

**Distribution**

- Front Desk Forms
- Child File

Enrollment Inquiry

Today's Date: ____/____/____

Person Accepting Call/Completing Tour: _____

Parent/Guardian(s) Name: _____

Address: _____ Home Phone: (____) ____-____

City: _____ State: _____ Zip: _____ Cell Phone: (____) ____-____

Email: _____ New to community? ☐ Yes ☐ No

Place of Employment: _____

Address: _____

How did you hear about Kids 'R' Kids? _____

What are you looking for in a childcare facility? _____

Program needs: (check all that apply)☐ Full-Time ☐ Part-Time ☐ Drop-In ☐ Pre-K ☐ Summer Camp☐ Before-School Care ☐ After-School Care ☐ School Holidays1. Child's Full-Name: _____ Date of Birth ____/____/____ ☐ M ☐ F2. Child's Full-Name: _____ Date of Birth ____/____/____ ☐ M ☐ F3. Child's Full-Name: _____ Date of Birth ____/____/____ ☐ M ☐ F4. Child's Full-Name: _____ Date of Birth ____/____/____ ☐ M ☐ F

Elementary/Middle School Child(ren) attends: _____

Specific Needs/Interests: _____

Follow-up: Center Use Only

Tuition Quoted: \$_____ per week/month

Mailed/emailed information: ☐ Yes ☐ No Date ____/____/____ Contents: _____

Follow-up Call: Date ____/____/____ Time: ____am/pm Comments: _____

Tour Scheduled? ☐ Yes ☐ No Tour Date: ____/____/____ Time: ____am / pmParent/Guardian Toured? ☐ Yes ☐ No Tour Date: ____/____/____ Time: ____am / pm

Tour Comments: _____

What follow-up is needed: _____



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 <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian	
Child's Home Address		Date of Admission	Date of Withdrawal
Name of Parent or Guardian Completing Form		Parent or Guardian Email Address	
List telephone numbers below where parents/guardian may be reached while child is in care.			
Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File <input type="radio"/> Yes <input type="radio"/> No
Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached			Relationship
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 telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.			
Name		Phone Number	
Name		Phone Number	
Name		Phone Number	

Consent Information

Check All That Apply:			
1. Transportation			
I give consent for my child to be transported and supervised by the operation's employees:			
<input type="checkbox"/> for emergency care	<input type="checkbox"/> on field trips	<input type="checkbox"/> to and from home	<input type="checkbox"/> to and from school
2. Field Trips			
<input type="radio"/> I give consent for my child to participate in field trips.			
<input type="radio"/> 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:

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

4. Receipt of Written Operational Policies (Check All that Apply)

I acknowledge receipt of the facility's operational policies, including those for:

☐ Discipline and guidance ☐ Procedures for release of children
☐ Suspension and expulsion ☐ Illness and exclusion criteria
☐ Emergency plans ☐ Procedures for dispensing medications
☐ Procedures for conducting health checks ☐ Immunization requirements for children
☐ Safe sleep ☐ Meals and food service practices
☐ Procedures for parents to discuss concerns with the director ☐ Procedures to visit the center without securing prior approval
☐ Procedures for parents to participate in operation activities ☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

5. Meals

I understand that the following meals will be served to my child while in care:

☐ 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		

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Phone Number
Name of Emergency Care Facility	Address	Phone Number

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

 Signature — Parent or Legal Guardian

Child's Additional Information Section

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? ☐ Yes ☐ No Plan Submitted on _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian

Date Signed

School Age Children

My child attends the following school

School Phone Number

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/her sibling under 18 years old

Authorized pick up/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.

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.

Check **only one** option:

1. ☐ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Signature — Health Care Professional

Date Signed

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

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

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

Name

Address of Health Care Professional

Signature — Parent or Legal Guardian

Date Signed

Requirements for Exclusion

- ☐ 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				<input type="radio"/> Pass	<input type="radio"/> Fail
Left				<input type="radio"/> Pass	<input type="radio"/> Fail

Signature

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)	

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
	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.	

Physician or Public Health Personnel Verification

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

Signature

Date Signed

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

Tori Peña

Center Designee

Date Signed

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specify: _____			
Does your child have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is your child on prescribed medication for Illness/Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> 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

**Distribution**

- Child's File
- Transportation Log

Transportation Agreement

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*Tori Peña*_____
Owner/Director Signature_____/_____/_____
Date_____/_____/_____
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**

- *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.

Name: _____ D.O.B.: _____

Allergic to: _____

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

**PLACE
PICTURE
HERE**

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

Extremely reactive to the following allergens: _____

THEREFORE:

- ☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- ☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

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

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

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

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

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

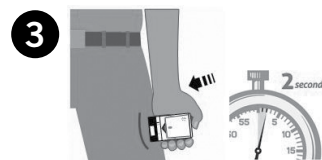
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

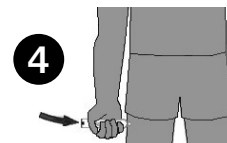
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



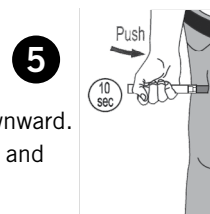
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

**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

**Distribution**

- Child's File
- Infant/Toddler Classroom Forms
- Pre-School/School-Age Classroom Forms

Child Profile

For children ages 1 and up

A new form is required with each classroom transition

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

Parent/Guardian's Name: _____

(Please Print)

1. List any nicknames your child may have. _____

2. Has your child had previous group care experiences? ☐ Yes ☐ No

3. What language(s) is spoken in your home? _____

4. List the names and ages of siblings.

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

6. What words are spoken in your home to describe everyday things (I.e. toileting, nap, eat, play and outside)?

Parent/Guardian Signature

____/____/____
Date



TUITION POLICY
(Please initial each statement)

- _____ We require a two weeks billable notice for any families leaving the center.
- _____ Tuitions is due on Friday for the upcoming week.
- _____ Tuition payments made on Monday of the week you are in are not late.
- _____ A \$35 late payment fee will be applied to your account with an unpaid balance as of the close of the center on Monday evening.
- _____ **Families out on vacation or out for general illnesses that have not taken care of tuitions previously will still be charged the appropriate late fee.**
- _____ In order to receive your ½ tuition discount for vacations and/or illnesses you must turn in the Account Adjustment Form and your account must be in good standing. Otherwise, you will be charged full tuition. Late fee policies apply for unpaid tuition/balances.
- _____ You must be in attendance for a full year (12 consecutive months) in order to receive a free vacation week. In order to receive your vacation credit you must turn in the Account Adjustment Form and your account must be in good standing. Otherwise, you will be charged full tuition.
- _____ Payments made after the close of business on Monday evening must include the \$35 late fee.
- _____ Payments made and asked to be held must include the appropriate late fee to be accepted for posting after the close of business on Monday.
- _____ Accounts with unpaid balances remaining at the close of business on Wednesday will have an additional \$35 late payment fee applied to their account.
- _____ Late fee charges can not be waived for any reason outside of immediate family medical emergencies and can only be discussed with the Director or Owner. This does not include general illness.
- _____ **If an account is still unpaid as of the close of business on Friday, your child's attendance will be suspended until the balance is taken care of. On Friday any unpaid accounts will be called to either clear your account balance or enforce suspension until payment is made in full.**
- _____ Families out on vacation or out for 5 consecutive days will pay half tuition in order to save their child's spot. This half tuition fee is due on the Friday before or the Monday of the vacation week or it will be considered late.
- _____ A Late pick-up fee of \$3.00 per minute per child will be applied to your account. We close at 6:30 and late pick-up fees will be applied for each minute starting at 6:31. For parents who are in the building no later than 6:30, your late pick-up fee will start at 6:36 for each minute that you are in the building after 6:35.

Child's Name: _____

Parent Signature: _____

Date: _____



16722 Squyres Road
Spring, Texas 77379
281/379-2998

NCI Enrollment Policy

Effective 1-1-2021

Child's Name: _____

Suite #: _____

Kids 'R' Kids Champions is proud to offer NCI as a courtesy to our families. We bill on a monthly basis. Tuition is due on the 1st of each month. Your child/children's attendance will be suspended if payment is not received **IN FULL** on the 1st. If payment is not received by the 5th of the month your enrollment will be terminated. We are happy to make weekly payment arrangements to keep your account current by the 1st of each month, however, until the account is current we will not allow attendance.

Please initial that you understand the following payment responsibilities:

_____ NCI only pays for tuition.

_____ NCI does not pay for field trips, in-house activities or enrichments.

_____ During the academic year Suites 450-Gym will go on field trips and you will be responsible for those fees.

_____ We charge \$100.00 annually per student (non-refundable) \$250 max per family. Due September 1st This fee is not covered by NCI.

_____ We charge a Summer Activity Fee for Suites 200-Gym. This fee is not covered by NCI.

_____ You are responsible for maintaining your attendance with NCI at all times and checking in/out at our Procure check in station.

_____ If NCI ends care at any time you are responsible for the tuition rates set by Kids 'R' Kids until you are re-instated with NCI.

_____ Kids 'R' Kids accepts NCI as a courtesy. We are not responsible for attendance, loss of care or renewal reminders.

I understand the above NCI Enrollment Policy. If I have any questions I understand that it is my responsibility to ask the front desk or Director.

Parent Signature

Date



Distribution
• *Child's File*

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.

KRK/REV/02/2020

Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

Discipline and Guidance Policy

Discipline must be:

- 1) Individualized and consistent for each child;
- 2) Appropriate to the child's level of understanding; and
- 3) Directed toward teaching the child acceptable behavior and self-control.

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:

- 1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
- 2) Reminding a child of behavior expectations daily by using clear, positive statements;
- 3) Redirecting behavior using positive statements; and
- 4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:

- 1) Corporal punishment or threats of corporal punishment;
- 2) Punishment associated with food, naps, or toilet training;
- 3) Pinching, shaking, or biting a child;
- 4) Hitting a child with a hand or instrument;
- 5) Putting anything in or on a child's mouth;
- 6) Humiliating, ridiculing, rejecting, or yelling at a child;
- 7) Subjecting a child to harsh, abusive, or profane language;
- 8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
- 9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures

(Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
 - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
 - (B) What behaviors would warrant the use of these measures; and
 - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date: _____

Signed by: _____

Role: ☐ Parent ☐ Caregiver/Employee ☐ Household Member (CH. 747 only)

Minimum Standards Related to Discipline

- Title 26, Chapter 746 Subchapter L: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y)
- Title 26, Chapter 747 Subchapter L: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y)
- Title 26, Chapter 744 Subchapter G: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y)

CACFP STUDENT ENROLLMENT

CM-1500

participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to annually review and make changes to enrollment data.

CHILD INFORMATION

Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Ethnic Identity (Check One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's First Name <input type="text"/>	Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander	
Child's Last Name <input type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Normal Days in Care Center's Days of Operation: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU	
Normal Hours in Care Center's Hours of Operation: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	Meals/Snacks Child Receives Meals/Snacks Served at Center: <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Ethnic Identity (Check One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Child's First Name <input type="text"/>	Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's Last Name <input type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Normal Days in Care Center's Days of Operation: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Normal Hours in Care Center's Hours of Operation: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	Meals/Snacks Child Receives Meals/Snacks Served at Center: <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS	
Center Enroll Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Ethnic Identity (Check One) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's First Name <input type="text"/>	Racial Identity (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Am. Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander	
Child's Last Name <input type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Child's Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Normal Days in Care Center's Days of Operation: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU	
Normal Hours in Care Center's Hours of Operation: <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM to <input type="text"/> <input type="checkbox"/> AM <input type="checkbox"/> PM	Meals/Snacks Child Receives Meals/Snacks Served at Center: <input type="checkbox"/> BRK <input type="checkbox"/> AMS <input type="checkbox"/> LUN <input type="checkbox"/> PMS <input type="checkbox"/> SUP <input type="checkbox"/> EVS	SITE / SPONSOR USE ONLY Withdrawal Date: <input type="text"/> / <input type="text"/> / <input type="text"/> Re-Enroll Date: <input type="text"/> / <input type="text"/> / <input type="text"/>

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature

Date

Parent First Name

Parent Last Name

Cell Phone

SITE / SPONSOR USE ONLY

Non - Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; This institution is an equal opportunity provider.

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

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

Part 1: List all enrolled children and household members.

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

Part 3: Skip this part.

Part 4: Skip this part.

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

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

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

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

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

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

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

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

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

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

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

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

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

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

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

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

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

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

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

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

Part 2: Skip this part.

Part 3: Skip this part.

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

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

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

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

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

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

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

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

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

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



Center Name _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)**Part 1. All Household Members****Name of Enrolled Child(ren):** _____**Names of all household members**
(First, Middle Initial, Last)CHECK IF A FOSTER CHILD (THE
LEGAL RESPONSIBILITY OF A
WELFARE AGENCY OR COURT)
* IF ALL CHILDREN LISTED BELOW
ARE FOSTER CHILDREN, SKIP TO
PART 5 TO SIGN THIS FORM.CHECK
IF NO INCOME☐
☐
☐
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☐
☐
☐**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME _____ ELIGIBILITY NUMBER: _____Check here if no eligibility number ☐**Part 4. Total Household Gross Income—You must tell us how much and how often**

A. Name (List only household members with income) (Example) Jane Smith	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
	\$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:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ 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 meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

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

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

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

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

This institution is an equal opportunity provider.

Infant Declaration Form:

Child Care Center Name _____

INSTRUCTIONS TO PARENTS:

Complete **BOTH** sections on this form. Sign and date where indicated. Submit to child care provider.

Section 1

Infant's Name _____ Birth Date ____/____/____

Parent's Name _____

My Child is allergic to the following foods:

(A Doctor's note is required for any foods that cannot be substituted within the same food group.)

Section 2

Your child care provider offers the following infant formula(s): _____

Parent Declaration - **Select only ONE of the following options.**

☐

Center will provide ALL meal components for infant named above.

OR

☐

Parent will provide ALL meal components for infant named above.

OR

☐

BOTH PARENT and CENTER will provide meal components for infant named above, as indicated below:

	<u>0-5 Months</u>	<u>6-11 Months</u>
() Center OR () Parent will provide Iron Fortified Infant Formula / Breast Milk	()	()
Infant Formula Brand Name: _____		
() Center OR () Parent will provide Iron Fortified Infant Cereal		()
() Center OR () Parent will provide Infant Fruits/Vegetables		()
() Center OR () Parent will provide Infant Meats		()
() Center OR () Parent will provide Crusty Bread/Crackers		()

*** This form must be updated and submitted any time there is a change in Section 2.

I understand that once my infant child turns 6 months of age, it is my responsibility to notify the child care center director as to any limitations of solid foods that my infant child is not developmentally ready to receive.

Parent Signature (_____)____-____-____/____/____
Parent Phone Number Date

Please include your phone number so our CACFP Sponsor can contact you if they have any questions.

For Sponsor Use Only



TO ENSURE A WELL ROUNDED PROGRAM, KRK INCLUDES THE FOLLOWING ENRICHMENT PROGRAMS IN YOUR WEEKLY TUITION:



Physical education class every Tuesday!



ABCMouse.com®
Early Learning Academy

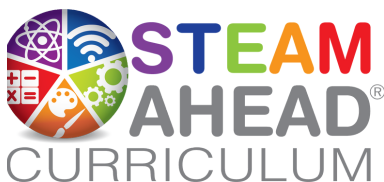
Complimentary
ABC Mouse membership



Music education class with Mr. Craig every Thursday!



Kids 'R' Kids exclusive Bran Waves Curriculum focused on brain development



Supplementary preschool curriculum that focus on science, technology, engineering, arts and math

More information on classroom enrichments schedules can be found on the class parent information board