A PLACE FOR CHILDREN - RICHMOND
6355 S Peek Rd
Richmond, TX 77407
832-321-3323

ENROLLMENT FORM

Today's Date _____ Start Date _____Referred By_____
Child's Name _____SSN#_____ - _____- _____ Date of Birth_____
Classroom: _____ Phone Number _____
Street Address: _____ State _____ Zip Code_____
Mother's Name: _____ Father's Name: _____
Mother's SSN#: _____ Father's SSN#: _____
Mother's DL: _____ Father's DL: _____
Work Address: _____ Work Address: _____
Zip Code: _____ Phone#:_____ Zip Code: _____ Phone#:_____

When a child is brought to the center, they will be left in the presence of a staff member. Please list persona approved to pick up your child, other than parents, and to be contacted in case of an emergency.

Name: _____ Phone: _____
Name: _____ Phone: _____

Emergency Release

Consent to emergency first aid and transportation:
I hereby give permission that my child, _____, may be given emergency treatment by a staff member at A Place for Children Learning Center, I also give permission for my child to be transported by car or ambulance to an emergency center for treatment.
Parent's signature_____ date _____

Consent to Medical Care and Treatment

In the event that I cannot be contacted immediately, medical and surgical treatment can be administrated to my child in case of an accident or emergency, presented by a treating physician.
Parent's signature_____ date _____

The license shall not be responsible for proving or paying for child health care or emergency care. I agree that neither I nor my child will bring any claims of any kind against A Place for Children Learning Center and its employees as a result of any injuries, expenses or damages that I or my child may suffer in any way or the use of our facilities toys, teachers or other children.
Dr._____ Address _____Phone_____

Permission for water activities, field trips and transportation as per the school requirements:
Yes _____ No_____

Consent to Medical Care and Treatment

Medicine _____ Food _____ Allergy _____
I hereby acknowledge the above and receipt the Parent Handbook of Policies and Procedures.
Person signing contract are responsible for payment. I have read it and understand it.
Signature _____ Date_____

Admission Information

Texas Dept of Family and Protective Services | Form 2935 | Aug 2010

Operation Name _____ Director Name _____

Childs full name _____ Child's date of birth _____ Child's home telephone _____

Child's Home Address _____

Date of Admission _____ Date of withdrawal _____

Parent's or Guardian's name _____ Address (if different from child address) _____

List telephone numbers below where parent/guardian may be reach while child will be in care:
Mother Telephone No. _____ Father Telephone No. _____

Guardian Telephone No. _____ Cell Phone _____

Give the name, address, phone number of person to call in case of an emergency if parents / guardian cannot be reached _____
_____ Relationship _____
I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name, telephone number for each. Children will only be released to a parent or person designated by the parent/guardian after verification of ID's
_____ | _____ | _____

1. Check all that apply: I hereby give [ ] don't give [ ]

Transportation [ ]

- Consent for my child to be transported and supervised by the operation's employees

Walk home [ ] for emergency [ ] on field trips [ ] to and from home [ ] to and from school

2. Check all that apply: I hereby give [ ] don't give [ ]

Field Trips [ ]

- My consent for my child to participate in field trips:

Parents Comments:

_____
_____

3. Check all that apply: I hereby give [ ] don't give [ ]

Water activities [ ]

- My consent for my child to participate in water activates:

[ ] sprinkler play [ ] splashing pools [ ] swimming pools [ ] water table play

4. [ ] RECEIPT OF WRITTEN OPERATION POLICIES

- I acknowledge receipt of the facility operational policies including those of discipline and guidance.

5. I UNDERSTAND THAT THE FOLLOWING MEALS WILL BE SERVED TO MY CHILD WHILE IN CARE:

[ ] None [ ] Breakfast [ ] AM Snack [ ] Lunch [ ] PM Snack [ ] Supper [ ] Evening Snack

6. MY CHILD IS NORMALLY IN CARE ON THE FOLLOWING DAYS AND TIMES:

[ ] Monday	From:	To:
[ ] Tuesday	From:	To:
[ ] Wednesday	From:	To:
[ ] Thursday	From:	To:
[ ] Friday	From:	To:
[ ] Saturday	From:	To:
[ ] Sunday	From:	To:

AUTHORIZATION FOR EMERGENCY ATTENTION:

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

Name of physicians: _____ Address: _____ Phone: _____

Name of emergency medical care facility: _____ Address: _____ Phone: _____

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

_____

Parent or Legal Guardian signature

List any special problems you child may have such as allergies, existing illnesses, previous serious illnesses, injuries and hospitalizations during the past 12 months, any medication prescribed for the long-term continuous use. Along with any other information the caregiver should be aware of

_____

_____

Childcare 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 or (800) 514-0383

SCHOOL AGE CHILDREN:

☐ My child attends the following school:

_____ _____

Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

☐ His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.

Name of sibling(s):

My child has permission to: ☐ walk to or from school or home, ☐ ride a bus, and/or ☐ be released to the care of his/her sibling(s) under 18 years old.

IMMUNIZATION RECORD:

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

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.

Please 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 / she is able to take part in the day care program.

_____ _____

Health Care Professional's Signature Date

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 will submit it to the child-care operation.

Name and address of health care professional:

_____ _____

Signature - Parent or Legal Guardian Date

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____

Signature – Parent or Legal Guardian Date

Discipline and Guidance Policy for _____

Name of Operation

- 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; and
  (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

_____ _____

Signature Date

Check one please:

☐ parent ☐ employee/caregiver ☐ household member of child-care home

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members CODE:A294

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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

NAME:_____ CASE 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 case number: NAME: _____ CASE NUMBER: _____

Check here if no case 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**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

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

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

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

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ 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) case 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: This explains what to do if you believe you have been treated unfairly. "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, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

This Center participates in the Child and Adult Care Food Program and provides meals to all children enrolled in this Center regardless of race, color, national origin, sex, age, disability, religion, or political belief.

Food Program Enrollment Form

Sponsor Name: **FP Assistance – (866) 454-3663**

Center Name: _____ CODE: A294

Child's Name: _____ Date of Birth: _____ Age: ___

Admission date: _____ Withdrawal Date: _____

1. Circle the days that your child will normally attend the Center:

   Mon Tue Wed Thu Fri Sat Sun

2. Circle the meals normally served to your child in the Center:

   Breakfast AM Snack Lunch PM Snack Supper Evening Snack

3. What hours will your child normally be in the Center:

   ____:_____ to ____:_____

_____ _____

Parent Signature Date of Signature

(_____) _____-_____

Day Time Phone Number

Please take the time to complete the attached MBIE form. The information will be kept confidential at the Sponsors Office.

Thank you,

FP Assistance

F R D