****Complete, Sign & Return****

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & .182; 3290.124 (a)(b), 3290.181 & .182

CHILD'S NAME	BIRTHDATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

 # 's Required

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

03891A

ORIGINAL

CY 867 - 1/93

****Complete, Sign & Return****

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(C); 3280.123 & 181(c); 3290.123 & 181(C)

Name of Child:	**Circle One:** ◯ Male ◯ Female
Child's Weekly Schedule: **Please circle the SET schedule your child will be attending weekly** ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	**Day Payment to be made:** FRIDAY, BEFORE CARE **Fee per Session, per child:** _____ **Weekly Contracted Tuition Fee:** _____ _____ **Administration fee.**

Services to be provided as part of the day care fee (examples: transportation, care, meals, etc.)

ALL DAY CARE CHILD SERVICE REPORTS AND BI ANNUAL CONFERENCES
BREAKFAST
LUNCH
PM SNACK

Child's Arrival Time:	**Child's Departure:**	**Person(s) designated by parent to whom child may be released:**
Late Fee: $1.00 PER MINUTE, PER CHILD		

Extra services to be provided at an additional fee if applicable:	**SCHOOL:** **GRADE:**
REGISTRATION- $25.00 per child (Waived for emergency care)	

I, the parent/guardian:

☐ Received complete written program information at the time of enrollment (I3270.121, 3280.121, 3290.121)

☐ Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months, at a minimum. (I3270.124, 3280.124, 3290.124)

☐ Understand that all fees are due weekly, up front, and are to be paid in full regardless of holiday, closing, vacation, illness, or in-service.

☐ Agree to give you two weeks' notice of care termination.

_____ _____

Signature- Operator Date **Signature-Parent/Guardian Date**

Date of Child's Admission:	**PERIODIC REVIEW** **Sign here at 6 month update:**
_____ **Date of Child's Withdrawl:**	_____ **Signature-Parent/Guardian Date**

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
◯ YES ◯ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

◯ YES ◯ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

CD 51 09/08

MEDICATION

Medication will not be administed at the child care center. Please arrange to administer your child's medication at home. The only medications that will be administed are those that are considered life sustaining.

Diaper cream/ointment is considered a medication by the Department of Human Services. We are now asking that if parent's wish for the center staff to apply this medication directly to their child,they must have a doctor's note from the child's pediatrician first. Once received a parent will need to fill out and sign a medication log and submit it, the diaper cream in the original container and a doctor's note to the center staff.

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FOR SOCIAL RESPONSIBILITY

Dear Parents & Families,

Due to new privacy acts that are now in place, you will need to sign permission to have your child's medication log and allergies posted in our center.

Allergy lists are posted in all food service areas in each classroom. Medication logs are also posted in each classroom. We post this information so that it is in clear view of all staff. If we were to start hanging this information in closets so that confidentiality is not compromised, we would be compromising the safety of your child/ren.

Your signature below will enable us to post allergy and medication logs, should the need arise during your child's enrollment with us.

☐ I give permission for the YMCA to post my child's allergy and medical information.

☐ I do not give permission for the YMCA to post my child's allergy and medication information.

Parent/Guardian Signature: _____

Date: _____

Medication Release Form

Name of Child: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Age:_ _ _ _ _ Date of Birth:_ _ _ _ _

TO BE FILLED OUT BY A PHYSICIAN/PRESCRIBING HEALTH CARE PROVIDER:

Name of medication, dose, method administered, time and indication of administration:_____

Condition for which medication is administered:_____

Is this a controlled drug? _____☐ YES_____☐ NO
DATES OF ADMINISTRATION: _____

Side effects to be notes/reported:_____

Other recommendations:_____

Physician Signature:_____ Print Name:_____

Date:_____ Telephone:_____

TO BE FILLED OUT BY PARENT/GUARDIAN:

I request that my child, named above, be permitted to be administered the medication prescribed by the physician whose signature appears above. I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, and name of medication; date of original prescription strength and dose of medication; and directions for use.

Parent/Guardian Name:_____Date: _____

Signature:_____
We will also need a photocopied prescription label along with this form.

MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133

PLEASE PRINT

Page _____ of _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____ (Date) To _____ (Date)

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

_____

_____

I give permission to administer medication to my child as stated above.

_____ (Parent Signature) _____ (Date)

FACILITY STAFF COMPLETE THIS SECTION				
Date Administered (mm/dd/yyyy)	**Time Administered (a.m. / p.m.)**	**Amount of Medication Administered**	**Comments/Reactions**	**Staff Initials**

This information is confidential and may not be shared or released without the parent's written permission.

COVID-19 WAIVER

Minor Participant Waiver, Release, Indemnification of All Claims & Covenant Not to Sue

PLEASE READ CARFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT YOU ARE RELEASING THE YMCA OF READING & BERKS COUNTY FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFOR

Assumption of Risk

I, in my legal capacity as parent/guardian of the minor named below ("Minor"), acknowledge and agree that any use of The YMCA of Reading & Berks County facilities, services, equipment and premises ("Facilities") and any participation in The YMCA of Reading & Berks County programs and activities ("Programs") comes with inherent risks including, but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease. I voluntarily, for myself and Minor, accept and assume full responsibility for these risks as well as any and all ccother risks of the use of Facilities and participation in Programs. I agree that I have full knowledge of the nature and extent of all such risks and am not relying on all such risks being described in this document.

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of Minor's use of Facilities and participation in Programs I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor that The YMCA of Reading & Berks County its officers, directors, agents, employees, volunteers, insurers and representatives ("Releasees") will not be liable for any personal injury, property damage, disability, death, sickness or disease incurred by Minor, however occurring including, but not limited to, the negligence of Releasees. I understand that Minor and I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease sustained from the use of Facilities and participation in Programs.

I further agree, in my legal capacity as the parent/guardian of Minor, on behalf of Minor, myself, and any and all legal successors and proxies, to release and **HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE** Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which Minor, myself, and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, disease or accident of any kind, arising out of or in any way related to the use of Facilities or participation in Programs, whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to, the negligence of Releasees.

In further consideration of the use of Facilities and participation in Programs, I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor to **INDEMNIFY AND HOLD HARMLESS** Releasees from any and all causes of action, claims, demands, losses, suits, liabilities or costs of any nature whatsoever, including claims of negligence, arising out of or in any way related to the use of Facilities and participation in Programs.

_____ _____

Minor Name (Print Clearly) Date

_____ _____

Parent/Guardian Signature Parent/Guardian Name (Print Clearly)

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Special Care Plan for a Child with Behavioral Problems

This sheet is intended to be used by health care providers and other professionals to formulate a plan of care for children with severe behavior problems that parents and child care providers can agree upon and follow consistently.

Part A: to be completed by the parent/guardian	
Child's Name:	Date of Birth:
Parent Name(s):	
Parent Emergency Numbers:	
Child Care Facility & School Name:	Phone #:
Health Care Provider's Name:	Phone #:
Other Specialist's Name/Title:	Phone #:

Part B: To be completed by a health care provider, pediatric psychiatrist, child psychologist, or other specialist.

Identify/describe the behavior problem:

Possible causes/purposes for this type of behavior (circle all that apply):

- ☐ Medical Condition: _____
- ☐ Attention seeking mechanism
- ☐ Gain access to restricted items/activities
- ☐ Escape performance of task
- ☐ Psychiatric disorder
- ☐ Tension release
- ☐ Developmental disorder
- ☐ Neurochemical imbalance
- ☐ Frustration
- ☐ Poor self-regulation skills
- ☐ Other: _____

Accommodations needed:

List factors known to trigger behavior:

How should the caregiver react when behavior begins (circle all that apply):

- ☐ Ignore behavior
- ☐ Avoid eye contact/conversation
- ☐ Request desired behavior
- ☐ Use helmet
- ☐ Use pillow or other device to block self-injury
- ☐ Physical guidance
- ☐ Model behavior
- ☐ Use diversion/distraction
- ☐ Use substitution
- ☐ Other: _____

List any special equipment this child needs:

List any medication/s this child receives:

List any training staff may need to care for the child:

List any other instructions for caregiver/s:

Part C: Signatures

Date to Review/Update this plan:

Health Care Provider's Signature:	Date:
Other Specialist's Signature:	Date:
Parent Signature(s): 1. 2.	Date:
Child Care Director's Signature:	Date:
Primary Caregiver Signature:	Date:

Part D: To be completed by a health care provider, pediatric psychiatrist, child psychologist, or other specialist.

Directions for use of helmet, pillow, or other behavioral protocol:

☐ **Check if there are no known behavioral problems.**

Parent/Guardian Signature _____ Date _____

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Parent Statement Understanding

I understand that YMCA staff and volunteers are not allowed to baby-sit or transport at any time outside of the YMCA program. Immediate disciplinary action will be taken by the YMCA toward staff & volunteers if a violation is discovered.

I understand that I am not to leave my child at the YMCA or program site unless a YMCA staff or volunteer is there to supervise my child.

I understand that my child will not be allowed to leave the program with an unauthorized person. Any authorized person to pick up my child must either be listed with the YMCA or other arrangements must be made by calling the YMCA office to inform them of a change.

I understand that should a person come to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact police.

I understand that the YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities.

I have received my copy of the YMCA Child Care Program Parent's Handbook.

I understand that it is my responsibility to direct any questions that I may have after reading this handbook to the Office Staff, Center Director, or Child Care Director.

I am aware of and agree to abide by the policies outlined in this manual:

☐ Parent manual

☐ Parent Statement of Understanding

☐ Non-discrimination in service

☐ Visitor's Policy

☐ Behavior Management Agreement

☐ Transportation Policy

☐ Medication Policy

☐ I am aware of the forms required for enrollment and on- going participation in child care, agreement, emergency, physical, immunization record, and food program application

Parent Signature _____ **Date** _____

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FOR SOCIAL RESPONSIBILITY

PHOTO AND VIDEO/AUDIO RECORDING RELEASE

I am 18 years of age or older and, if not, my Mother/Father/Legal Guardian has also signed below.

For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA) , I hereby give my permission and consent, now and for all time, to YMCA of the USA and collaborating third parties to make, reproduce, edit, broadcast or rebroadcast any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities, for publication, display, sale or exhibition thereof in promotions, advertising, education and legitimate business uses without any compensation to, and/or claim, by me. I may, or may not be, identified in such reproductions; however, I shall not be stated by name to have endorsed any particular commercial products or commercial services.

I further agree to the following:

- Any video film, footage, sound track recordings, and photo reproductions of me and/or my narrative account of my experience during said activities, I authorize, according to this Release, shall belong to YMCA of the USA and collaborating third parties. Therefore, they will have full right of disposition of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities;
- Any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities will not be subject to any obligation of confidentiality and may be shared with and used by YMCA of the USA and collaborating third parties;
- YMCA of the USA and collaborating third parties collaborating shall not be liable for any use or disclosure to a third party of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience; and
- YMCA of the USA and collaborating third parties shall exclusively own all known or later existing rights to worldwide and shall be entitled to the unrestricted use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience for any purpose without compensation to me.

I agree that my consent and this release are irrevocable. I hereby release and discharge YMCA of the USA and collaborating third parties from any and all claims in connection with the uses and reproductions, any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience as described herein.

Signature: _____ Date: _____

Printed Name: _____ Age: _____

Address: _____

_____

I am the Mother/Father/Legal Guardian of _____[child's name].

For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Signature of Mother/Father/Legal Guardian: _____

YMCA OF THE USA
101 N Wacker Drive, Chicago IL 60606
P 800 872 9622 F 312 977 9063 ymca.net

CACFP Meal Benefit Income Eligibility Form Instructions

The Child and Adult Care Food Program (CACFP) makes good food a regular part of your child's day care! Please fill out the *CACFP Meal Benefit Income Eligibility* form. It helps us find out if your household qualifies for free or reduced-price meals. This lets us know how much money CACFP will give to support your day care home or center.

Instructions

Here are instructions to help you fill out the form. Before you begin, turn the form over to learn why we ask for this information. It tells you how we use the information and what rights you have. It also tells you how to contact USDA if you believe you are treated unfairly.

Please make sure to fill in all of the requested information. Use a pen to mark your answers on one form. When you are finished, please return the form to us.

Step 1:

List all the children from your household in the day care. Use one line for each child's name. Write one letter in each box. Stop if you run out of space. If there are more children, add their names on a second piece of paper.

Do you have any foster children? If you answer *Yes*, mark the *Foster Child* box next to the child's name. If you are only applying for foster children, finish Step 1 and go to Step 4. If you are applying for both foster and non-foster children, go to Step 2.

Are any children migrant, runaway, homeless, or enrolled in Head Start? If *Yes,* mark the correct boxes next to the child's name and go to Step 4.

Step 2:

You qualify for free meals if you live in a household that receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR).

Do any household members, including you, currently receive SNAP, TANF, or FDPIR? If *Yes*, write the case number in the box and go to Step 4. You only need to provide one case number. If *No*, go to Step 3.

Step 3:

Report current income for all household members. Skip this step if you answered Yes in Step 2.

How do you report child income? Turn the form over and use the *Source of Income for Children* chart to see if your household has income to report. Write the amount in the boxes in part A of the form. Mark how often the amount is earned. Write *0* in the box if there is no income to report.

How do you report income of adult household members? Turn the form over and use the *Source of Income for Adults* chart to see if your household has income to report.

In part B, list all the adults in your household, including you, even if each of you doesn't receive income. Include all adults, such as grandparents, other relatives, and friends who live with you and share household income and expenses. Write the amount of income each of you receives, in the boxes next to your names. Mark how often the amount is received. Write *0* in the box if there is no income to report.

Make sure you report the current amount of money you get before taxes. Don't include SNAP, FDPIR, WIC, student financial aid, or money you receive for a foster child as income.

Count the number of all children and adults in your household. Include all infants, children, students, and adults. Write the total number in the box under the list of adult household members.

Do you or another adult household member have a Social Security number? Write the last four digits in the boxes. If there is no Social Security number, mark the *Check if no SSN* box.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, don't include overtime pay, if you don't normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children don't have to be U.S. citizens to qualify for meal benefits.
You are in the military	Don't include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Step 4:

An adult household member must sign this form. The signer promises that all information is true and complete.

Print the name, address, and telephone or email of the adult signer. Sign and write today's date in the marked boxes.

Optional

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

Sharing Information with Medicaid and SCHIP

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to*. Medicaid and SCHIP *only* use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

☐ **No! I do not** want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name:
_____

Child's Name:
_____

Child's Name:
_____

Child's Name:
_____

Today's Date:
_____

Print Your Name:
_____

Address:
_____

Signature of Parent or Guardian:
_____

Child and Adult Care Food Program **Sponsor:_____**
Child Enrollment Form (Sample) **Center:_____**

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD NAME BIRTH DATE AGE	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FOURTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FIFTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

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

This portion of the form can be used to capture multi-year annual updates.

****
****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** _____________________

Signature Center Administrator/Home Provider____________________________ **Date** _____________________

****
****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** _____________________

Signature Center Administrator/Home Provider____________________________ **Date** _____________________

****
****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** _____________________

Signature Center Administrator/Home Provider____________________________ **Date** _____________________

****
****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** _____________________

Signature Center Administrator/Home Provider____________________________ **Date** _____________________

****
****

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Check all that apply

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	◯	◯	◯	◯

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯
	$	◯	◯	◯	◯	$	◯	◯	◯	◯	$	◯	◯	◯	◯

Total Household Members (Children and Adults) ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - ☐☐☐☐

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of 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 or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT 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

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility Free ○ Reduced ○ Denied ○

Determining Official's Signature | Date | Confirming Official's Signature | Date | Follow-up Official's Signature | Date

YMCA of Reading & Berks County
Child Care Getting To Know You

Child's Name _____Nickname (if any)_____

Parent Name(s) _____ Date _____

Family Composition Questions:

1. Please list your child's household members (including relations and ages of siblings).

2. Are there any custody situations that you would like to share with us?

3. Is there any other information about your family's composition that you would like to share?

4. Does your family have pets?

5. What is your child's favorite food? Least Favorite?

6. What makes your child happy?

7. What makes your child sad?

8. Any other information you would like to provide to help us better know your child?

Child Information:

1. Has your child been in an early learning program before? Yes☐ No☐
2. If so, which of the following? ☐Family Home Care ☐Relative? Neighbor ☐Licensed Provider
3. Are there any special concerns we should be aware of?

4. Any special needs (medical, developmental, social, mental health)?

5. Does your child have an IEP (Individualized Education Plan) or ISFP (Individualized Family Service Plan)? _____

   If so; we would like a copy of this plan so we can provide the best possible learning experience for your child.

6. Does your child have any allergies?
☐Food Allergies ☐Environmental Allergies ☐Allergies to Medicine

Questions for the Parent:

1. What are your expectations of our program?

2. Is there any other information you would like to share about your child or do you have questions about the program?