

## **G. Child's preadmission record**

DHR-CDC-739

## **CHILD' S PREADMISSION RECORD**

**This section is to be completed by the child's parent or guardian. This form must be kept in the child's file in the Child Care Facility (home/center).**

Child's Name:	Name child is known by:
Child's birthdate:	Child's home address:
Name(s) of parent(s)/guardian(s):	Home telephone number: (      )
Address of parent(s)/guardian(s):	
Mother's Employer:	Father's Employer:
Mother's Email Address:	Father's Email Address:
Employer's address:	Employer's address:
Employer's Telephone Number: (      )	Employer's Telephone Number: (      )
List telephone numbers such as pager, cellular phone, etc.	Instructions regarding how parent/guardian may be reached in an emergency:

**Person(s) to be contacted in an emergency if parent(s)/guardian(s) cannot be reached:**

Name	Relationship to child	Address	Telephone number

Name of child's doctor:	Address:	Telephone number: (        )
-------------------------	----------	---------------------------------

## **Emergency Authorization:**

**EMERGENCY Authorization:** I give permission for the child care facility to obtain emergency medical treatment, including emergency transportation, for my child if I cannot be reached immediately. I agree to be responsible for any emergency medical expenses incurred. *(If parent/guardian refuses to sign, instructions must be attached stating what procedure the facility is to follow in an emergency.)*

**Signature**

Date

**Form not valid without signature of child's parent/guardian**  
*Page one of two-form not valid without second page*

*Child's Preadmission Record (continued) - page two of two - form not valid without first page*

Describe any special needs or instructions below:


Person(s) the child may be released to:

Name	Relationship to child	Address	Telephone number

***I understand that the Department of Human Resources does not inspect activities away from the child care facility (home or center). The licensee of the child care facility assumes full responsibility for such activities.***

\_\_\_\_\_  
*Signature of parent/guardian*

\_\_\_\_\_  
*Date*

I give permission for my child to participate in:

(Circle yes or no and sign each line)

Activities away from the facility:	<input type="checkbox"/> yes	<input type="checkbox"/> no	Signature of parent/guardian	Date
Transportation provided by the facility:	<input type="checkbox"/> yes	<input type="checkbox"/> no	Signature of parent/guardian	Date
Swimming/wading activities provided by the facility:	<input type="checkbox"/> yes	<input type="checkbox"/> no	Signature of parent/guardian	Date

**Form not valid without signature of child's parent/guardian in each space indicated above.**

This section is to be completed by the facility's staff.

Child's first day of attendance: \_\_\_\_\_ Child's withdrawal date: \_\_\_\_\_

*Additional information may be attached.*

## AGREEMENT PAGE

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

I have read and understand the Parent Handbook and agree to abide by the policies and procedures as stated.

Parent/Guardian: \_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print)

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

# Emergency Preparedness and Response Plan

## Agreement Page

I have read and understand and agree with  
the Emergency Preparedness and Response  
Plan.

Sign:

Date:

## CHILD CARE FOOD PROGRAM

(Household Letter for Non-Pricing Programs in Child Care Centers)

To: The Household Member

From: The Official Representative of the Sponsor

(Name of Center or Organization) Higher Heights Learning Center

Please help us to comply with the requirements of the USDA Child and Adult Care Food Program (CACFP). The information requested on this Income Eligibility Form (IEF) is necessary in order for us to receive reimbursement for meals served to participants in our center. The form will be placed in our files and will be treated as confidential information.

### INSTRUCTIONS FOR COMPLETING THE INCOME ELIGIBILITY FORM

**PART 1 - ENROLLED CHILDREN:** Print names of all children in household who are enrolled in the center. List the date of birth for each child. If a child is enrolled in Head Start or Even Start, is a foster child or the legal responsibility of the Welfare Agency or a court, or the child is homeless, indicate by marking the appropriate box.

**PART 2 – IF ANY MEMBER OF THE HOUSEHOLDS RECEIVES SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) OR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF):**

1. List the type of benefit SNAP or TANF.
2. List that person's current SNAP or TANF case number.
3. Sign the form in PART 4. An adult household member must sign. **SKIP PART 3**

#### PART 3 – HOUSEHOLD INCOME

1. List the names of all household members not listed in part one. Include yourself, children not enrolled in the center, your spouse, grandparents, and other related and unrelated people in your household. Use a separate sheet of paper if you need more space.
2. Write the amount of income each person now receives on the same line as their name, how often the person receives it, such as weekly, every two weeks, twice a month or monthly, and where it comes from. Income is all money before taxes or anything else is taken out. If any amount last month was more or less than usual, write that person's usual monthly income. If any of the household members receive no income, check the box in the last column.
3. Complete PART 4.

The participant in the day care facility may qualify for free or reduced priced meals if their household income falls within the limits on the current Evaluation Sheet for Income Eligibility.

#### PART 4 - SIGNATURE AND SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART

1. An adult household member must sign the form.
2. The form must have the last four digits of the social security number of the adult who signs **if part 3 was completed**. If the adult does not have a social security number, select the box indicating this. If all children in a family are foster children, a social security number is not required.

**PART 5 – ETHNIC AND RACIAL IDENTITY:** This information is requested solely for the purpose of determining compliance with Federal civil rights laws and will not affect your approval. If you do not mark this, a visual identification will be made and recorded.

**Confidentiality:** The information on the application is used only to determine eligibility for free or reduced-price meals and to verify eligibility.

The information reported on this form is valid for one year. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

### 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, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or 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 discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at [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](mailto:program.intake@usda.gov).

USDA is an equal opportunity provider, employer, and lender.

# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) FY: \_\_\_\_\_

**Part 1. Enrolled Children: list names of all enrolled children**

Names of all enrolled children: Use additional pages if necessary (First and Last)	BIRTH DATE MM/DD/YYYY	CHECK IF IN HEAD/EVEN START	CHECK IF FOSTER CHILD	CHECK IF HOMELESS CHILD
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

TYPE OF BENEFIT: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

**Part 3. Total Household Gross Income — You must tell us how much and how often**

A. Name – First and Last (List only household members not listed in Part 1)	B. Gross Income and how often it was received				
	For example \$200/week or \$150/twice a month				
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. Other Income	5. Check if income
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>

**Part 4. Signature and Last Four Digits of Social Security Number (Adult must sign)** - An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number, mark the "I do not have a Social Security Number" box. (See Privacy Act Statement below)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give; that center officials may verify the information on the form; and that deliberate misrepresentation of the information subject me to prosecution under applicable State and Federal laws.

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

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

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

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

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) case number for the participant or other (FDPIR) identifier or when you indicate that the 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.

**Part 5. 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"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other

**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

Household size: \_\_\_\_\_ Total Annual Income: \_\_\_\_\_ SNAP/TANF Household: \_\_\_\_\_

Determination for: Free Meals \_\_\_\_\_ Reduced-Price Meals \_\_\_\_\_ Paid Meals \_\_\_\_\_ # Foster free \_\_\_\_\_ # Head/Even Start Free \_\_\_\_\_

# Homeless Free \_\_\_\_\_

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