CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child _____ Birthdate _____ Sex _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name _____

Relation to child _____

Home address _____

_____

Phone Number _____

Place of employment _____

_____

Address _____

Phone Number _____

Working hours _____

Name _____

Relation to child _____

Home address _____

_____

Phone Number _____

Place of employment _____

_____

Address _____

Phone Number _____

Working hours _____

OTHER PERSON TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED

Name _____

Phone Number _____

Address _____

Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____

Phone Number _____

Address _____

Hospital or Clinic _____

PROGRAM

Days per week _____

Rate of pay (optional) _____

Hours of care _____

_____ Signature of parent or other person placing child

_____ Signature of caregiver

_____ Date

A completely filled in form must be kept by the licensee for each child not related to the licensee. Please have this form available at all times to licensing representatives of the Department of Children and Family Services. Contact the Area Office for supplies of this form.

If the child has any of the following, please explaining:

Medical problems _____

Physical handicaps _____

Restrictions for play—outdoors _____

Restrictions for play—indoors _____

Allergies _____

Food likes _____

Food dislikes _____

Fears _____

Does the child take a nap? _____ Time _____ Length _____

Is the child toilet trained? _____

Does the child have special names for objects? (potty, cookies, drinks, etc.) _____

Does the child regularly take medication? _____ If so, what kind and directions _____

If the child is an infant, what are the feeding instructions? _____

Time _____ Amount _____ Temperature _____

Diaper changes: Powder _____ Ointment _____

Other information that will help in caring for the child _____

Comments:

_____

_____

_____

_____

_____

_____

_____

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY

AUTHORIZATION FOR PICK UP

Please list all persons, including parents and guardians, authorized to pick up your child along with a 4 digit ID code that will allow them to sign in and/or out your child. The 4 digit code cannot start with a 0.

Name	Address	Phone #	Relationship to Child	ID Code

Parent Signature: _____ Date:_____

MISS MONA'S EMERGENCY INFORMATION FORM

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

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Father's Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact: _____

Relationship to Child: _____ Phone: _____

List Authorized Adults Allowed to Pick Up Child:

Name	Address	Phone

List Any Medical Conditions: _____

_____

Allergies: _____

Name of Physician: _____ Phone: _____

Address: _____

Choice of Hospital: _____

My Child May View Movies Rated: (Please circle): G PG PG13

If I cannot be reached in an emergency, please seek medical attention: Yes No

Signature of Parent/Guardian: _____ Date: _____

FOR USE IN DCFS CHILD CARE FACILITIES

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	School	Grade Level /ID#

Address (Street, City, ZIP code) | Parent/Guardian | Telephone # Home | Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23)						
Other (Specify hepatitis A, meningococcal, etc.)						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature Title Date

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) Title Date

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) Title Date

ALTERNATIVE PROOF OF IMMUNITY

1. **Clinical diagnosis is acceptable if verified by physician.** *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title Date

3. **Laboratory confirmation (check one)** ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B ☐ Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																						
Age/Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Printed by Authority of the State of Illinois

(Complete Both Sides)

444-4737 (R-01-05)

FS 600
ev 1/2005

Student's Name (Last / First / Middle)	Birth Date (Month/Day/Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma?	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night coughing	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐Braces ☐Bridge ☐Plate Other			
				Other concerns?			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes Parent/Guardian Signature Date			
Bone/Joint problem/injury/scoliosis?	Yes	No					

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS HEIGHT WEIGHT BMI B/P

DIABETES SCREENING BMI>85% age/sex Yes ☐ No ☐ And any two of the following Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ At Risk Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten
Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Blood Test Result (Blood test required in Chicago and other high risk zip codes)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result mm

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support cup

DENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified, please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) Yes ☐ No ☐ Limited ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name Signature Date

Address Phone

(Complete both sides)

Late Pick Up Policy Amendment
June 2005

The late pick-up policy of Miss Mona's Child Care Center states that if your child is here past the center's closing time, you will be charged the late pick-up fee of $10.00 for 15 minutes or any part of thereof and $1.00 per minute thereafter. This policy remains in effect with the following additions:

1. The staff member in charge will attempt to reach the parents via emergency contact information, which has been provided by the parent. After a reasonable amount of time as passed, if the parents have not been contacted, staff member would contact authorities for help in contacting parents.

2. The director will periodically check emergency information as to accuracy for this exact purpose.

3. The staff member in charge will be certain at all times to be responsible for the child's well-being and at no time will the staff member make the child feel responsible for the situation.

==========

I _____
parent/guardian

of _____
child

Have read and understand this amendment to the Late Pick Up Policy of Miss Mona's Child Care Center.

_____ _____
Signed Date

Miss Mona's Child Care Center

Hopedale Medical Complex

Consent to Treat/Wavier and Release

Minor Child's Name: _____

Waiver & Release

Miss Mona's, LLC, d/b/a Miss Mona's Childcare Center, and the Hopedale Medical Foundation, d/b/a Hopedale Medical Complex, hereinafter referred to individually and collectively as "Miss Mona's", is committed to conducting its programs and activities in a safe manner and holds the safety of our children in high regard. The parents/guardians and custodians of minors enrolled in our program(s)/activity(ies) understand that although child safety is Miss Mona's number one concern, there is still an inherent risk of injury to children when they participate in our programs/activities, especially when playing or engaging in physical activity.

In light of the above, in consideration of Miss Mona's providing its services to the minor child/children, the undersigned on his/her behalf and on behalf of the minor child/children, does hereby fully release and forever discharge Miss Mona's , LLC and the Hopedale Medical Foundation, d/b/a the Hopedale Medical Complex, and their respective managers, officers, directors, employees, agents, successors and assigns, from and against any and all claims for injuries, damages or losses and liability that the undersigned or the minor child/children may sustain or which may accrue to the undersigned or the minor child/children, which arises out of, or is connected with Miss Mona's program and activities, unless said losses/liability or damages are the result of willful and wanton conduct.

The undersigned has read and fully understands the above waiver and release of all claims. The undersigned's signature below is on his/her behalf of any and all minor child/children enrolled in or participating in Miss Mona's programs and activities, even if said minor child/children's names are not specifically listed below. If both parents/guardians have not signed this document, the undersigned states that he/she is authorized to sign on behalf of the other parent/guardian, and the undersigned agrees to indemnify and hold harmless Miss Mona's, LLC and the Hopedale Medical Foundation and the released entities from and against any and all liability, losses, claims/demands made against said entities by the non-signing parent/guardian.

Consent to Treat:

In the event of an accidental injury or sudden acute illness to the minor child participant, the undersigned, for himself/herself and on behalf of the minor child participant, HEREBY CONSENTS and permits the Miss Mona's and Hopedale Medical Complex personnel to administer First Aid or contact local EMS to care for and treat the minor child and to transport said child to the hospital Emergency Room if deemed necessary by EMS, HMC or Miss Mona's personnel. If Hopedale Medical Complex or Miss Mona's personnel are unable to immediately reach the parent/guardian of the minor child participant to obtain verbal consent, said permission to treat and transport by HMC and/or EMS personnel is granted. Note: Miss Mona's personnel will always attempt to immediately contact a parent/guardian/authorized person in an emergency.

This release and consent also applies to any other related programs conducted at or by Miss Mona's, regardless of location, whether on site or off premises, and shall remain in force and effect for 5 years or until revoked by the undersigned in writing by delivering a copy to the C.O.O of Hopedale Medical Complex, whichever occurs first. This consent may not be retroactively evoked.

_____

Parent/Guardian (Signature) Date

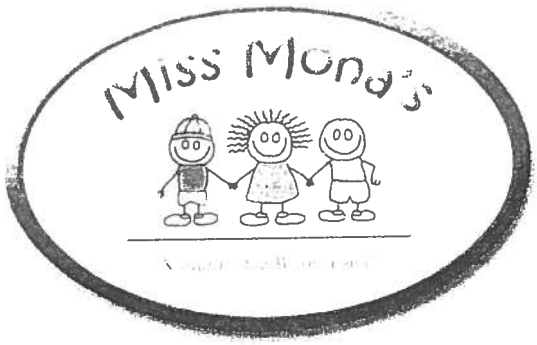
_____

Name of Minor Child (Please Print) Age

Emergency number where parent/guardian/authorized person can be reached if minor child participant is in need of Emergency medical treatment or in an emergency:

Authorized Contact No. 1:_____ Phone # _____

Authorized Contact No 2:_____ Phone # _____



PO Box 267

Hopedale, IL 61747

CONSENT TO PHOTOGRAPH AND USE IMAGES

The undersigned parent/guardian hereby consents to the photographing of his/her minor child doing activities at Miss Mona's. These photos will be taken by an agent of Hopedale Medical Complex (HMC) and Miss Mona's Childcare. In consideration of the above the undersigned will be provided a free copy of any photographs taken by HMC of his/her child/ward and **the undersigned hereby gives consent** to Miss Mona's and HMC to publish and display said photographs on site at Miss Mona's, on HMC or Miss Mona's advertising or brochures. No further consideration will be paid for the use of said photos.

Signed_____

Minor Child's name_____

Date_____

MISS MONA'S AUTHORIZATION FORM

EMERGENCY MEDICAL TREATMENT

This authorizes the staff at Miss Mona's Child Care Center to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. In the event of an emergency a staff member will take your child to be treated at the Hopedale Medical Complex Emergency Room. I/we will be responsible for the emergency medical charges upon receipt of the statement.

Signature of Parent/Guardian _____ **Date** _____

ADMINISTER PRESCRIPTION MEDICATION

I/we authorize Miss Mona's Child Care Center to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Signature of Parent/Guardian _____ **Date** _____

ADMINISTER OVER THE COUNTER MEDICATION

I/we authorize Miss Mona's Child Care Center to administer over the counter medication to my/our child as specified in written instructions.

Signature of Parent/Guardian _____ **Date** _____

FIELD TRIPS

I/we authorize Miss Mona's Child Care Center to take my/our child on walking trips, special excursions, and to nearby public park facilities.

Signature of Parent/Guardian _____ **Date** _____

PUBLICITY

I/we authorize Miss Mona's Child Care Center to photograph/video tape my/our child with the understanding that such photos or videos may be used for publicity.

Signature of Parent/Guardian _____ **Date** _____

Policy Sign-off

I/we, the parent/guardians of _____,
have received and read a copy of Miss Mona's Child Care Policies and Informational Packet, understand it including the Guidance and Discipline Policy, and agree to its terms.

Signature_____ Date_____

Signature_____ Date_____

** Please sign and return to Child Care Director.

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
CHILD AND ADULT CARE FOOD PROGRAM

All Household Members

1. NAMES OF ALL HOUSEHOLD MEMBERS Middle Initial Last	Ages of Children at Center	2. FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children skip to #6	3. SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway _____ Signature of School Homeless Liaison or Migrant Coordinator _____ Date

Total Household Gross Income (before deductions) You must tell us how much and how often.

NAMES LIST ALL HOUSEHOLD MEMBERS WITH INCOME	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example $100/month $100 /twice a month $100/every other week $100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions Retirement Social Security		Worker's Comp Unemployment SSI etc (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
	$		$		$		$	
	$		$		$		$	
	$		$		$		$	
	$		$		$		$	
	$		$		$		$	

Signature and Social Security Number (Adult must sign)

dult household member must sign the application. If Part 5 is completed or if zero income is l, the adult signing the form must also list the last four digits his or her social security number ark the *I do not have a social security number* box

X X X - X X - _ _ _ _ Social Security Number

☐ I do not have a social security number

fy all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois Board of Education, or Office of Inspector General may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under cable state and federal laws

Date *Printed Name of Adult Household Member* *Signature of Adult Household Member*

Contact Information (Optional)

Telephone Number (Include Area Code) *Home Telephone Number (Include Area Code)* *Home Address (Number Street City State Zip Code)*

Optional – Sharing Information With All Kids Insurance Program

we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If yes, do not sign below

No, I do not want my information from this application shared with the *All Kids Insurance Program*

Sign here _____

'ACY 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 ot approve your child 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 l 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 F) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member g the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and cement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine fits for their programs; auditors for program reviews; and law enforcement officials to help them look into violations of program rules.

D CARE REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION - COMPLETE SECTIONS A, B and C BELOW

w the Instructions for Institutions to Process Household Eligibility Applications available at www.isbe.net/nutrition

TION A Annual Income Conversion: Weekly X 52; Every 2 Weeks X 26; Twice a Month X 24; Once a Month X 12. *Convert income only if different frequencies of pay are reported.*

AL
OME $ _____ Per ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year NUMBER IN HOUSEHOLD _____

Free based on:
☐ foster child
☐ SNAP or TANF
☐ homeless
☐ migrant
☐ runaway
☐ household's income

☐ Reduced based on:
☐ household's income

☐ Denied—Reason
☐ income too high
☐ incomplete application
☐ Non-qualifying SNAP/TANF

Date _____

TION B Signature of Determining Official _____

TION C Effective Date of this application _____

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which the child's eligibility is certified

ILLINOIS STATE BOARD OF EDUCATION
Annual Enrollment Form
Child and Adult Care Food Program

his form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs

his form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters

arents/Centers This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious eals for your child(ren) Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling eir child(ren) and every year thereafter This information will help ensure all children receive appropriate meals during their care The parent or center may omplete Sections 1 through 4 The parent must review to ensure accuracy, then complete Section 5, sign and date Section 6 If parent does not complete ection 5, center staff should complete to the best of their ability (by observation) and initial the section The center will review completed enrollment form

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS DURING WEEK							4 MEALS RECEIVED
st Child	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	☐ Early Morning Snack ☐ Breakfast ☐ A M Snack ☐ Lunch ☐ P M Snack ☐ Supper ☐ Evening Snack
ame		AM	PM	TIME	AM	PM	TIME	Leaves Center / Returns To Center	
irth Date									
ge		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours							
econd Child	☐ **Same Days as Above**	☐ **Same Times as Child Above**							☐ **Same Meals as Above**
ame	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	☐ Early Morning Snack ☐ Breakfast ☐ A M Snack ☐ Lunch ☐ P M Snack ☐ Supper ☐ Evening Snack
irth Date		AM	PM	TIME	AM	PM	TIME	Leaves Center / Returns To Center	
ge		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours							
hird Child	☐ **Same Days as Above**	☐ **Same Times as Child Above**							☐ **Same Meals as Above**
ame	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	☐ Early Morning Snack ☐ Breakfast ☐ A M Snack ☐ Lunch ☐ P M Snack ☐ Supper ☐ Evening Snack
irth Date		AM	PM	TIME	AM	PM	TIME	Leaves Center / Returns To Center	
ge		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours							

lease answer both questions. This information is voluntary

5 ETHNIC/RACIAL CATEGORIES—

A Ethnic data of child(ren) — Mark only one: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B Racial data of child(ren) — Mark one or more that apply: ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 SIGNATURE

I certify the information above is correct _____ *Signature of Parent or Guardian* _____ *Date* _____ *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY

ffective Date of this enrollment form _____

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

he U S Department of Agriculture prohibits discrimination against its customers, employees and applicants for employment on the bases of race, color, national origin, age, disability ex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is erived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department (Not all prohibited ases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination omplaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter ontaining all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have peech 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.

Miss Mona's Childcare Rates

Childcare	Rate (weekly/daily)
Infants (6wks-14mos)	$171/$37
Toddlers (15mos-2yrs)	$163/$35
Two & Three Years	$153/$33
Four & Five Years	$138/$30

List Of Things To Bring

Bottles-Filled with water, and marked with child's name. Please mark bottle and cap.

Formula & Baby Food-If not using the centers.

Diapers-You may bring a large pack if you like. Only the package of diapers needs to be marked.

Pacifier

Blanket

Extra clothes for cubby

Shoes, coats, sweaters, hats, mittens, etc. for the appropriate season. We go outside to play and go for walks, when weather permits.

* Please mark everything with your child's name on it. This will help a lot when there is a sub in the room.