EAST UNION EARLY CHILDHOOD CENTER

2017 - 2018 Registration/Enrollment Form

Application forms may be returned to the Early Childhood Center Director

641-347-5790

1916 High School Drive, Afton, Iowa 50830

_____ _____ _____

Child's full name Birth date Home Telephone Number

_____ _____

Parent/Guardian 1 Parent/Guardian 2

_____ _____

Cell Number Parent/Guardian 1 Cell Number Parent/Guardian 2

_____ _____

Child's Address Town and Zip code

_____ _____

Parent/Guardian 1 (if living in home) Employer & Work Phone Hours worked per week

_____ _____

Parent/Guardian 2 (if living in home) Employer & Work Phone Hours worked per week

Parent 1 email address_____Parent 2 email address_____

Emergency Contact is not a parent. We will always try to reach a parent first.

Emergency Contact #1_____Phone #_____

Emergency Contact #2_____Phone #_____

Name of Doctor_____Insurance Provider_____

Bus Transportation: AM PM Bus Driver/Number:_____

TOTAL NUMBER OF PEOPLE LIVING IN HOUSEHOLD _____

All household GROSS income needs to be included below (meaning support, alimony, Social Security and income of all people within household). Automatic Qualifiers include the following: AFDC/FIP, Food Stamp Number, And Foster Child. Please indicate if your earned income is weekly, biweekly, monthly or yearly. All applicants must submit 30 days of most recent paycheck stub(s) or a copy of their 2016 Income Tax Forms for proof of income (If you do not have your 2016 taxes completed you may turn in 2015 until they are available).

Gross Earned Income _____ Weekly, Biweekly, Monthly, Yearly (circle one)

Total Other Support Income _____ (child support, social security, disability, etc)

I understand I am responsible for tuition charges for days registered regardless of attendance, and that a $5.00 late fee will be added each week for balances over $20.00.

Registered days of attendance: Full Time_____ Part Time_____

Mon _____ Tue _____ Wed _____ Thurs _____ Fri _____

Parent/Guardian Signature_____ Date_____

OFFICE USE ONLY

Registration paid_____ FOB #_____

Start Date_____ Weekly Charge_____

East Union Early Childhood Center

PROGRAM: The program is open Monday-Friday, 6:30-6:00 year round. Breakfast, lunch and a snack will be available at set times. School bus transportation is available for four year olds, the same as for the district K-12 student population.

AGE: Your child may attend if they are be 2 ½ (30 mo.) to age five to be eligible for the 2017-2018 program year. A BIRTH CERTIFICATE IS REQUIRED with application (photocopy accepted).

REQUIREMENTS

All students that attend East Union Early Childhood Center must have the following items. They must present a birth certificate at the time of turning in the child's registration. Your child's teacher will be doing a home visit in August prior to the start of school. We require the following documents: current physical (no more than one year old), lead test, and current immunization documentation. Students will be required to have a dental exam within 90 days of entering the program. A registration fee (non-refundable) of $30.00 per child with a max of $50.00 per family will be required when registering.

CLASS SIZE

East Union Early Childhood Center will follow NAEYC Accreditation child teacher ratios. Classrooms will have a licensed certified early childhood teacher during preschool hours and assistant teachers as needed to maintain ratios. Sometimes High School Service Learning Students or adult volunteers may be providing additional assistance to the regular staff.

FINANCIAL STATUS REQUIREMENTS AND CHANGES

Each household will need to complete a Free/Reduced Lunch Form before the start of school year. If a student is already participating in East Union Early Childhood Center and there is a change in their household's financial situation, the head of the household is to contact the Center Director and request a new F/R Form to complete. No student will be put out of the program due to any financial status change in his or her household.

2017 - 2018 FEES

Full day preschool

Age 2 ½ - 3 @ $120.00 wk

Age 4 - 5 @ $115.00 wk

Part Time

Age 2 ½ - 3 @ $90.00 wk

Age 4 - 5 @ $85.00 wk

2nd child discount of 10% on the oldest (lowest fee) child

The East Union Early Childhood rate **does** include the cost of meals.

Families qualifying for reduced meals will receive first priority for grant dollars for tuition.

Families that do not qualify for free or reduced lunches (full pay) may still qualify for grant dollars towards tuition.

Contact Hope Hall Center Director with any questions - office 641-347-5790 or cell 641-344-0565

East Union Early Childhood Center
MEDICATION POLICY AND PROCEDURES

1) All medication (prescription and non-prescription) will be administered and stored in a locked container by center personnel certified in medication administration. No medication shall be kept by students.

2) Prescription medication must be brought to school in the original pharmacy labeled container. A note from the prescribing physician should accompany the medicine if there are any special instructions that vary from the container label. Parents must give special permission for the school to administer the medicine. The note should include the time(s) of day the medication is to be given.

3) Non-prescription medication should be brought in the original labeled container with the student's name and the amount to be given. Parents MUST also give written permission and instructions as to how the medication should be given.

4) Students shall take at least one dose of medication at home before school staff will administer the medication.

5) Only staff certified in medication administration shall administer medication. Staff certified in medication administration will have on file an annual written performance evaluation completed by a licensed health professional regarding the five right practices of medication administration, which are:
    1. Verify that the right child receives the medication.
    2. Verify the right medication is being given.
    3. Verify that the right dose is given.
    4. Verify that the dose is given at the right time.
    5. Verify that the dosage is given by the right method with signed documentation each time.

POLICY PROCEDURES MUST BE FOLLWED AT ALL TIMES

Please contact Hope Hall (641-347-5790) or school nurse at (641-347-5411) if you have any questions regarding the medication policy and procedures.

I have read and understand the above medication policy and procedures.

_____ _____

Parent/Guardian Signature Date

6/08/10

CONFIDENTIALITY POLICY

While volunteering in the classroom, all observations concerning the children and families in the program are kept confidential!

East Union Early Childhood Center program requires files and records to be completed on your child and you may review these records at any time.

Your child's complete file is kept at the center where your child is enrolled. These files are kept in a locked file cabinet.

Agencies/personnel that view my child's file:

- East Union Community School District Administration
- East Union Community School District Financial
- East Union School Nurse
- Area Education Association Mental Health Professional
- Area Education Association Audiology (hearing) specialists
- Area Education Association Speech and Language specialists
- Union County Nurse Consultant, Sharon Campbell, R.N.
- East Union Early Childhood Center staff

NO VOLUNTEER WORKER WILL HAVE ACCESS TO THESE FILES!

Only with a parent's written consent will any information be shared with any other agency or unauthorized persons. Information shared will be used for the purpose of needed services and the developmental needs of the below named child.

This is to verify that I have received the East Union Early Childhood Center Confidentiality Policy. I have read the above policy, it has been explained and I understand the procedure.

CHILD'S NAME _____
(Print Clearly)

SIGNATURE OF
PARENT or GUARDIAN _____

DATE ____/____/____

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

Please Print:

Student's Last Name:	Student's First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home): (mobile):	
Address: Street	City:	County:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female

Treatment Needs (check ONE):

☐ Yes ☐ No **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ Yes ☐ No **Requires Dental Care** – tooth decay or a white spot lesion is suspected in one or more teeth.

☐ Yes ☐ No **Requires Urgent Dental Care** – obvious tooth decay is present in one or more teeth, the child is experiencing pain, or there is evidence of infection or injury.

Definitions:

Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.

White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. A white spot lesion is considered an early indicator of tooth decay, especially in primary teeth.

Date of Dental Screening: _____

Provider Type*:
☐ DDS ☐ RDH ☐ MD/DO ☐ PA ☐ Nurse *High school screening can only be provided by DDS or RDH.

Provider Name: _____ Provider Signature: _____

Business Address: _____

Business Phone: _____

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.

Iowa Department of Public Health, Oral Health Bureau
515-281-3733 • 866-528-4020 • http://www.idph.state.ia.us/hpcdp/oral_health.asp

7/1/08

Deleted: o

MATURA Action I-Smile™ Program
Head Start Consent Form and Release of Information

Child's Name:		Age	Date of Birth
Street address/city:	Phone:		
Doctor:	Dentist:		
Medicaid ID number:	Race of child:	____ Girl ____ Boy	

_____ Yes, I give permission for my child to a dental screening and a fluoride varnish application.

_____ No, I do not give permission for my child to receive dental services.

Please answer the following medical questions.

1. Does your child have a regular medical doctor? ____Yes ____No
   When was your child's last doctor visit? _____
2. Are your child's immunizations (shots) up to date? ____Yes ____No
3. Does your child have medical insurance? ____Yes ____No
4. Is your child taking any medications right now? ____Yes ____No
5. Is your child allergic to anything? ____Yes ____No

   If you answered Yes to #4 or #5 please list: _____

_____

Please answer the following dental questions.

1. Does your child have a regular dentist? ____Yes ____No
   If yes, how often does your child see that dentist? Every 6 months OR Yearly
2. Your child's most recent dental visit was within the past: (check one)
   _____ 6 months ____ 1 year ____ 3 years ____ 5years ____Has never seen a dentist
3. How do you pay for your child's dental care? (check one)
   ____ Self-Pay ____ Medicaid/Title19 ____ *hawk-i* ____ Private dental insurance ____ Other

- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Bureaus of Family Health or Oral and Health Delivery Systems, or designee.
- I understand this consent is good for 1(one) year unless withdrawn in writing by the parent or guardian.
- **This Dental service does not replace your child's regular Dental visits.**

_____

Parent or Guardian Signature Printed Name Date

I voluntarily authorize MATURA Action to release, obtain, or exchange information with the following: physicians, dentists, schools and Head Start staff .
This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

_____

Parent/Guardian Signature **Date**

University of Iowa Children's Hospital®
University of Iowa Health Care

Iowa KidSight Consent Form

Date of Screening:_____

Has this child seen an eye doctor within the last year? ☐ No ☐ Yes
If yes, the screening is not necessary. Continue appointments with your eye doctor.

Free vision screening will be offered to children by a local Lions Club. Screenings are in conjunction with Iowa KidSight, in the Department of Ophthalmology and Visual Sciences at University of Iowa Children's Hospital. Vision screening produces images of a child's eyes to determine the presence of eye disorders including far- and near-sightedness, astigmatism, anisometropia (unequal refractive power), strabismus, (misaligned eyes), and media opacities (e.g., cataracts). No physical contact is made with a child and no eye drops are used during the vision screening. This screening is approximately 85-90% effective in detecting problems that can cause reduced vision.

Participation is voluntary. This screening is designed for pre-school-aged children. Children who are younger than 6-months old will not be screened. No child will be screened without a signed and completed consent form. Each individual child needs his/her own consent form. If you have questions, please contact: Iowa KidSight, 2431 Coral Court #5, Coralville, Iowa 52241, or 319-353-7616, or kidsight@uiowa.edu.

Please print or type the information below:

Child's Name _____ (_____)
First **Middle** **Last** **Initials**

Male _____ **Female** _____ **Child's Date of Birth** _____/_____/_____ **Child's Age** _____
(MM/DD/YY)

Parent's Name _____

Address _____ **City** _____ **Zip** _____

Home Phone (_____**)**_____ **Work Phone (**_____**)**_____

Cell Phone (_____**)**_____ **E-mail address** _____

I, the undersigned, hereby give permission for my child, _____, to participate in the screening event. I understand the following regarding this program:

1. The information obtained from this screening is preliminary only and does not constitute a diagnosis of vision problems.
2. I will be contacted with the results of the screening through Iowa KidSight at University of Iowa Children's Hospital, or through my child care provider who aided in arranging the screening. I may be contacted regarding follow-up for vision referral by Iowa KidSight staff at University of Iowa Children's Hospital.
3. This screening result may satisfy the requirement for vision screening upon entry to kindergarten, and may be recorded in the Iowa Immunization Registry.
4. I am responsible for arranging a full eye examination with a doctor of my choosing if my child has been referred as a result of the vision screening. Iowa KidSight recommends a dilated eye examination.
5. The results of your child's eye examination will be shared with Iowa KidSight as a means to help evaluate the screening program's effectiveness.
6. Iowa KidSight will maintain the confidentiality of all records and results.
7. I will not hold the Lions Club and its volunteers, Lions Clubs organizations, University of Iowa Children's Hospital, or affiliates, accountable for any errors of commission, omission or other misdiagnosis. There are no foreseeable risks to participating in the Iowa KidSight vision screening.

_____ _____
Signature of Parent or Guardian **Date**

Revised 7-2016

Suggested Goals
Suggestions for Child's Education Plan/Parent Input

Mark the goals that you would like your child to master this school year.

Education

Recognize basic colors
Use scissors appropriately - Thumb in the thumb hole
Cut on straight/curved line
Recognize his/her name
Print first name
Print last name
Practice holding pencil properly
Practice drawing, lines, shapes, persons
Learn concepts such as on, under, beside, between etc.
Simple object counting such as three, five, or seven objects
Recognize/use common objects such as comb, pencil, scissors, etc.
Know first name . . . when asked, will say first, middle and last names
Address – town and street and house number
Names shapes and/or recognize
Able to work on a 5-8-piece puzzle
Listen to a story for 5-10 minutes
Can identify some body parts
Follow directions
Develop longer attention span
Recall words in songs/finger plays
Hears and discriminates the beginning sounds in language
Beginning letter formation
Know that print carries a message
Identifies some alphabet letters
Identifies all 26 letters of alphabet lower and upper case
Arrange things in a series (small to large)
Recognizes patterns and can repeat them
Make comparisons (big/little tall/short)
Identifies some numbers
Identifies 10 numbers
Count one-to-one correspondence to 10
Count to 20
Write some numbers
Knows and recites their birth date

Nutrition

Taste each food served including "new" foods
Use good manners at table using words such as "please pass," and "thank you"
Use appropriate language and voice level at table
Pours liquids and drinks at meal times
Use utensils properly and serve self
Clean up spills
Remains at table for meal time.

Mental Health

Share with peers through play and conversation
Express his/her feelings with words rather than actions such as hitting, pushing, etc.
Keeps hands to self
Ability to be part of a group and walk in a line as a group
Use appropriate language and voice level in classroom and outside
Accept praise and encouragement
Recognize the importance of being an individual through art expression and individual encouragement
Ask for help when needed
Take turns . . . will wait for his/her turn
Follow rules
Gain attention in an appropriate way such as asking nicely

Physical/Health

Uses bathroom independently
Flush stool and wash hands after using the bathroom
Cover cough with hand
Get Kleenex, use appropriately and dispose of properly when needed
Put on coat, hat, mittens, boots, shoes for self
Zip/snap own clothing
Wash hands before snacks/breakfast and lunch
Use toothbrush properly
Improve coordination (walks, runs, hops, etc.)
Walks backward and frontward when directed
Throws ball/beanbag with coordination or catches ball/beanbag
Can draw a recognizable person (head, eyes, mouth, arms, legs, etc.)
Experience using glue

EAST UNION EARLY CHILDHOOD CENTER
PERMISSION FORM

Child's Name _____

Parent/Guardian Initials **I give my permission for:**

Yes **No**

___ ___ East Union and/or East Union Early Childhood Center staff to monitor height and weight, do vision screenings, developmental screenings, and assessments.

___ ___ Iowa Kids Sight/Iowa Lions to do a vision screening.

___ ___ Area Education Agency 14 to do speech and hearing screenings, classroom observations, and consultation.

___ ___ Mental health professionals to observe my child in the classroom setting.

___ ___ Medical, dental and developmental information to be forwarded to East Union Elementary School where my child will be attending kindergarten.

___ ___ East Union Early Childhood Center staff to administer sunscreen to my child. I have the option to bring my own sunscreen if my child has a certain skin condition that may cause a rash or reaction, but I must notify staff of the condition.

___ ___ East Union Early Childhood Center Staff to apply insect repellent containing DEET when it is recommended by public health authorities due to a high risk of insect-borne disease.

___ ___ East Union Early Childhood Center staff to take my child on field trips scheduled by the program. I understand that I will be notified, in advance, of each trip.

___ ___ Use of photos, films, and/or recordings of my child by East Union Early Childhood Center for training, advertising, and newsletters. These photos can be posted to the school website or used in the Elementary School yearbook. Photos , films and or recording may be used within TriUMPH Early Childhood Program and Early Childhood Institute.

___ ___ East Union Early Childhood Center has permission to share and gain information with and between external agencies including but not limited to (PAT,CHSC, AEA, and Lifeline)

_____ _____

Parent/Guardian's Signature Date

Updated: 2011

Pick Up/Drop Off Permission Form

Here are our guidelines for picking up and dropping off your child if he/she does not ride the bus.

1. **All parents will be asked to complete a pick up/drop off permission form.** Any changes to the pick up form must be done in writing as soon as possible! **A parent may telephone the teacher to have someone else pick up their child**, but that person must be listed on the pick up/drop off form. IN AN EMERGENCY, a parent may phone a request that someone not listed be allowed to pick up the child. They must follow up with a written change to the form as soon as possible.
2. **Anyone picking up a child at the center MUST be listed on the pick up form** and show identification when asked. Staff is required to ask for identification if they do not know the person picking up the child.
3. **A child cannot be picked up by anyone other than a responsible adult.** A responsible adult is defined as a parent/legal guardian or individual of at least 14 years of age.
4. **Staff may release a child to either biological parent, UNLESS we have a copy of custody orders or court documents on file.** If there is no court document available or there is any doubt that the child should leave with the other parent, the following precautionary steps may be taken: call the parent/guardian or legal guardian that the child lives with or call the police department.
5. **Children will not be allowed to arrive at school before the normal scheduled start time** 6:30 am for Wrap Around child care or 8:00 am Pre School. Parents will be charged for a full hour of Wrap Around care when child is brought before their scheduled time.
6. When bringing or picking up your child at school, **you are required to walk him/her into the building.** This will assure the safe arrival of your child.
7. **Children must be picked up promptly at dismissal time.** Late pick up charges of $1.00 per minute will be added to your account when a child is picked up later than his/her scheduled time. If a child has not been picked up from the center within 15 minutes of dismissal time and a parent or emergency contact will be called.

Please list below all possible adults that may pick up or drop off your child during this school year. As the parent/guardian you are still responsible for letting the school know when the following people are picking up your child.

Adult's name Relation to child (ex. Grandmother, brother, aunt, friend of family)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

East Union Early Childhood Center
Family Survey

Child's name: _____ Date of birth: _____
(First) (Middle) (Last)

Date of School entrance: _____

Person completing survey: ___ Mother ___ Father ___ Grandparent
___ Guardian ___ Other

Who lives in your household?

Name	Age	Relationship to child

What language is spoken in your home? If more than one language list all the languages.

Where was your child born?

Were there any complications with the pregnancy?

Did you carry to full term(9 months)?

Was your child born premature?

What country or countries are most important to your family's cultural background?

What does your preschooler call his mother/guardian?

What does your preschooler call his father/guardian?

What name do you use for your child? _____ If you would like us to call your child a different name, please specify: _____

Please list any schooling your child attended before coming to our program:

List foods you child likes to eat?

List foods your child does NOT like to eat?

Does your child enjoy looking at books?

Do you have children's books available in your home in your child's language?

Does your family have religious beliefs?

Are there holidays that your family does not celebrate?

Iowa Eligibility Application

FFY 17-18

Complete one application per household. Fiscal Year 2017-2018

Part 1. Check all applicable boxes:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home(HP) Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision. NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

Name of household member with Case Number _____ **List Case Number** _____

Part 4. Children enrolled. REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income. DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3.
Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	**Gross Income: Report income by how often the household member is paid.** Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: X XX - X X - ____ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form_____

Signature of Adult Completing Form | Printed Name of Adult Completing Form | Date Signed

Address of Adult Completing Form | Town | ZIP Code | Work Phone | Home Phone | Cell Phone

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $ _____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _____

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk
Application Denied: ☐ Incomplete ☐ Over income limits

☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature | **Effective Date**

Name of Adult Completing Form_____

hawk-i /Medicaid Information Form: Read this information and sign if you do not want your name released to _hawk-i_ or Medicaid.

If your children do not have health insurance, many families getting free and reduced price meals can also get free or low-cost health insurance for their children.

The law requires schools to share your free and reduced price meal eligibility information with Medicaid and *hawk-i*, the State's medical insurance program for children. Specifically, we will give them your child's name and your name and address. Medicaid and *hawk-i* can only use the information to identify children who may be eligible for free or low-cost health insurance and then to contact you. They are not allowed to use the information from your free and reduced meal application for any other purpose.

Childcare organizations may share this information at their option.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the *hawk-i* program. It will not affect your children's eligibility for free and reduced price meals. If you do NOT want your information shared with Medicaid or *hawk-i*, you must tell us by completing the information below at the time you complete this eligibility application. If you want further information, you may call *hawk-i* at 1-800-257-8563.

I DO NOT want school/home sponsor/child care or Head Start center officials to share information from my free and reduced price meal application with Medicaid or *hawk-i*. Also, if you are already receiving Medicaid or *hawk-i*, please sign below. This will avoid another contact.

Child's Name: _____ School/Child Care/Head Start Center:_____

Child's Name: _____ School/Child Care/Head Start Center:_____

Child's Name: _____ School/Child Care/Head Start Center:_____

Parent/Guardian Name (Printed)_____ **Signature**_____ **Date**_____

Self-Employment Income Worksheet: This worksheet will assist you in calculating the amount to report if you engage in farming, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for the free and reduced price meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this application, it is not possible to have a negative income. **The least self employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for free or reduced price meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price eligibility. Wages paid to a spouse or other family member in the operation of a farm or private business must be shown as household income in Part 5 of the application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return - Form 1040. Use the lines from the 1040 that are identified.

Line 12 - Business income or (loss) $_____

Line 13 - Capital gain or (loss) $_____

Line 14 - Other gains or (losses) $_____

Line 17 - Rental real estate, royalties, partnerships, S corporations, trusts, etc. $_____

Line 18 - Farm income or (loss) $_____

Total $_____

The least income possible is zero (a negative number cannot be reported) Total ÷12* = _____

*Enter amount in the "All Other Income Last Month" column in Part 5 on the front of the Iowa Eligibility Application.

enrollment information on an annual basis. This form will be placed in center files and treated as confidential information.

April 2017

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Birthdate	Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander
This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it,-the center's-Program representative is required to note race/ethnicity on the basis of visual observation.

Infants only (0 to 12 months): ☐ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

☐ I will provide breastmilk for my infant. ☐ Yes ☐ No Center formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

☐ I would like to breastfeed on site, if this option is available*. ☐ Yes ☐ No If yes, time(s)_____

☐ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____

☐ I accept the center's formula for my infant. Name of iron-fortified formula: _____

☐ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____

☐ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

☐ I will provide solid foods for my infant*. The center may supplement with additional solid foods when my infant needs them: ☐ Yes ☐ No

*The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

Parent Signature_____ Date:_____

Parent Signature_____ Date:_____ (Make any needed changes above, sign and date)

Parent Signature_____ Date:_____ (Make any needed changes above, sign and date)

* Ask your center if you can breastfeed on site.

USDA is an equal opportunity provider and employer.

5/2015

Iowa Child and Adult Care Food Program
ALLERGY/FOOD EXCEPTION STATEMENT

Description: The Child and Adult Care Food Program (CACFP) is funded by the United States Department of Agriculture (USDA). The CACFP reimburses centers for participant's meals that meet USDA requirements. If an infant, child or adult participant needs to avoid specific foods for a medical reason, reimbursement is allowed only if a recognized medical authority has documented the need for an exception to the CACFP meal pattern and signed the statement.

Please complete this form and return to: _____
(Name of center)

Participant's Name: _____ Birth Date: _____

Parent/Caregiver/Guardian's Name: _____

1) Disability: Does the participant have a disability? ☐ Yes ☐ No
If yes, describe the major life activity or activities affected by the disability:
If yes, explain why the disability restricts the participant's diet:
2) Special Dietary/Feeding Needs: Does the participant have a food allergy or intolerance? ☐ Yes ☐ No
If yes, describe the nature of the allergy/intolerance:

3) Food(s) or Formula to Avoid:	**Food(s) or Formula to Substitute:**
Infants at CACFP centers must receive iron-fortified infant formula or breast milk unless an allergy/exception statement is on file.	

4) Other dietary or feeding needs for the participant including texture modifications:

Date for a recheck or re-evaluation: _____

Medical authority: _____ _____
Name (Print or Type) Title

[A recognized medical authority is one of the following: medical doctor (MD), doctor of osteopathic medicine (DO), physician's assistant (PA), or advanced registered nurse practitioner (ARNP)].

Address: _____

_____ _____
Signature of Medical Authority Date

To be completed by the parent/guardian: If the participant has a disability, the center must offer to supply the food substitutions unless doing so would be a documented financial hardship.

Check if you wish for the center to supply the substitute foods. ☐
Check if the parent wants to supply the substitute foods. ☐

Signature: _____ Date: _____
(For permission to release information to the center)

If the participant does not have a disability, the center is encouraged but not required to supply the food substitutions.

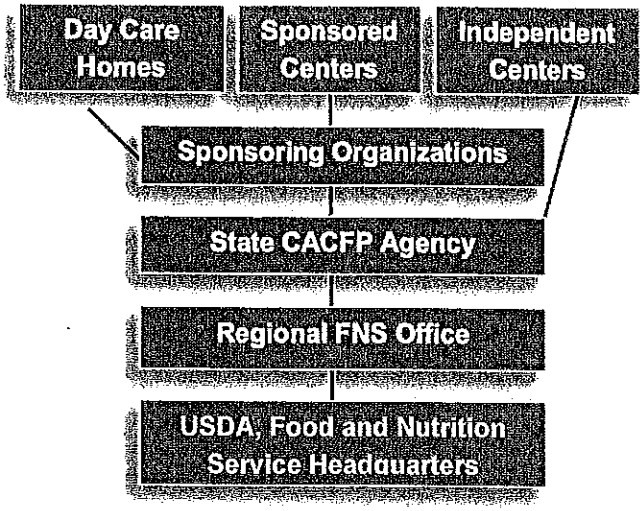
How Does CACFP work?

CACFP reimburses participating centers and day care homes for serving nutritious meals. It is administered at the Federal level by the Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA).

The **Iowa Department of Education** administers CACFP in Iowa. The State agency approves sponsoring organizations and independent centers to operate the Program at the local level. The State also monitors the Program and provides guidance and assistance to ensure requirements are met.

Sponsoring organizations play a critical role in supporting day care home providers and/or centers through training, technical assistance, and monitoring. Several types of organizations are approved by the State agency to serve as home or center sponsors, including community action agencies, nonprofit organizations, public agencies, and churches. Centers may operate independently, but all day care homes must come into the Program under a sponsoring organization.

CACFP Partners



Nondiscrimination Policies

USDA Nondiscrimination Statement:

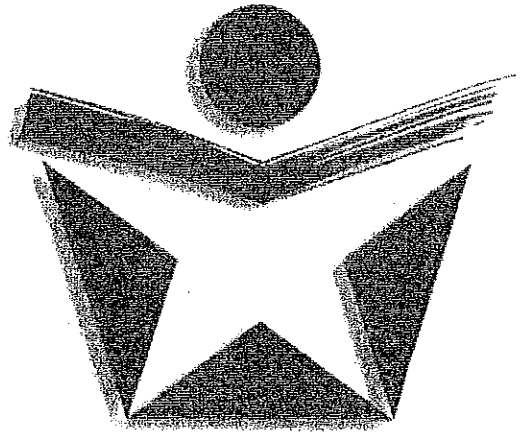
USDA is an equal opportunity provider

Iowa Nondiscrimination Statement:

It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office Building, 400 E. 14th St. Des Moines, IA 50319-1004; phone number 515-281-4121, 800-457-4416; website: https://icrc.iowa.gov/.

Revised 3-2017

Child and Adult Care Food Program (CACFP)



Building FOR THE Future

Iowa Department of Education
Bureau of Nutrition and Health Services
Grimes State Office Building
400 E. 14th St.
Des Moines, IA 50319
Phone: (515) 281-5356

What is CACFP?

CACFP is the Child and Adult Care Food Program, a Federal program that provides reimbursement for serving healthy meals and snacks to children and adults receiving day care.

Each day more than 3.2 million children and almost 112,000 older adults participate in CACFP. Through CACFP, participants' nutritional needs are supported on a daily basis. The Program plays a vital role in improving the quality of day care and making it more affordable for many low-income families.

In addition to day care, CACFP helps make afterschool programs more appealing to at-risk children and youth. Afterschool centers that serve meals and snacks draw students into constructive activities that are safe, fun, and filled with learning opportunities.

Children who are homeless or from temporarily displaced families can also receive up to three meals each day through emergency shelters that operate the Program.

Who is eligible for CACFP meals?

- Children age 12 and under,
- Migrant children age 15 and younger,
- Children and youths through age 18 in afterschool programs in low-income areas,
- Children and youths age 18 and under residing in emergency shelters, and
- Adults age 60 and older enrolled in an adult day care center, and functionally impaired adult participants in day care or emergency shelters.

What kinds of meals are served?

CACFP facilities follow the meal patterns established by USDA.

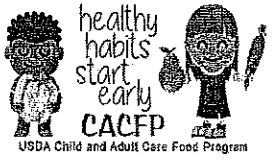
- Breakfast requires of a serving of milk, fruit or vegetable, and grains
- Lunch and supper require milk, grains, meat or meat alternate, a vegetable, and a fruit (or two different vegetables).
- Snacks require two different servings of the five components: milk, fruits, vegetables, grains, and meat or meat alternate.

Infants follow a separate meal pattern.

CACFP Facilities

Many different facilities operate CACFP, all sharing the common goal of serving nutritious meals and snacks to participants.

- **Child Care Centers**
  Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers serving meals to large numbers of low-income children.
- **Day Care Homes**
  Small groups of children receive nonresidential day care in DHS registered private homes.
- **"At-Risk" Afterschool Care Programs**
  Centers in low-income areas provide free meals and snacks to school-age children and youth.
- **Homeless Shelters**
  Emergency shelters provide temporary shelter and food services to homeless children.
- **Adult Day Care Centers**
  Public, private nonprofit, and some for-profit adult day care facilities provide structured, comprehensive services to functionally impaired nonresident adults.



Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Child Care Facility _____ Telephone # _____
Parent/Guardian name #1		Parent/Guardian name #2
Child home address #1		Telephone # 1
Child home address #2		Telephone #2
Where parent/guardian # 1 works	Work address	Home phone # Work # Cellular # Home email Work email
Where parent /guardian # 2 works	Work address	Home phone # Work # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian. ☐ YES ☐NO

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name:_____ Phone # _____

Relationship to child: Cellular # _____

Child's doctor's name	Doctor telephone # 1	Hospital choice **Phone #**_____
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company _____ **ID #**
Child's dentist's name (or family's dentist name)	Dentist Telephone # 1	Does child have dental insurance? ☐Yes, Company _____ **ID#**
Dentist's Address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty	Telephone #	☐ **Please help us find health or dental insurance.**

PARENT/GUARDIAN COMPLETE THIS PAGE **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

Growth
☐ I am concerned about my child's growth.

Appetite
☐ I am concerned about my child's eating/ feeding habits or appetite.

Rest -
☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child
☐ had a serious illness, injury, or surgery..

Please describe:

Physical Activity - My child
☐ must restrict physical activity.

Please describe:

Development and Learning
☐ I am concerned about my child's behavior, development, or learning.

Please describe:

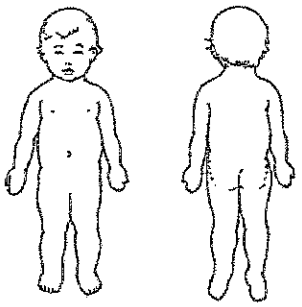
☐ **Allergies**-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

Body Health - My child has problems with
☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: _____

Birthdate: _____ **Age today:** _____

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr: _____

Hgb or Hct- @ 12 mo: _____

Lead Risk Assessment: _____

Blood Lead Level: date _____ results _____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth

Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious.

☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at the child care facility: (include *over-the-counter* and *prescribed*)

Medication Name Dosage

☐ Diaper crème:

☐ Fever or Pain reliever:

☐ Sunscreen:

☐ Other

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

☐ Referred to ***hawk-i*** today 1-800-257-8563

☐ Other: _____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(please attach)

May use stamp

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP
Address: Telephone:

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf