal o si señala un identificador de elegibilidad del Programa de Asistencia Nutricional Suplementaria (SNAP), del Programa de Asistencia Temporal para Familias Necesitadas (TANF), del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) o de otro programa calificado, o bien cuando se indica que el integrante adulto del grupo familiar que firma la solicitud no tiene un número de Seguro Social. Utilizaremos su información para determinar si el participante es elegible para recibir comidas gratuitas o a precio reducido, así como para la administración y ejecución del programa.

Declaración de no discriminación.

De conformidad con la legislación federal de derechos civiles y los reglamentos y políticas en materia de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta institución tiene prohibido discriminar por motivos de raza, color, origen nacional, sexo, discapacidad, edad o represalias por actividades anteriores en materia de derechos civiles.

La información sobre programas puede estar disponible en otros idiomas distintos al inglés. Las personas con discapacidades que requieran medios alternativos de comunicación para obtener información sobre programas (por ejemplo, braille, letra grande, cinta de audio, lenguaje de señas estadounidense, etc.) deben comunicarse con la agencia estatal o local responsable que administra el programa, con USDA's TARGET llamando al (202) 720-2600 (voz y TTY) o bien ponerse en contacto con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en programas, el reclamante debe completar el formulario AD-3027 ("Formulario de presentación de quejas por discriminación en programas del USDA"), que se puede obtener en línea en https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, desde cualquier oficina del USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida al USDA. La carta debe incluir el nombre, la dirección, el número de teléfono y una descripción escrita de la presunta acción discriminatoria del reclamante con suficiente detalle con el fin de informar al secretario adjunto de derechos civiles (ASCR) sobre la naturaleza y la fecha de la presunta contravención en materia de derechos civiles. El formulario AD-3027 completado o la carta deben enviarse al USDA así:

(1) Correspondencia: U.S. Department of Agriculture (2) fax: (833) 256-1665 o (202) 690-7442; o (3) correo electrónico:program.intake@usda.gov.
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

Esta institución es un proveedor que ofrece igualdad de oportunidades.

Ven a WIC de Texas

Estamos aquí para servirte

"Gracias a WIC, ahora tengo las herramientas que necesito para asegurar que mi familia siga el camino hacia un estilo de vida saludable."

—Roxie, cliente de WIC

Como cliente de WIC, recibirás:

- Alimentos deliciosos
- Asesoramiento individualizado con nutricionistas
- Recetas sencillas de preparar
- Clases sobre nutrición
- Apoyo para la lactancia
- Evaluaciones médicas y sobre las vacunas
- Demostraciones de cocina
- Apoyo personalizado
- Actividades para niños

¿Calificas?

Ocho millones de mujeres, bebés y niños reciben beneficios de WIC. El Programa WIC va dirigido a mujeres embarazadas, nuevos padres, bebés y niños menores de cinco años. Si ya recibes Medicaid, TANF o SNAP, es posible que califiques.

Requisitos de ingresos de WIC de Texas

Número de personas en el hogar*	Ingresos mensuales	Ingresos anuales
2	$ 3,261	$ 39,128
3	$ 4,109	$ 49,303
4	$ 4,957	$ 59,478
5	$ 5,805	$ 69,653
6	$ 6,653	$ 79,828

Vigente a partir del 1 de mayo de 2025

* El número de personas en el hogar de una mujer embarazada aumenta según los bebés que espera. Si son más de seis personas, llama a la oficina local de WIC.

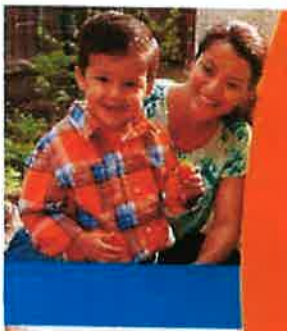
** Los ingresos también se calculan por semana o por quincena.

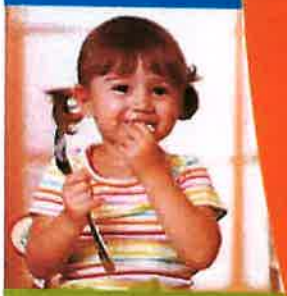
Empieza hoy mismo. Llama al 1-800-942-3678 o visita TexasWIC.org

TEXAS Health and Human Services

TEXAS WIC

Esta institución es un proveedor que ofrece igualdad de oportunidades. Rev. 5/21





Construyendo Para El Futuro

Este guardería infantile recibe asistencia monetaria del gobierno federal para server comidas nutritivas a sus niños. ¡Buena nutrición hoy significa un mañana más saludable!

Comidas servidas aquí deben de seguir los requisitos nutricionales establecidos por el programa "Child and Adult Care Food Program" del Departamento de Agricultura de los Estados Unidos (USDA por sus siglas en inglés).

¿Preguntas? ¿Inquietudes?

Llame gratuitamente a USDA al
1-866-873-2263

OR

Alimentación y Nutrición al
1-800-TELL-TDA
(835-5832)

Centro de cuidado de niños de su hijo al

Información del contacto:
Dirección
Número de teléfono
Dirección de correo electrónico
Otra información necesaria

Linea para reportar un fraude: 1-866-5-FRAUD or 1-866-537-2834
P.O. Box 12847 Austin TX 78711
www.SquareMeals.org
USDA es un proveedor y empleador que ofrece oportunidad igual para todos.

TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

Food and Nutrition Division | Child and Adult Care Food Program. Esta institución ofrece igualdad de oportunidades.

Actualizado 12/2018