Sign & Return

EMERGENCY CONTACT 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	BIRTH DATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

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 REACTIONS)
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)

PARENTS 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

SIGNATURE OF PARENT OR GUARDIAN

DATE

Sign & Return

AGREEMENT

Name of Child:	Circle One: Male Female
Childs 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** **Weekly Contracted Tuition Fee:**

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

- All day care
- Breakfast, lunch, PM snack
- Center/age-appropriate curriculum
- Bi yearly child service reports

Child's arrival time:	Child's departure time:	Registration Fee: $75 per child Late Fee: $1 per minute, per child

Person(s) designated by parent to whom child may be released:

I, the parent/guardian:

- Received complete written program information at the time of enrollment (§3270.121, 3280.121, 3290.121)
- Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months, at a minimum. (§3270.124, 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.

Date of child's admission:

Signature Operator Date	Signature Parent/ Guardian Date

Periodic Review: Sign here at six month update:

Signature Parent/ Guardian Date

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

Sign & Return

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

Sign & Return

ALLERGY SIGN OFF

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 all staff can clearly see it.

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 medical information.

Child's Name: _____

_____

Signature Parent/ Guardian Date

Sign & Return

MEDICATION RELEASE FORM

Child's Name: _____ **Age:** _____ **DOB:** _____

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 noted/ reported: _____

Other recommendations: _____

Physician Name: _____ **Phone:** _____

Physician Signature: _____ **Date:** _____

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: _____

Parent/Guardian Signature: _____ **Date:** _____

A PHOTOCOPIED PRESCRIPTION LABEL MUST BE PROVIDED ALONG WITH THIS FORM

Sign & Return

MEDICATION LOG

55 PA. CODE §3270.133; §3280.133; §3290.133

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-prescription Refrigeration: ☐ Yes ☐ No

If prescription, prescriber's name: _____ Number: _____

Dosage amount: _____ Time to administer: _____ AM PM _____ times/ day

Dates for administration: From _____ To _____

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/Guardian Signature: _____ Date: _____

FACILITY STAFF COMPLETE THIS SECTION

Date Administered (MM/DD/YYYY)	Time Administered (AM/PM)	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.

Sign & Return

Last name:

Emergency Information Form for Children With Special Needs

American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Name	Birth date:	Nickname:
Home Address:	Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:	
Signature/Consent*:		
Primary Language:	Phone Number(s):	

Physicians:

Primary care physician:	Emergency
	Phone: Fax:
Current Specialty physician:	Emergency
Specialty:	Phone: Fax:
Current Specialty physician:	Emergency
Specialty:	Phone: Fax:
Anticipated Primary ED:	Pharmacy:
Anticipated Tertiary Care Center:	

Diagnoses/ Past Procedures/ Physical Exam:

1.

2.

3.

4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Sign & Return

Diagnoses/Past Procedures/Physical Exam continued:

Medications: **Significant baseline ancillary findings (lab, x-ray, ECG):**

1.

2. **Prostheses/Appliances/Advanced Technology Devices:**

3.

4.

5.

6.

Management Data:

Allergies: Medications/Foods to be avoided **and why:**

1.

2.

3.

Procedures to be avoided **and why:**

1.

2.

3.

Immunizations (mm/yy)

Dates					
DPT					
OPV					
MMR					
HIB					

Dates					
Hep B					
Varicella					
TB status					
Other					

Antibiotic prophylaxis: Indication: Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	**Suggested Diagnostic Studies**	**Treatment Considerations**

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: **Print Name:**

Sign & Return

ACCEPTANCE OF HANDBOOK

Child's Name: _____

I have read and understand the YMCA Early Learning Programs Childcare Handbook.

I understand that this handbook is the framework to create a partnership that will help YMCA staff and parents to come together for the benefit of your child, as well as all children at Y Care. I understand and agree to comply with all of the requirements set forth by the YMCA of Reading & Berks County and their program. If I have any further questions and/or concerns regarding this handbook I know that I am to speak with the Center or Program Director for further explanation.

I understand that the YMCA School Age Program has a zero-tolerance policy for serious behavior infractions since the goal is to provide a healthy, safe, and fun environment for every program participant.

Parent/ Guardian's Signature: _____

Parent/ Guardian's Name: _____ **Date:** _____

Sign & Return

PARENT STATEMENT OF UNDERSTANDING

The following information is important for the safety and protection of your child. Please read the information, sign this form, and return it to the YMCA.

Please keep and refer to your copy of the YMCA Program Policies in your Parent/ Guardian Handbook. Your signature below indicates that you have received and read them.

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

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 receive and supervise my child.

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

I understand that should a person arrive 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 the police. (Note: please do not put staff in a position where they must make this judgment.)

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

I have received a copy of the YMCA Before & After SchoolParent/Guardian Handbook and have read and understand it.

Parent/ Guardian's Signature: _____

Parent/ Guardian's Name: _____ **Date:** _____

Sign & Return

PHOTO/ VIDEO AND 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, soundtrack 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, soundtrack 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, soundtrack 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, soundtrack recordings and photo reproductions of me and/or my narrative account of my experience as described herein.

I am the legal guardian of _____ (child's name)

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

_____

Parent Signature Date

_____

Printed Name

RICHMOND ELC ONLY

Sign & Return

ACCESS CARD SIGN-OFF

Child's Name: _____

Parents's Name: _____

I _____ understand as a parent/ guardian of a child enrolled at the YMCA Early Learning Center (Richmond) that I am borrowing a security door access card for the duration of care.

Each child will receive two cards for a $20 security deposit. If you return both cards at the end of care, the $20 security deposit will be returned.

Additional security cards available at $10 per card, refundable upon return. Please complete below who will have possession of additional card(s).

Name: _____

Name: _____

Name: _____

Replacement card(s) lost or damaged will cost $20 apiece, non-refundable.
HOLE PUNCHING AND WRITING ON CARDS IS CONSIDERED DAMAGE TO THE CARDS.

I understand that these security card(s) must be returned to the YMCA at the end of care or my refundable deposits will not be returned.

_____

Parent Signature Date

Sign & Return

GETTING TO KNOW YOU: INFANT/ TODDLERS

Child's Name: _____ DOB: _____ Date: _____

Family Members: _____

ABOUT YOUR FAMILY

Tell me about your family.

What language(s) do you speak at home?

What are some activities your family enjoys doing together?

Is this your child's first early childhood program experience?

What is the best way for our program to exchange information with you about your child?

ARRIVAL/ DEPARTURE

What time will you usually arrive?

What will help you and your child say good-bye to each other in the morning?

What time will you usually come to pick up your child?

What will help you and your child say hello to each other at the end of the day?

DIAPERING AND TOILETING

What type of diapers do you use?

How often do you change your child's diaper? When does your child usually need a diaper change?

Sign & Return

Are there any special instructions for diaper changes?

Is your child beginning to use the toilet? If so, are their any special instructions for toileting?

SLEEPING

How will we know that your child is tired and needs to sleep?

When does your child usually sleep? How long does your child usually sleep?

What helps your child to fall asleep? Do they use a pacifier?

We put babies to sleep on their backs. Is your baby used to sleeping on their back?

Is your baby swaddled for sleep? We do not swaddle with blankets.

How does your child wake up? Does he or she wake up quickly or slowly? Does your child like to be taken out of the crib immediately or to lie alone in the crib for a few minutes before being held?

EATING-

BABIES

Are you breastfeeding or bottle-feeding your baby?

If breastfeeding, how will you provide the expressed breast milk?

If bottle-feeding,

Will you be using the formula we provide? If not, what formula will you provide?
Similac Total Comfort Similac 360 Total Care Other:

How do you prepare the bottles? How much do you prepare at one time?

How much does your baby drink at one time?

How much time between each feeding?

Sign & Return

Ages 6 months through 11 months: (Once solid foods are introduced at home we will switch to a breakfast, lunch and pm snack routine. Please notify your teacher of which foods you have begun; we supply Gerber stage 2 foods)

Is your baby eating solid foods?

If so, which ones?

When?

How do you prepare the baby's solid foods?

How much does your baby eat at one time?

In what position is your baby use to being fed?

Does your baby eat any finger foods? If so, which ones?

ALL CHILDREN

What are some of your child's favorite foods?

What foods does your child dislike?

Is your child sensitive or allergic to any foods? If so, please list them.

DRESSING

Is there anything special we should know about dressing and undressing your child?

AWAKE TIME

How does your baby like to be held? What position does your baby prefer when awake?

What does your child like to do when awake?

How do you play with your child?

ADDITIONAL INFORMATION

What else would you like us to know about your child and family?

Sign & Return

GETTING TO KNOW YOU: PRESCHOOL/ PRE-K

Child's Name: _____ DOB: _____ Date: _____

Family Members: _____

ABOUT YOUR FAMILY

Tell me about your family.

What language(s) do you speak at home?

What are some activities your family enjoys doing together?

Is this your child's first early childhood program experience?

What is the best way for our program to exchange information with you about your child?

FAVORITE ACTIVITIES AND SPECIAL INTERESTS

What are some of your child's favorite activities?

With whom does your child play? How do they play together? What do they play together?

What is your child most interested in right now? How can you tell?

Does your child have favorite toys? How does your child play with them?

What books does your child like to read? Does your child read alone or with you?

What songs does your child know and like to sing?

Sign & Return

ARRIVAL/ DEPARTURE

What time will you usually arrive?

What will help you and your child say good-bye to each other in the morning?

What time will you usually come to pick up your child?

What will help you and your child say hello to each other at the end of the day?

MEALTIME

Describe your child's mealtimes and how your child eats or is fed. Do they like to eat alone or in a group?

What are some of your child's favorite foods? What foods does your child dislike?

Is your child sensitive or allergic to any food? If so, what are they?

NAP TIME/ RESTING

Does your child nap during the day? If so, what helps your child fall asleep?

How long does your child usually sleep?

When does your child usually sleep?

If your child does not nap during the day, does your child have rest time? What quiet activities does your child usually do during this rest time?

Sign & Return

OTHER ROUTINES

Does your child use the toilet? If so, are there any special instructions for toileting? How does your child let you know that he or she needs to use the toilet?

Does your child stay dry while napping?

Is there anything special that we should know about dressing and undressing your child?

ADDITIONAL INFORMATION

What else would you like us to know about your child and family?

Sign & Return

Child and Adult Care Food Program
Child Enrollment Form

Sponsor/Center Name: _____

Agreement #: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

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									☐ EARLY MORNING SNACK ☐ 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* ☐ EARLY MORNING SNACK ☐ 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* ☐ EARLY MORNING SNACK ☐ 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* ☐ EARLY MORNING SNACK ☐ 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* ☐ EARLY MORNING SNACK ☐ 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: Effective Date of This Enrollment Form: _____ _____

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.

Sign & Return

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** _____________________

****

Sign & Return

CACFP Meal Benefit Income Eligibility (Child Care)

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

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.

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

Check all that apply

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 Children listed in STEP 1 here.

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

B. All 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 Household Members (First and last)	Earnings from Work	Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/Social Security/SSI/VA Benefits	Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

(How often? columns apply to the income column before them.)

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. This form is not valid without signature and date of adult household member

"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

Revision 08/16/2021

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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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: (833) 256-1665 or (202) 690-7442;
EMAIL: or program.intake@usda.gov.

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

This institution is an equal opportunity provider.

For Official CACFP Sponsor Use Only NOT VALID WITHOUT DETERMINING OFFICIAL'S SIGNATURE AND DATE

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 (second check) _____ Date

_____ Follow-up Official's Signature (For Pricing Institutions - Verification Official) _____ Date

Effective Date: If the Institution is using the parent/guardian signature date as the effective date, the form must have been signed by the Institution representative within the same month the parent signed the form or the immediately following month.

Sign & Return

pennsylvania
DEPARTMENT OF EDUCATION

CACFP Infant Enrollment Form

Center/Provider Name:_____

Dear Parent/Guardian,
This childcare center/provider participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires childcare centers/providers to follow specific meal patterns according to the age of the infant.

Childcare centers/providers participating in the CACFP **are required** to offer at least one iron fortified infant formula for infants who are enrolled in care. You may decline the infant formula offered, and supply breast milk and/or your own CACFP approved iron-fortified formula.
(NOTE: A CACFP approved iron-fortified formula must have 1 mg of iron or more per 100 calories of formula when prepared using the label directions and must be regulated by the FDA.)

Additionally, when you determine, in consultation with your physician, that your infant is developmentally ready, the childcare center/provider will also be **required** to offer iron fortified infant cereal and other infant foods.

Infant's Name_____Infant's Date of Birth_____

Iron Fortified Formula offered by the Center/Provider_____

Breast milk and/or Formula preference

Record date to indicate your preference (choose all that apply) ***I understand that I may change my decision at any time with advance notice**	**Birth -5 months Date & Initial**	**6 – 11 months Date & Initial**
I will provide expressed breast milk for my infant.		
I will breast feed my infant on site at the center/provider.		
I want the childcare center/provider to provide the infant formula it offers for my infant.		
I will provide the infant formula for my infant. (must be iron fortified) **Name of infant formula I will provide:** _____		
My infant has a special dietary need that requires a formula that does not meet the criteria for an approved iron fortified formula. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, and the recommended substitution. **Name of infant formula:** _____ ☐ Center will provide the formula. ☐ I will provide the formula.		

Sign & Return

Preference regarding infant cereal and other foods

Record date to indicate your preference *I understand that I may change my decision at any time with advance notice	**6 – 11 months Date & Initial**
I want the childcare center/provider to provide the iron fortified infant cereal and other foods for my infant.	
I want the childcare center/provider to provide all food items with one exception. (This option is only applicable if center/provider is providing the iron-fortified infant formula) **One food item that I will provide (must be a creditable CACFP food item): _____**	
My infant has a special dietary need that requires modifications to the infant meal pattern requirements. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, the foods to avoid and the recommended substitutions	
I am aware and understand the all information provided on this form and my ability to have my infant participate in the CACFP; however, **I decline** the infant formula and food offered by the center/provider and elect to furnish ALL infant formula and food for my infant. **(Center/Provider may not claim meals for this infant)**	

Parent/Guardian _____ **Date** _____ **Center/Provider signature** _____ **Date** _____

This supplemental infant form must be completed for all infants in care and must be maintained by center/provider and if applicable, a copy must be maintained by the Sponsoring organization.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

Sign & Return

pennsylvania
DEPARTMENT OF EDUCATION

Formulario de inscripción de bebés en CACFP

Centro/Nombre del proveedor:_____

Estimado Padre/Tutor:
Este centro/proveedor de cuidado infantil participa en el Programa de alimentos para el cuidado de niños y adultos (Child and Adult Care Food Program, CACFP) y recibe reembolso del Departamento de Agricultura de EE. UU. (US Department of Agriculture, USDA) por servir comidas nutritivas a bebés conforme a los requisitos del programa. La participación en este programa requiere que los centros/proveedores de cuidado infantil cumplan patrones de comida específicos según la edad del bebé.

Los centros/proveedores de cuidado infantil que participan en el CACFP <u>tienen la obligación</u> de ofrecer al menos una leche de fórmula para bebés fortificada con hierro para los bebés que están inscritos a su cuidado. Puede rechazar la leche de fórmula para bebés ofrecida y suministrar leche materna y/o su propia leche de fórmula fortificada con hierro aprobada por el CACFP.
(NOTA: La leche de fórmula fortificada con hierro aprobada por el CACFP debe contener 1 mg de hierro o más de 100 calorías de leche de fórmula al prepararse conforme a las instrucciones de la etiqueta y debe estar regulada por la FDA).

Además, cuando usted determine, junto con su médico, que su hijo está listo desde el punto de vista de desarrollo, el centro/proveedor de cuidado infantil también tiene la obligación de ofrecer cereales para bebés fortificados con hierro y otros alimentos para bebés.

Nombre del bebé_____**Fecha de nacimiento del bebé**_____

Leche de fórmula fortificada con hierro provista por el centro /proveedor_____

Leche materna y/o preferencia de leche de fórmula

Registrar la fecha para indicar su preferencia (elegir todas las que apliquen) *Comprendo que puedo cambiar mi decisión en cualquier momento con notificación por adelantado	**Del nacimiento a los -5 meses Fecha e inicial**	**6– 11 meses Fecha e inicial**
Suministraré leche materna extraída para mi bebé.		
Amamantaré a mi bebé en el sitio en el centro/proveedor.		
Deseo que el centro/proveedor de cuidado infantil brinde la leche de fórmula para bebés que ofrece a mi bebé.		
Suministraré la leche de fórmula para bebés para mi bebé. (debe estar fortificada con hierro) **Nombre de la leche de fórmula para bebés que suministraré** _____		
Mi bebé tiene una necesidad de dieta especial que requiere una leche de fórmula que no cumple con los criterios de leche de fórmula fortificada con hierro. Entregué al centro/proveedor un Plan médico de cuidado firmado por una autoridad médica con licencia que incluye la limitación que restringe la dieta del bebé, cómo le afecta al bebé y el reemplazo recomendado. **Nombre de la leche de fórmula para bebés** _____ ☐ El centro de cuidado infantil proveerá la leche de fórmula. ☐ Yo proveeré la leche de fórmula.		

Sign & Return

Preferencia sobre cereales para bebé y otros alimentos

Registrar la fecha para indicar su preferencia *Comprendo que puedo cambiar mi decisión en cualquier momento con notificación por adelantado	**6– 11 meses** **Fecha e inicial**
Deseo que el centro/proveedor de cuidado infantil brinde el cereal para bebés fortificado con hierro y otros alimentos a mi bebé.	
Deseo que el centro/proveedor de cuidado infantil suministre todos los alimentos con una excepción. (Esta opción solo aplica si el centro/proveedor suministra leche de fórmula para bebes fortificada con hierro) **Alimento que suministraré (debe ser un alimento aprobado por el CACFP)** _____	
Mi bebé tiene una necesidad de dieta especial que requiere modificaciones a los requisitos de patrones de comidas para bebés. Entregué al centro/proveedor un Plan médico de cuidado firmado por una autoridad médica con licencia que incluye la limitación que restringe la dieta del bebé, cómo le afecta al bebé, los alimentos que hay que evitar y los reemplazos recomendados	
Estoy al tanto y comprendo toda la información provista en este formulario y la posibilidad de que mi bebé participe en el CACFP; sin embargo, **rechazo** la leche de fórmula para bebés y los alimentos ofrecidos por el centro/proveedor y elijo entregar TODA la leche de fórmula para bebés y alimentos para mi bebé. **(El centro/proveedor no podrá reclamar comidas para este bebé)**	

Padre/tutor **Fecha** **Firma del centro/proveedor** **Fecha**

De acuerdo con la ley federal de derechos civiles y las normas y políticas de derechos civiles del Departamento de Agricultura de los Estados Unidos (USDA), esta entidad está prohibida de discriminar por motivos de raza, color, origen nacional, sexo (incluyendo identidad de género y orientación sexual), discapacidad, edad, o represalia o retorsión por actividades previas de derechos civiles.

La información sobre el programa puede estar disponible en otros idiomas que no sean el inglés. Las personas con discapacidades que requieren medios alternos de comunicación para obtener la información del programa (por ejemplo, Braille, letra grande, cinta de audio, lenguaje de señas americano (ASL), etc.) deben comunicarse con la agencia local o estatal responsable de administrar el programa o con el Centro TARGET del USDA al (202) 720-2600 (voz y TTY) o comuníquese con el USDA a través del Servicio Federal de Retransmisión al (800) 877-8339.

Para presentar una queja por discriminación en el programa, el reclamante debe llenar un formulario AD-3027, formulario de queja por discriminación en el programa del USDA, el cual puede obtenerse en línea en: https://www.fns.usda.gov/sites/default/files/resource-files/usda- program-discrimination-complaint-form-spanish.pdf, de cualquier oficina de USDA, llamando al (866) 632-9992, o escribiendo una carta dirigida a USDA. La carta debe contener el nombre del demandante, la dirección, el número de teléfono y una descripción escrita de la acción discriminatoria alegada con suficiente detalle para informar al Subsecretario de Derechos Civiles (ASCR) sobre la naturaleza y fecha de una presunta violación de derechos civiles. El formulario AD-3027 completado o la carta debe presentarse a USDA por:

(1) **correo:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue,SW
Washington, D.C. 20250-9410; o

(2) **fax:**
(833) 256-1665 o (202) 690-7442; o

(3) **correo electrónico:**
program.intake@usda.gov

Esta entidad es un proveedor que brinda igualdad de oportunidades.

Dear families,

Building and maintaining a strong home–school connection and keeping you involved in your child's day-to-day learning experiences at our school is of the utmost priority. We are excited to announce that we are rolling out a wonderful family engagement program called tadpoles®.

The tadpoles® program makes it easy for your child's teacher to share real-time information about your child, giving you an unparalleled view into the caregiving events, learning experiences, discoveries, and accomplishments that make your child's days with us so special.

Your child's teacher will use tadpoles® to share photos, videos, and daily reports with you securely via email, online at www.tadpoles.com, or via the free tadpoles® Parent app for iOS or Android devices. As a family member, you can use tadpoles® to enter morning drop-off notes, mark your child absent, and share other important information with your child's teacher.

Each classroom will have a mobile device that is solely for use with the secure tadpoles® software. Teachers will not have access to any other functionality on these dedicated devices, ensuring the privacy and security of all information exchanged on the platform. Only you and other designated contacts will receive information about your child.

To create your account on the tadpoles® Parent app:

1. Download the tadpoles® Parent app.
2. Select "Sign Up".
3. Create an account using the email where you receive your tadpoles® messages.
4. Check your email for a link to set up a password.

To create your account on the tadpoles® website:

1. Go to http://www.tadpoles.com
2. Select "Log in"
3. Choose "Parent"
4. Select "Sign Up"
5. Create an account using the email where you receive your tadpoles® messages.
6. Check your email for a link to set up a password.

For more information on setting up your account, please review this article. For more information on using the tadpoles® Parent app, please review this article.

We are confident that you will find tadpoles® easy to use and welcome the insight it gives you into your child's experiences here at our school. As always, we are happy to answer any questions and address any concerns you have about this new initiative. Thank you for continuing to be a partner in your child's learning!

Building for the Future

In the child and Adult Care Food Program (CACFP)

What is CACFP?

- CACFP is the Child and Adult Care Food Program. It is a Federal program that pays for healthy meals and snacks for children and adults in day care.
- CACFP improves the quality of day care.
- It makes the cost of day care cheaper for many low-income families. Besides providing meals in day care, CACFP makes afterschool programs more appealing to at-risk children and youth. Serving afterschool meals and snacks attracts students to learning activities that are safe and fun.
- Children and youth who are homeless can also receive meals at shelters that participate in CACFP.

How does CACFP work?

- Day care homes and centers receive money for serving nutritious meals. The Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA) oversees CACFP.
- States approve sponsors and centers to operate the program. States also monitor and provide training and guidance to make sure CACFP runs right. Sponsoring organizations support day care homes and centers with training and monitoring. All day care homes participate in CACFP through a sponsor.

Who is eligible for CACFP meals?

- Daycare homes and centers receive money for serving nutritious meals. The Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA) oversees CACFP.
- States approve sponsors and centers to operate the program. States also monitor and provide training and guidance to make sure CACFP runs right. Sponsoring organizations support day care homes and centers with training and monitoring. All day care homes participate in CACFP through a sponsor.

What kinds of meals are served?

CACFP meals follow USDA nutrition standards.

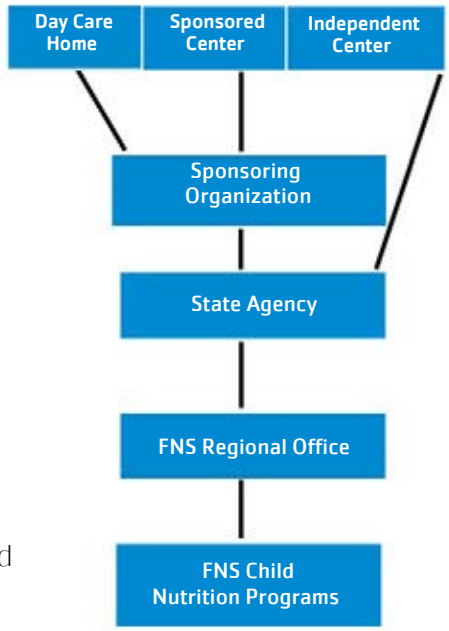
- Breakfast consists of milk, fruits or vegetables, and grains.
- Lunch and Supper require milk, grains, meat or other proteins, fruits, and vegetables.
- Snacks include two different servings from the five components: milk, fruits, vegetables, grains, or meat or other proteins.

Where are CACFP meals served?

Many types of facilities participate in CACFP.

Child Care Centers: Licensed child care centers and Head Start programs provide day care with meals and snacks to large numbers of children.
Outside-School-Hours Care Centers: Licensed centers offer before or afterschool care with meals and snacks to large numbers of school-aged children.
Family Day Care Homes: Licensed providers offer family child care with free meals and snacks to small groups of children in private homes.
"At-Risk" Afterschool Care Programs: Centers in low-income areas provide learning activities with free meals and snacks to school-age children and youth.
Emergency Shelters: Homeless, domestic violence, and runaway youth shelters provide places to live with free meals for children and youth.
Adult Day Care Centers: Licensed centers provide day care with meals and snacks to enrolled adults.

CACFP Partners



USDA FNS-319 October 2019 USDA is an equal opportunity provider, employer and lender.

PENNSYLVANIA WIC
WOMEN · INFANTS · CHILDREN

pennsylvania
DEPARTMENT OF HEALTH
www.health.pa.gov | www.pawic.com

How do I apply?

Get started online at pawic.com or call 1-800-WIC-WINS (1-800-942-9467).

What is WIC?

WIC is the Special Supplemental Nutrition Program to help improve the health of women, infants and children. WIC services are provided at no cost to you and your family.

"WIC has helped me make healthier choices for my child, and I can save on my grocery bill" - WIC mom

Who is eligible?

- Women who are pregnant, breastfeeding or recently had a baby (under 6 months)
- Infants
- Children under age 5

You must live in Pennsylvania, have a nutrition need and not exceed the income guidelines. WIC is for married and single parents, working families and the unemployed. If you are a father, mother, foster parent or other legal guardian of a child under age 5, you can apply for WIC for your child.

How can WIC help my family?

WIC offers screenings and referrals to health care and other services

- Iron testing for anemia
- Immunization, health and lead screenings
- Referrals for SNAP, MA, TANF, CHIP, Healthy Beginnings Plus, Head Start, food banks, etc.

Gives advice for healthy eating

- One-on-one nutrition education
- Nutrition materials
- Online information

Supports breastfeeding; Breastfeeding provides many health, nutritional, economical and emotional benefits to mother and baby. WIC helps mothers continue breastfeeding even if they return to work.

Provides healthy food:

- Milk
- Cheese
- Yogurt
- Soy-based beverages
- Tofu
- Fruits & vegetables (fresh, frozen, or canned)
- Dried or canned beans/peas
- Eggs
- Peanut butter
- Canned fish
- Juice
- Cereal
- Whole grains (bread, tortillas, oats, brown rice and pasta)
- Infant foods
- Formula and medically necessary supplements

Did you know?

- Even if you receive SNAP, MA or TANF, you may also apply for WIC.
- In most instances, WIC has higher income guidelines than SNAP, MA or TANF. Even if you don't qualify for these programs, you may qualify for WIC.
- Most families in Head Start and Early Head Start qualify for WIC.
- Foster children under age 5 qualify for WIC. Foster parent income is not considered.
- WIC does not require proof of citizenship.

WIC Income Guidelines

Household Size	*Monthly (Approx.)
1	$1,968
2	$2,658
3	$3,349
4	$4,040

For each additional person, add $691

***Income (before taxes) is effective July 1, 2020 For each unborn infant, add one to household size.**

PA WIC is funded by the USDA. This institution is an equal opportunity provider.
H511.967P. Rev. 7/20

*Income (before taxes) is effective July 1, 2020 For each unborn infant, add one to household size.