EARLY EDUCATION CENTER

ENROLLMENT PACKET
TODDLER/EHS
TODDLER/PRESCHOOL/PKC

Educating and empowering children ages 6 weeks through 12 years

315 King Street
Pottstown, PA 19464
P: 610-323-1888

301 King Street
Pottstown, PA 19464
P: 484-949-8291

YWCA Tri-County Area is proud to offer Pennsylvania Keystone stars approved child care. Keystone Stars provides Standards, Training, Assistance, Resources and support (STARS) to qualifying child care centers that choose to exceed state Department of Human Service health and safety certification standards.

YW3CA IS ON A MISSION TO ... EDUCATE CHILDREN

www.ywcatricountyarea.org  @ywcatricountyarea
<table>
<thead>
<tr>
<th>CHILD’S NAME</th>
<th>BIRTHDATE</th>
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<tbody>
<tr>
<td>MOTHER’S NAME/LEGAL GUARDIAN</td>
<td>BIRTHDATE</td>
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<tr>
<td>ADDRESS</td>
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<tr>
<td>BUSINESS NAME</td>
<td>EMAIL ADDRESS</td>
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<tr>
<td>ADDRESS</td>
<td>CELL PHONE</td>
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<tr>
<td>EMAIL</td>
<td>BUSINESS TELEPHONE NUMBER</td>
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| FATHER’S NAME/LEGAL GUARDIAN | BIRTHDATE |
| ADDRESS | SOCIAL SECURITY # |
| BUSINESS NAME | HOME TELEPHONE NUMBER |
| ADDRESS | CELL PHONE |
| EMAIL | BUSINESS TELEPHONE NUMBER |

| EMERGENCY CONTACT PERSON(S) | NAME | TELEPHONE NUMBER |

| PERSON(S) TO WHOM CHILD MAY BE RELEASED | NAME | ADDRESS | TELEPHONE NUMBER |

| NAME OF CHILD’S PHYSICIAN/MEDICAL CARE PROVIDER | TELEPHONE NUMBER |
| ADDRESS | |

| SPECIAL DISABILITIES (IF ANY) | ALLERGIES (INCLUDING MEDICATION REACTION) |
| MEDICAL OR DIETARY INFO NECESSARY IN AN EMERGENCY SITUATION | MEDICATION, SPECIAL CONDITIONS |
| ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD |

Email Address—print clearly

| HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS | POLICY NUMBER (REQUIRED) |

| PARENT’S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT |
| OBTAINING EMERGENCY MEDICAL CARE | ADMIN OF MINOR FIRST-AID PROCEDURES |
| WALKS AND TRIPS | SWIMMING |
| TRANSPORTATION BY THE FACILITY | WASHING |
| PERIODIC REVIEW |

| SIGNATURE OF PARENT OR GUARDIAN | DATE |

| SIGNATURE OF PARENT OR GUARDIAN | DATE |
Child’s Name:  
Date of Birth:  

Child’s Arrival Time: ________________  Child’s Departure Time: ________________  Admission Date: ________________

☐ ELRC (please check only if enrolled in ELRC)  ELRC Caseworker name: ____________________________

## Tuition Fees:

*Effective 9/2017-Includes breakfast, lunch, snack, and baby wipes for the early childhood education program. Subsidy may not cover full cost of tuition and there may be an additional fee. All tuition cost and fees are evaluated annually. You will receive 30 day notice on any changes to tuition fee.

New families: Registration Cost per family (One - time payment which includes current year activity fee):

$30

Returning families: Annual Activity Cost per family (Due at the beginning of each school year):

$25

Days attending:

Full week ___ Monday___ Tuesday___ Wednesday___ Thursday___ Friday___

___Infant (6 weeks to 12 mos.) – select days attending above:
5 days $332  5 half days $223.25  Daily Full Day $66.40  Daily Half Day $45

___Younger Toddler (12 to 24 mos.) - select days attending above:
5 days $322.75  5 half days $209  Daily Full Day $64.55  Daily Half Day $45

___Older Toddler (24 – 35 mos.) – select days attending above:
5 days $309.75  5 half days $196  Daily Full Day $61.95  Daily Half Day $340

___Preschool (36 mos. – entering kindergarten) – select days attending above:
5 days $265  5 half days $155  Daily Full Day $53  Daily Half Day $40

___Pre-K Counts (before and after-school) – select days attending above:
5 days $166  Before Only $66  After Only $100  Before Daily $15  After Daily $25

___School Age (before and after-school) – select days attending above:
5 days $166  Before Only $66  After Only $100  Before Daily $15  After Daily $25

**Fee Agreement and Contract Terms (some policies do not apply or may vary for CCIS families):**

PLEASE READ AND INITIAL EACH TERM:

**Contract Terms:**

1. _____I agree to notify the center by 9:00am when child is absent.  I must notify center staff if my school age child does not need to be picked up from school or will not arrive at their designated van stop.

2. _____YWCA Tri-County Area reserves the right to dis-enroll any child without notice if it is in the best interest of the child or the program.  This will not occur without appropriate attempts being made to resolve any issues or concerns.  _____A one time, non-refundable family Registration Fee of $30 is to be paid at time of Enrollment.  An annual family activity fee of $25 will be due each year at the time of re-enrollment application is submitted.

3. _____The [Child Health Assessment Form must be completed and submitted] within 30 days in order for your child to attend the Early Childhood Education Center. If Assessment is not received on the 30th day they will not be permitted to return until Child Health Assessment Is received.

**Fee Agreement:**

4. _____The Center is open from 6:30 a.m. to 6:30 p.m. Monday through Friday.  A late pick-up fee of $1 per minute per child will be charged when a child is left past the center’s closing time.  If an authorized persons does not pick up my child and/or do not contact the center, and after the center staff exhaust all attempts to reach authorized persons, as per state child care licensing
5. _____ Tuition fees are not pro-rated for illness, holidays, or emergency closures of the center.
6. _____ Families will not be charged for any YWCA full day business closures.
7. _____ Weekly tuition is due each Monday. Tuition payments can be made by check, money order or credit card only. Make checks payable to YWCA Tri-County Area.
8. _____ Private pay family discounts are provided for those with more than one child in attendance at YWCA. The discount is 10% off of the lowest tuition in each family.
9. _____ Accounts that are two weeks behind may result in immediate termination of service; however, once balance is paid, the child may return into care. (Subsidized families adhere to policies contracted with CCIS regarding delinquent copays.)
10. _____ The terms of this Agreement, including tuition, fees and policies are able to be changed by YWCA Tri-County Area with 30 days’ notice. This agreement can be terminated by the center at any time.
11. _____ There will be a $30.00 charge for checks returned for insufficient funds. Payments should be made at the main office. Full payment is required in spite of absences.

Persons to whom child may be released:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone Number while child in care</th>
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I certify that I have read, understand and accept all of the terms and conditions in the Parent/Guardian Agreement.

Parent/Guardian Signature  ___________________________ Date: ____________

Center Director Signature  ___________________________ Date: ____________

Parent/Guardian Signature  ___________________________ Date of six month review: ____________

Center Director Signature  ___________________________ Date of six month review: ____________

YWCA Tri-County Area

YWCA Finance Department Use Only

Tuition and copays do not fluctuate based on child’s attendance

<table>
<thead>
<tr>
<th>Reason for Tuition/Copay Adjustment</th>
<th>Amount of Adjustment</th>
<th>Total Tuition</th>
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<tbody>
<tr>
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Date of Withdrawal: ________________ Reason: _____________________________________________________________
We want your child’s transition from our Early Education Center to another educational environment to be smooth and without interruption to his/her educational progress. During your child’s stay with us, we will be accumulating periodic assessments of your child’s developmental progress and samples of artwork and writing skills. These records are valuable tools for child care providers and kindergarten teachers to best work with your child at his/her level.

By signing this release, you are giving YWCA Tri-County Area Early Education Centers the authority to pass your child’s records on to another child care provider you may be enrolling with or to the school district for review prior to your child entering kindergarten.

I give my permission for ____________________ records to be transferred to the school district in preparation for kindergarten or to another child care provider should I enroll my child with a different child care provider.

I also understand that I may have a copy of my child’s records at any time.

____________________________________                                               _________________
     Parent’s Signature                                                                                                                  Date

____________________________________
     Print Name

_____CC      _____P
I hereby agree and consent to the use of photographs taken of my child for assessment, classroom use, and advertising and publicity purposes. I waive all claims for any compensation for such use or for damages.

Description of Use: Photo will appear on YW3CA Facebook page, Twitter, in newspapers, newsletters, videos, and in Tadpoles and Teaching Strategies Gold portfolio and publications involving the Early Education Center. These photos may be shared with you via email. Please include your email address below.

Print name of minor to be photographed________________________________________

Signature of Parent or Guardian________________________________________________________________________________________

Print name of above signatory________________________________________________

Print email address______________________________________________________________________________________________

Address___________________________________________________________________________________________________________

Date__________________________

______CC _______ P

(12/28/15)
CIVIL RIGHTS COMPLIANCE
PARENT AWARENESS

In accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as a resident of this agency, have the right:

To be provided services at this agency and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, age or sex.

To file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, ancestry, national origin, age or sex.

Complaints of discrimination may be filed with any of the following:

YWCA Tri-County Area
315 King Street
Pottstown, PA 19464

Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

U. S. Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

PA Human Relations Commission
Philadelphia Regional Office
110 N. 8th Street
Suite 501
Philadelphia, PA 19107

Commonwealth of Pennsylvania
DHS Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

____________________________________
Parent/Guardian Signature  Date

____________________________________
Staff Signature    Date

(6/24/19 kis)
# CHILD HEALTH REPORT

(55 PA CODE 553270.131, 3280.131 AND 3290.131)

**CHILD'S NAME:** (LAST) (FIRST)   
**PARENT/GUARDIAN:** 
**DATE OF BIRTH:**   
**HOME PHONE:**   
**ADDRESS:** 
**CHILD CARE FACILITY NAME:** 
**FACILITY PHONE:**   
**COUNTY:** 
**WORK PHONE:** 

- [ ] I authorize the child care staff and my child’s health professional to communicate directly if needed to clarify information on this form about my child. 
- [ ] PARENT'S SIGNATURE: 

---

**DO NOT OMIT ANY INFORMATION**

This form may be updated by a health professional. Initial date and any new data. The child care facility needs a copy of the form.

- [ ] HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): 
  - [ ] NONE

- [ ] MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRE ECONOMY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
  - [ ] NONE

- [ ] CHILD'S ALLERGIES (DESCRIBE, IF ANY):
  - [ ] NONE

- [ ] LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
  - [ ] NONE

---

**IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?**

- [ ] YES  [ ] NO

- [ ] IF NO, PLEASE EXPLAIN YOUR ANSWER:

---

**HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS (SEE SCHEDULE AT WWW.AAP.ORG)?**

---

**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL IF THE SCREENING WAS ABNORMAL. PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**

**VISION** (subjective until age 3) 
**HEARING** (subjective until age 4) 
**LEAD**

---

**RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD’S IMMUNIZATION RECORD**

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>DATE</th>
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<th>DATE</th>
<th>COMMENTS</th>
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<td>OTHER</td>
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**MEDICAL CARE PROVIDER:**  
**SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN’S ASSISTANT:**

**ADDRESS:**  
**PHONE:**  
**LICENSE NUMBER:**  
**DATE FORM SIGNED:**
Authorization to Obtain/Release Information

I, ___________________________________, authorize **YWCA Tri-County Area** to obtain

(Parent/Guardian Full Name)

and/or release information, as well as communicate with, the following individuals and/or

organizations including school districts, in an effort to coordinate services for

______________________________.

(child’s name)

<table>
<thead>
<tr>
<th>Name of Organization, School District</th>
<th>Contact Person</th>
<th>Address</th>
<th>Phone number</th>
<th>Fax Number</th>
<th>Email Address</th>
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I understand that I may revoke this authorization at any time by contacting the YWCA Tri County Area Child Care Director.

__________________________________________  ________________________
(Signature of Parent/Guardian)                    (Date)

__________________________________________  ________________________
(Signature of Child Care Director)    (Date)
**CHILD’S NAME**


**ARRIVAL**
What time will you usually arrive at the Early Education Center?

What will help you and your child say good-bye to each other in the morning?

**DIAPERING AND TOILETING**
What type of diapers do you use? (EHS provides diapers)

How often do you change your child’s diaper? When does your child usually need a diaper change?

Are there any special instructions for diaper changes?

Is your child beginning to use the toilet? If so, are there any special instructions for toileting?

What are the words your family uses to talk about toileting?
Are there any special terminology for private parts?  ____ YES  ____ NO

**SLEEPING**

How will we know that your child is tired and need to sleep?

When does your child usually sleep? For how long does he or she usually sleep?

What helps your child to fall asleep?

We put babies to sleep on their backs. Is your baby used to sleeping on his or her back?  ____ YES  ____ NO

Does your toddler sleep in a bed?  ____ YES  ____ NO

How does your child wake up? Does he or she wake up quickly or slowly? Does your child like to be taken out of the crib/cot immediately or to lie alone in the crib a few minutes before being held?

**EATING**

*Babies:*

Are you breast-feeding or bottle feeding your baby?  ____ YES  ____ NO
If breast-feeding, will you come to the center to breast-feed?  ____YES  ____ NO
If so, at what times?

If not, will you send expressed breast milk?  ____YES  ____ NO

If bottle feeding,
What kind of formula do you use?

How do you prepare the bottles?

How much do you prepare at a time?

How much does your baby drink at one time?

Does your baby drink bottles of water during the day?  ____YES  ____ NO
If so, when and how much?

Is your baby eating solid foods?  ____YES  ____ NO
If so, which ones?
When?

How do you prepare your baby’s solid foods?

How much does your baby eat at one time?

How is your baby used to being fed (in what position)?

Does your baby eat any finger foods?  ____YES  ____ NO

If so, which ones?

All Children:
What are some of your child’s favorite foods?

What foods does your child dislike?

Is your child sensitive or allergic to any foods?  ____YES  ____ NO
Are there any foods you don’t want your child to eat?

**Dressing**
Is there anything special that we should know about dressing and undressing your child?

**Awake Time**
How does your baby like to be held? What position does your baby prefer when awake?

What does your child like to do when awake?

How do you play with your child?

**Departure**
What time will you usually come to pick up your child?
What will help you and your child say hello to each other at the end of the day?

**Additional Questions:**

**Family Information:**
Tell me about your household (neighborhood, names of people living in the home and relationship to child)

Does your child have any parents who do not live in the home? ____YES  ____ NO
Which parent(s)?

Does your child visit parent(s)? ____YES  ____ NO
Additional details you’d like to share:

Are there any custody issues we should discuss? ____YES  ____ NO
Additional details you’d like to share:

Does your child have any siblings (please list names, ages)? ____YES  ____ NO

Does your child have any pets? ____YES  ____ NO
Names of Pets:

Does your child have any nicknames for family members? ____YES  ____ NO
Additional details you’d like to share:
Is there any other information about your family you’d like to share:

**Child information**
Has your child been in an early learning program or child care before? ____YES  ____ NO

If yes, would you share some information with us (where, what kind of care, when, for how long)?

Is there a reason for leaving the program you would like to share with us? ____YES  ____ NO

Do you have any of your child’s records from that program? ____YES  ____ NO

How does your child react to other children and adults?

What do you think will happen the first day you leave your child with us?

Does your child have any imaginary friends? ____YES  ____ NO

Additional details you’d like to share:

Are there any special problems or fears that we should know about? ____YES  ____ NO

Additional details you’d like to share:
Are there any special needs we should know about? ____ YES  ____ NO

Additional details you’d like to share:

Do any special need require special care from our teachers? ____ YES  ____ NO

Additional details you’d like to share:

Does your child have an IEP (Individual Education Plan) or IFSP (Individualized Family Service Plan)?

_____ YES  _____ NO

If so, we’d like a copy of the plan so we can provide the best possible learning experience for your child.

What program(s) or individuals work with your child?

Are you willing to sign a release with them so we can speak to them about how to provide the best support for your child? ____ YES  ____ NO

Does your child have any allergies (consider food, environmental or medicine allergies)?

_____ YES  _____ NO

Additional details you’d like to share:
How are allergies treated?

Is there any special medical or dietary information we should have in an emergency situation (medicine to keep on hand, people to call, etc.)?

Any other medical or special needs information?

Is there any additional information you would like to share?
45 Day Family Meeting

Enrollment Date: ________________________________

Meeting Date: ________________________________

Family Members Attending: __________________________________________________________

____________________________________
Family refused meeting    ____YES    ____NO

Comments:

We have had the opportunity to meet with my child’s teacher to review my child’s progress to date and to make revisions on this form, if necessary.

____________________________________  ________________________________
Family Member (guardian)       Date

____________________________________  ________________________________
Teacher                  Date
### Medical Plan of Care for Child Nutrition Programs (CACFP and SFSP)

**Please read pages 1 and 2 before completing this form.**

<table>
<thead>
<tr>
<th>Participant’s Name</th>
<th>Date of Birth</th>
<th>Age/Classroom</th>
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<tbody>
<tr>
<td>Name of Center/Program/Site</td>
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<tr>
<td>Name of Parent/Guardian or Participant’s Representative</td>
<td>Phone Number of Parent/Guardian/Representative</td>
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<tr>
<td>Signature of Parent/Guardian or Participant’s Representative</td>
<td>Date</td>
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1. **Provide an explanation below of how the participant’s physical or mental impairment restricts the participant’s diet:**

2. **Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the participant’s needs:**

3. **List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. Foods to be omitted:**

4. **Suggested substitutions:**

5. **Indicate texture modifications, if applicable:**
   - [ ] Chopped/Cut into bite-sized pieces
   - [ ] Diced/Finely Ground
   - [ ] Pureed
   - [ ] Other: _

6. **List any required special adaptive equipment:**

**Name of Physician/Medical Authority & Title (Please Print)**

**Provider Phone Number**

**Signature of Physician/Medical Authority**

**Date**

**Signing the following section is optional, but may prevent delays by allowing the Program to speak with the physician/medical authority.**

**Health Insurance Portability and Accountability Act Waiver**

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize ______________________ (medical authority) to release such protected health information of the participant as is necessary for the specific purpose of Special Diet Information to ______________________ (center/program/site) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning the participant with the childcare/adult care/summer food program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for the participant. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on __________ (date). This information is to be released for the specific purpose of Special Diet Information. The undersigned certifies that he/she is **(circle one):** Parent, Guardian, Adult participant or Representative of participant listed on this document and has the legal authority to sign on behalf of that person.

**Signature:**

**Date:**

Revised August 2017
## Child and Adult Care Food Program

**Child Enrollment Form (Sample)**

**ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)**

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

**PARENTS:** This institution 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 and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

### Full Name of Enrolled Child (Include Birth Date/Age)

<table>
<thead>
<tr>
<th>Days of Week in Attendance</th>
<th>Time-In</th>
<th>Time-Out</th>
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<tbody>
<tr>
<td></td>
<td>AM</td>
<td>PM</td>
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<tr>
<td><strong>First Child</strong></td>
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<tr>
<td>Name</td>
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<tr>
<td>Birth Date</td>
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<tr>
<td>Age</td>
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**Time-In Normally Attends During Week**

- AM
- PM
- Time
days
- Leaves Center
- Returns to Center

**Time-Out Normally Attends During Week**

- AM
- PM
- Time
days
- Leaves Center
- Returns to Center

**Meals Received**

- Breakfast
- A.M. Snack
- Lunch
- P.M. Snack
- Supper
- Evening Snack

**Enrollment Date:**

**Withdrawal Date:**

### Second Child

- Same as Above
- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

**Time-In Normally Attends During Week**

- AM
- PM
- Time
days
- Leaves Center
- Returns to Center

**Time-Out Normally Attends During Week**

- AM
- PM
- Time
days
- Leaves Center
- Returns to Center

**Meals Received**

- Same as Above
- Breakfast
- A.M. Snack
- Lunch
- P.M. Snack
- Supper
- Evening Snack

**Enrollment Date:**

**Withdrawal Date:**

### Third Child

- Same as Above
- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

**Time-In Normally Attends During Week**

- AM
- PM
- Time
days
- Leaves Center
- Returns to Center

**Time-Out Normally Attends During Week**

- AM
- PM
- Time
days
- Leaves Center
- Returns to Center

**Meals Received**

- Same as Above
- Breakfast
- A.M. Snack
- Lunch
- P.M. Snack
- Supper
- Evening Snack

**Enrollment Date:**

**Withdrawal Date:**

**Signature of Parent or Guardian**

**Date**

**Telephone Number of Parent or Guardian**

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**Child Care Representative Use Only:**

**Name of Representative/Signature**

**Date**

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

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3. **email:** program.intake@usda.gov.

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