

Discovery Years Early Learning Center  
Director: Darlene Seaman  
7020 Fry Road, Cypress, TX 77433  
(281) 861-8755 | discoverycypress.com

## Enrollment Application

Please do not leave blanks and print clearly.  
Por favor no deje espacios en blanco y escriba claramente.

(Office Use | Uso en oficina)

/ /  
Date of Admission | Fecha de admision

### Child's Information | Información del Niño

Full Name | Nombre Completo

Home Address | Dirección de Casa

Date of Birth | Fecha de Nacimiento

City, State, Zip | Ciudad, Estado, Código Postal

Home Phone Number | Número de Teléfono de Casa

My child will normally be in attendance the following days and times | Mi hijo asistirá normalmente los siguientes días y horas

Monday | Lunes

Tuesday | Martes

Wednesday | Miércoles

Thursday | Jueves

Friday | Viernes

From | De: Until | Hasta:

### Parent One's Information | Información del padre

### Parent Two's Information | Información del padre dos

Full Name | Nombre Completo

Full Name | Nombre Completo

Relationship to Child | Relación con el Niño

Relationship to Child | Relación con el Niño

Lives with Child | Vive con el Niño

Lives with Child | Vive con el Niño

Yes | Sí  No | No  Other | Otro

Yes | Sí  No | No  Other | Otro

Work Phone Number | Número de Teléfono del Trabajo

Work Phone Number | Número de Teléfono del Trabajo

Home/Cell Phone Number | Número de Teléfono de Casa/Celular

Home/Cell Phone Number | Número de Teléfono de Casa/Celular

Home Address | Dirección de Casa

Home Address | Dirección de Casa

City, State, Zip | Ciudad, Estado, Código Postal

City, State, Zip | Ciudad, Estado, Código Postal

Email Address | Dirección de Correo Electrónico

Email Address | Dirección de Correo Electrónico

Place of Employment | Lugar de Empleo

Place of Employment | Lugar de Empleo

Work Address | Dirección de Trabajo

Work Address | Dirección de Trabajo

Is there a custody order? | ¿Existe una orden de custodia?

Yes\* | Sí\*  No | No  Pending | Pendiente

\*If yes, a current copy of the court order must be attached.

\*En caso afirmativo, debe adjuntarse una copia actualizada de la orden judicial.

### Emergency Contacts and Alternative Pickups | Contactos de Emergencia y Alternativas de Recogida

Please list the names and phone numbers of the people to contact if the parents are unable to be reached in an emergency, as well as anyone that is authorized to pickup the child. Sign your initials for each role a person is authorized for.

Indique los nombres y números de teléfono de las personas de contacto en caso de que no se pueda localizar a los padres en caso de emergencia, así como de las personas autorizadas para recoger al niño. Firme con sus iniciales cada función para la que esté autorizada una persona.

Full Name | Nombre Completo

Phone Number | Número de Teléfono

Emergency Contact

Contacto de Emergencia

Authorized to Pickup Child

Autorizada para Niño de Recogida

Full Name | Nombre Completo

Phone Number | Número de Teléfono

Initials | Iniciales

Initials | Iniciales

Full Name | Nombre Completo

Phone Number | Número de Teléfono

Initials | Iniciales

Initials | Iniciales

Full Name | Nombre Completo

Phone Number | Número de Teléfono

Initials | Iniciales

Initials | Iniciales

Full Name | Nombre Completo

Phone Number | Número de Teléfono

Initials | Iniciales

### My Child Attends The Following School | Mi Hijo Asiste a la Siguiente Escuela

School Name | Nombre de la Escuela

School Address | Dirección de la Escuela

City, State, Zip | Ciudad, Estado, Código postal

Phone Number | Número de teléfono

Child's Special Care Needs (Check all that apply) | Necesidades especiales del niño (Marque todas las que procedan)

- |                                                                                                                                       |                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Environmental Allergies   Alergias Ambientales                                                               | <input type="checkbox"/> Has Benadryl   Tiene Benadryl                                   |
| <input type="checkbox"/> Food Allergies   Alergias Alimentarias                                                                       | <input type="checkbox"/> Has Epinephrine Autoinjector   Tiene autoinyector de epinefrina |
| <input type="checkbox"/> Asthma   Asma                                                                                                | <input type="checkbox"/> Has Daily Inhaler   Tiene Inhalador Diario                      |
|                                                                                                                                       | <input type="checkbox"/> Has rescue inhaler   Tiene inhalador de rescate                 |
| <input type="checkbox"/> Food Intolerances   Intolerancias Alimentarias                                                               | <input type="checkbox"/> Injuries and Hospitalizations   Lesiones y hospitalizaciones    |
| <input type="checkbox"/> Adaptive Equipment   Equipos de adaptación                                                                   | <input type="checkbox"/> Existing Illnesses   Enfermedades Existentes                    |
| <input type="checkbox"/> Limitations or restrictions on child's activities   Limitaciones o restricciones de las actividades del niño |                                                                                          |
| <input type="checkbox"/> Reasonable accommodations or modifications   Adaptaciones o modificaciones razonables                        |                                                                                          |
| <input type="checkbox"/> Symptoms or indications of complications   Síntomas o indicios de complicaciones                             |                                                                                          |
| <input type="checkbox"/> Medications prescribed for long-term use   Medicamentos prescritos a largo plazo                             |                                                                                          |
| <input type="checkbox"/> Medications for use as needed   Medicamentos para uso según sea necesario                                    |                                                                                          |
| <input type="checkbox"/> None of the above   Ninguna de las anteriores                                                                |                                                                                          |

Explain any needs selected above | Explique las necesidades seleccionadas

I have submitted a Food Allergy Emergency Plan. | He presentado un Plan de emergencia para alergias alimentarias.

Sign  
Here

Signed | Firmado

Dated | Fechado

/ /

I give consent for Discovery Years to post my child's allergies and medications in the classroom.  
Doy mi consentimiento para que Discovery Years publique las alergias y medicamentos de mi hijo en el aula.

Sign  
Here

Signed | Firmado

Dated | Fechado

/ /

#### Emergency Medical Care | Asistencia Médica de Urgencia

In the event I can't be reached to arrange for emergency medical care, I authorize the person in charge to take my child to the following facility:  
En caso de que no se me pueda localizar para organizar la atención médica de urgencia, autorizo a la persona encargada a llevar a mi hijo al siguiente centro:

Name of Physician | Nombre del Médico

Phone Number | Número de Teléfono

Address | Dirección

Name of Emergency Care Facility | Nombre del Centro de Urgencias

Phone Number | Número de Teléfono

Address | Dirección

I give consent for Discovery Years and any medical professionals they deem necessary, to secure any and all necessary emergency medical care for my child.  
Doy mi consentimiento para que Discovery Years y cualquier profesional médico que considere necesario, asegure cualquier y toda la atención médica de emergencia necesaria para mí hijo.

Sign  
Here

Signed | Firmado

Dated | Fechado

/ /

#### Consent Declarations | Declaraciones de Consentimiento

I give consent for my child to be transported and supervised by the operation's employees for the following purposes:  
Doy mi consentimiento para que mi hijo sea transportado y supervisado por los empleados de la operación para los siguientes fines:

- |                                                                              |                                                                                      |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> For emergency care   Para atención de urgencia      | <input type="checkbox"/> For emergency evacuations   Para evacuaciones de emergencia |
| <input type="checkbox"/> To and from school   Para ir y volver de la escuela | <input type="checkbox"/> On field trips   En las excursiones                         |
| <input type="checkbox"/> To and from home   Desde y hacia casa               |                                                                                      |

- I give consent for my child to participate in field trips.  
Doy mi consentimiento para que mi hijo participe en excursiones.

I give consent for my child to participate in the following water activities:

Doy mi consentimiento para que mi hijo participe en las siguientes actividades acuáticas:

- |                                                                                       |                                                                        |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Water table play   Mesa de agua                              | <input type="checkbox"/> Aquatic playgrounds   Parques acuáticos       |
| <input type="checkbox"/> Sprinkler play   Juego de aspersores                         | <input type="checkbox"/> Water slides   Toboganes acuáticos            |
| <input type="checkbox"/> Splashing or wading pools   Piscinas para chapotear o vadear | <input type="checkbox"/> Splash pads   Protectores contra salpicaduras |

From time to time we may take photographs to document and share the children's experiences.

De vez en cuando podemos tomar fotografías para documentar y compartir las experiencias de los niños.

- I give consent for Discovery Years to take photographs of my child and waive any consideration due.  
Doy mi consentimiento para que Discovery Years tome fotografías de mi hijo/a y renuncio a cualquier contraprestación debida.

- I would like my child to be excluded from any photographs taken.  
Deseo que se excluya a mi hijo de las fotografías que se tomen.

Sign  
Here

Signed | Firmado

Dated | Fechado

/ /

## Medical Compliance | Cumplimiento Médico

You must attest to one of the following statements within one week of admission.

Debe dar fe de una de las siguientes declaraciones en el plazo de una semana a partir de su admisión.

My child is currently attending pre-kindergarten or school away from Discovery Years.  
Mi hijo asiste actualmente a preescolar o a una escuela fuera de Discovery Years.

A signed and dated copy of a healthcare professional statement is attached stating the child is able to attend.  
Se adjunta una copia firmada y fechada de la declaración de un profesional sanitario en la que se indica que el niño puede asistir.

Medical diagnosis and treatment conflict with the tenants and practices of our recognized religious organization, which I adhere to or and a member of. I have attached a signed and dated affidavit stating this.  
El diagnóstico y el tratamiento médicos entran en conflicto con los principios y prácticas de nuestra organización religiosa reconocida, a la que me adhiero o de la que soy miembro. He adjuntado una declaración jurada firmada y fechada en la que se afirma lo anterior.

My child has been examined within the past year by the following health care professional and is able to participate in the daycare program. Within 12 months of admission I will obtain a healthcare professional's signed statement and submit it to the child care operation.  
Mi hijo ha sido examinado en el último año por un profesional sanitario y puede participar en el programa de la guardería. Dentro de los 12 meses siguientes a la admisión, obtendré una declaración firmada por un profesional de la salud y la presentaré a la guardería.

Name of Physician | Nombre del Médico

Phone Number | Número de Teléfono

You must attest to one of the following statements:  
Debe dar fe de una de las siguientes afirmaciones:

I have attached a signed and dated copy this child's vaccine record.  
He adjuntado una copia firmada y fechada de la cartilla de vacunación de este niño.

My child's immunization records are on file at their school and are current.  
La cartilla de vacunación de mi hijo está archivada en la escuela y está al día.

I have attached a signed and dated affidavit stating that I declined immunizations for reason of conscience, including religious belief, no later than the 90th day after that affidavit is notarized.  
He adjuntado una declaración jurada firmada y fechada en la que declino la vacunación por motivos de conciencia, incluidas las creencias religiosas, a más tardar 90 días después de que dicha declaración jurada sea notariada.

If your child turns 4 on or after September 1st, you must attest to one of the following statements:  
Si su hijo cumple 4 años el 1 de septiembre o después, debe dar fe de una de las siguientes afirmaciones:

I have attached a signed and dated copy this child's hearing and vision screening records.  
He adjuntado una copia firmada y fechada de las pruebas de audición y visión de este niño.

My child's hearing and vision screening records are on file at their school and are current.  
Los registros de las pruebas de audición y visión de mi hijo están archivados en su escuela y están actualizados.

I have attached a signed and dated affidavit stating that vision or hearing screening conflicts with the tenants and practices of a church or religious denomination that I am an adherent or member of.  
He adjuntado una declaración jurada, firmada y fechada, en la que afirmo que los conflictos relacionados con las pruebas de visión o audición son prácticas de una iglesia o confesión religiosa a la que pertenezco o de la que soy miembro.

My child had varicella disease chicken pox on or about the below date and does not need varicella vaccine.  
Mi hijo tuvo varicela en la fecha indicada a continuación o alrededor de esa fecha y no necesita la vacuna contra la varicela.

/ /

### Acknowledgements | Agradecimientos

I acknowledge and understand that breakfast, lunch, and afternoon snack will be served.  
Reconozco y entiendo que se servirá desayuno, almuerzo y merienda.

**Sign Here**  
Signed | Firmado

Dated | Fechado / /

I acknowledge receipt of the facilities operational policies including those for discipline and guidance.  
Acuso recibo de las políticas de funcionamiento de las instalaciones, incluidas las de disciplina y orientación.

**Sign Here**  
Signed | Firmado

Dated | Fechado / /

I acknowledge that I have received a copy of my rights as a parent or guardian of a child enrolled at this daycare.  
Reconozco que he recibido una copia de mis derechos como padre o tutor de un niño inscrito en esta guardería.

**Sign Here**  
Signed | Firmado

Dated | Fechado / /

I hereby certify that, to the best of my knowledge, all of the provided information in this application is true and accurate.  
Por la presente certifico que, a mi leal saber y entender, toda la información facilitada en esta solicitud es verdadera y exacta.

**Sign Here**  
Signed | Firmado

Dated | Fechado / /



## Parent Orientation Checklist

Name of child: \_\_\_\_\_

Name of parent/guardian: \_\_\_\_\_

- Opportunity to tour the facility
  - Introduction to the teaching staff
  - Parent visit with the classroom teacher
  - Overview of the parent handbook
  - Policy for arrival and late arrival
  - Opportunity for an extended visit in the classroom by both myself and my child for a period of time to allow us both to be comfortable
  - Explanation of the Texas Rising Star Program
  - Encouragement to share elements of my CCS enrollment so that the provider may assist, if applicable
  - Family support resources and activities in the community
  - Child development and developmental milestones
- Expectations of families:
- The significance of consistent arrival time, including:
    - before the educational portion of the school begins
    - impact of disrupting other children's' learning
    - the importance of consistent routines in preparing children for the transition to Kindergarten
  - Statement about limiting technology use on site to improve communication between staff, children and families
  - Statement reflecting the role and influence of families

I acknowledge receipt of the above information.

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Parent/Guardian Signature

Date



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Staff Signature

Date

Measure: P-FE-01



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

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

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

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

**Part 3:** Skip this part.

**Part 4:** Skip this part.

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

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

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

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

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

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

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Skip this part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Part 2:** Skip this part.

**Part 3:** Skip this part.

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

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

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

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

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

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

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

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

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

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

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

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



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### Part 1. All Household Members

Name of Enrolled Child(ren):

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

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

NAME: \_\_\_\_\_ ELIGIBILITY NUMBER: \_\_\_\_\_

**Part 3. (Applies only to parents/guardians with children enrolled in a day care home)** If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: \_\_\_\_\_ ELIGIBILITY NUMBER: \_\_\_\_\_

Check here if no eligibility number

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

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

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

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

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

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Last four digits of Social Security Number: \* \* \* - \* \* - \_\_\_\_\_  I do not have a Social Security Number



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity: Mark one or more racial identities:

- |                                                 |                                                    |                                                                    |
|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Hispanic or Latino     | <input type="checkbox"/> Asian                     | <input type="checkbox"/> American Indian or Alaska Native          |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> White                     | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
|                                                 | <input type="checkbox"/> Black or African American |                                                                    |

### Part 7. Sharing Information With Other Programs: OPTIONAL

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

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

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

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

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

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

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

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

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

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

### Privacy Act Statement:

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

### Non-discrimination Statement:

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

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

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

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

This institution is an equal opportunity provider.

**NEW**  **UPDATE**  **DROP IN**

Institution Name: Anita Moreau Food Program Specialist

Agreement Number: \_\_\_\_\_

Facility/Provider Name: Discovery Years 2

### **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  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.	Today's Date 6 - 11 months

*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: \_\_\_\_\_

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA Director Office of Adjudication and Compliance, 1400 Independence Avenue SW, Washington, DC 20250-9401 or call (866) 632-9992, (202) 260-1026 or (202) 401-0216 (TDD). This institution is an equal opportunity provider and employer.



# **Discovery Years**

## **Early Learning Center**

### **Doctor's Statement**

### **Declaración Del Médico**

**NOTE:** Please do not forget to get a copy of your child's vaccination records, and hearing and vision screening records!

**NOTA:** No olvide obtener una copia de la cartilla de vacunación de su hijo, así como de sus pruebas de audición y visión.

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**Child's Name**

Nombre del niño

I have examined the above named child within the past 12 months and have found them to be in good health, and free from any contagious disease. They may participate in all group activities.

He examinado al niño arriba mencionado en los últimos 12 meses y he comprobado que goza de buena salud y no padece ninguna enfermedad contagiosa. Pueden participar en todas las actividades del grupo.

**Physician's Name:**

Nombre del médico: \_\_\_\_\_

**Address:**

Dirección: \_\_\_\_\_

**Phone:**

Teléfono: \_\_\_\_\_

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**Physician's Signature**

Firma del médico

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**Date**

Fecha



# **Emergency Preparedness Plan**

Discovery Years Early Learning Center  
7020 Fry Rd  
Cypress, TX 77433

## **When Fire Alarm Sounds**

Teachers must take their classroom roll sheets and all their students to the fence at the rear of the property. Each teacher is then responsible for taking roll for their class. Once all children are accounted for, teachers and students should stay put, and wait for further instructions. When the “all clear” signal is given, everyone may reenter the building, and report back to their respective classroom.

## **Emergency Evacuation Plan**

If relocation is needed during an emergency such as fire, flood, toxic fumes, etc. The first responsibility of staff is to move children to a designated safe area.

### **Designated safe area:**

Discovery Years Early Learning Center  
6847 Addicks Satsuma  
Houston, TX 77084  
(281) 861-0404

Teachers will accompany children to the barn area and secure the gate behind them. They will supervise the children until the buses arrive. To facilitate boarding, teachers will remove a few fence boards so that children can board the bus one by one. A roll call will be conducted to ensure all children are accounted for. In case of an emergency, information for contacting parents and adhering to childcare licensing requirements can be found in the emergency preparedness binder. It is the teachers' responsibility to ensure the safety and well-being of the children.

## **In Case of Inclement Weather**

Teachers must take their classroom roll sheets and all their students to the hall nearest their room. Students should be instructed to sit, facing the either wall (north or south), with their heads in their laps, and their hands over their heads. Each teacher is then responsible for taking roll for their class. Once all children are accounted for, the teachers should assume the same sitting position as the children and wait for further instructions. When the “all Clear” signal is given, everyone may report back to their respective classrooms.

