

**Merrimack Valley YMCA - Methuen & Lawrence  
Branch Preschool Child Care Program  
Service Agreement 2020-2021**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Once enrolled in the program, you will be required to pay two week's tuition in advance and understand that payment is due on or before Friday of the week prior to services. Once enrolled, NO deduction or credit for individual absences will be given. There is a 2 day minimum (Tue/Thur), limited availability, at the Directors discretion. A Preschool YMCA general membership is given to the child and is valid during the time that the child is enrolled in the Preschool Child Care Program. I understand the cost of the program is:

- Full Time Toddler Care= \$336.25 per week (10 hours max per day)
- Full Time Preschool = \$245.00 per week (10 hours max per day)
- Part Time Preschool = \$140 per week (less than 6 hours per day)

Please see the attached holiday closure list in our handbook.

*In addition as the parent/guardian, I understand and agree to:*

- Pay my weekly tuition fee one week in advance of service at all times. Payment is due on or before Friday each week.
- Pay a late pick up fee of \$1.00 per child each minute after the program ends based on my registration.
- Pay a \$1.00 late fee per child, per minute for subsidy families exceeding the part time (6 hrs max) / full time (10 hr max) hours. Pay the full day private rate (part time private/assistance families) if part time hours (6 hrs max) are exceeded
- A \$25.00 late fee will be applied to my delinquent account.
- Pay a \$25.00 charge for any check that is returned from the bank. (Check must be replaced with a certified check or money order.)
- Provide the program with all completed registration forms and a completed, up to date health form and update as necessary (Example: New phone number, change of address, allergies, etc.).
- Children are to be in their classrooms no later than 9:00 am to begin their daily structured activities.
- Call the program prior to your child's start time if the child is going to be absent.
- Abide by the guidelines stated in the parent handbook.
- Attend parent meetings.
- Pay my weekly tuition for any vacation time my child is out of care in which my child's slot will be held; cannot go unpaid.
- Provide a two-week written notice to change my child's schedule, submit vacation request or to remove my child from the program. I understand that the 2 weeks will begin the date the notice is received and I understand that I am responsible for payment during this period.

*The YMCA PSCC Program Agrees to:*

- Uphold Massachusetts EEC Regulations.
- Uphold NAEYC Accreditation Standards.
- Uphold all YMCA guidelines.
- Provide a nutritious breakfast, lunch & two nutritious snacks each day.
- Provide trained, qualified staff.
- Provide supervised social, educational, and recreational activities.
- Provide advanced notice of fieldtrips.
- Keep all information about children and families in confidential files, to be released only with permission of the parent/guardian.
- Provide the parent/guardian with community health and social service information upon request.

*Required Documents for Registration:*

- Copy of parent's photo ID
- Copy of all children's birth certificate in the household
- Copy of current physical and immunization record for child; lead, hearing and vision test results must be on physical
- Copy of child's social security card
- Recent photo of child
- Signed Code of Conduct
- USDA Completed Paperwork

After reading the YMCA PSCC Parent Handbook and reviewing the highlighted policies above, I agree to the conditions of this service agreement. I understand that the YMCA reserves the right to amend this agreement upon written notification. I also understand that the YMCA reserves the right to dismiss my child if his/her actions or behavior interferes with the safety and/or enjoyment of planned activities. I agree to familiarize myself and my child with the information contained in the handbook as well as the YMCA rules and understand that it constitutes the policies and guidelines of the YMCA PSCC Program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Intake Worker's Signature

\_\_\_\_\_  
Date

**2020-2021 Group Day Care Registration Form**

(Do not tear pages out of this registration packet.)

Andover/ North Andover Branch

Lawrence Branch

Methuen Branch

Child's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age at Admission: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_

Family E-Mail Address: \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Parent/Guardian Information**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer City: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Work Hours: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer City: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Work Hours: \_\_\_\_\_

**Emergency Contacts (EC) & Alternate Pick up Person (APP):** You are required to list at least 2 people with whom you feel comfortable leaving your child and who can assume responsibility for your child if you could not be reached immediately in an emergency, or for some reason you could not pick up your child & were unable to communicate with the program. Any changes to this list must be done in writing. No Exceptions! Please understand that we will ask for positive identification from anyone unfamiliar to us.

**#1** Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_ EC \_\_\_ APP \_\_\_

**#3** Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_ EC \_\_\_ APP \_\_\_

**#2** Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_ EC \_\_\_ APP \_\_\_

**#4** Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_ EC \_\_\_ APP \_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Merrimack Valley YMCA  
EMERGENCY CARD  
INFORMATION

|                      |             |
|----------------------|-------------|
| For Office Use Only: |             |
| Admission Date:      | ___/___/___ |
| Date of Birth:       | ___/___/___ |
| Physical Date:       | ___/___/___ |

Andover/ North Andover Branch

Lawrence Branch

Methuen Branch

Child's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age at Admission: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

**Parent/Guardian Information:**

|             |  |                  |  |
|-------------|--|------------------|--|
| Name:       |  | Relationship:    |  |
| Address:    |  | City, State, zip |  |
| Cell Phone: |  | Work Phone:      |  |
|             |  |                  |  |
| Name:       |  | Relationship:    |  |
| Address:    |  | City, State, zip |  |
| Cell Phone: |  | Work Phone:      |  |

**Emergency Contact Person(s):**

|             |  |                  |  |
|-------------|--|------------------|--|
| Name:       |  | Relationship:    |  |
| Address:    |  | City, State, zip |  |
| Cell Phone: |  | Work Phone:      |  |

|             |  |                  |  |
|-------------|--|------------------|--|
| Name:       |  | Relationship:    |  |
| Address:    |  | City, State, zip |  |
| Cell Phone: |  | Work Phone:      |  |

**Pediatrician or Source of Health Care:**

|               |  |                  |  |
|---------------|--|------------------|--|
| Doctors Name: |  | Phone:           |  |
| Address:      |  | City, State, zip |  |

Medical Conditions/Allergies:

\_\_\_\_\_

\_\_\_\_\_

Insurance Information (optional):

Company Name: \_\_\_\_\_ Policy # \_\_\_\_\_

**The following people are NEVER allowed to pick up my child (If this is a custody issue, you must provide the Child Care Director a copy of court documents.):**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**Emergency Authorization**

I hereby give permission for the staff of the Merrimack Valley YMCA, to provide first aid and/or CPR/AED treatment to my child, \_\_\_\_\_, when necessary and in the event of a more serious illness or injury; I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency medical treatment. I also authorize ambulance/rescue squad attendants to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted. I understand that YMCA personnel will make every effort to contact me regarding any emergency involving my child.

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Medical Information

Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

List any chronic conditions, dietary restrictions, or medications:  
\_\_\_\_\_

List any allergies, reactions and treatment:  
\_\_\_\_\_

Does your child have an IEP (Individualized Education Plan) or a 504 Plan? If yes, please attach: \_\_\_\_\_

Does your child have an Individual Health Plan (for children with a chronic health condition)? \_\_\_\_\_  
If yes, please attach

Do you have a custody agreement, court order, and/or restraining order pertaining to the child? \_\_\_\_\_  
If yes, please attach

Promotional Release

I give permission to the YMCA to public my child's name and photograph in YMCA brochures, newspaper or other publications.  
\_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, Initial: \_\_\_\_\_ Date: \_\_\_\_\_)

I give my permission for my child to attend instructional classes and/or recreational swims at the designated Merrimack Valley YMCA Branch.  
[Lawrence/Andover/North Andover Only]  
\_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, Initial: \_\_\_\_\_ Date: \_\_\_\_\_)

I give permission to the Merrimack Valley YMCA Staff to speak and/or exchange documents concerning my child with school personnel. \_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, Initial: \_\_\_\_\_ Date: \_\_\_\_\_)

I give permission for my child to go on walks in surrounding neighbors of YMCA.  
\_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, Initial: \_\_\_\_\_ Date: \_\_\_\_\_)

## 2020-2021 YMCA Developmental History Form

Child's Name: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Skin Color: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_ Primary Language: \_\_\_\_\_

List any physical limitations or special situations your child has: \_\_\_\_\_

List any allergies or food intolerance that your child may have: \_\_\_\_\_

Does your child take medication(s) regularly?       Yes     No

If yes, please list the name of the drug, how often they receive this medication and what time it is to be given. (Please check the parent handbook regarding our policy on dispensing medication during program hours.):

List all Holidays, celebrations and occasions that your family celebrates: \_\_\_\_\_

List your child's special interests and hobbies: \_\_\_\_\_

Favorite physical activities: \_\_\_\_\_

Favorite Game/Toy: \_\_\_\_\_ Favorite TV Show: \_\_\_\_\_

Favorite Snack: \_\_\_\_\_ Favorite Book: \_\_\_\_\_

Does your child enjoy musical activities?       Yes     No

Does your child primarily use his/her right or left hand?       Right Hand     Left Hand     No Preference Yet

By nature is your child:

Aggressive       Shy       Serious       Friendly       Withdrawn       Easy Going

How do you reassure your child when he/she is upset? \_\_\_\_\_

Does your child nap?       Yes     No

How does your child get along with other children? \_\_\_\_\_

Does your child prefer to play alone or with other children? \_\_\_\_\_

Do you feel your child will adjust easily?       Yes     No      If no, why? \_\_\_\_\_

Does your child demand a lot of attention? \_\_\_\_\_

Is your child the only child in your family?       Yes     No      If no, do they all reside in your home?       Yes     No

Please list siblings & ages: \_\_\_\_\_

How does your child show:

Happiness \_\_\_\_\_

Anger \_\_\_\_\_

Disappointment \_\_\_\_\_

What do you find is the best way to effectively deal with inappropriate behaviors? \_\_\_\_\_

Who does the disciplining in your family? \_\_\_\_\_

At what age was your child toilet trained? \_\_\_\_\_ Does your child have accidents? \_\_\_ Yes \_\_\_ No

What special words does your child use to describe bathroom needs? \_\_\_\_\_

Is your child frightened by:

\_\_\_ Animals \_\_\_ Loud Noises \_\_\_ New Situations \_\_\_ Storms Other \_\_\_\_\_

Has your child attended swimming lessons? \_\_\_ Yes \_\_\_ No If yes, was it at this YMCA \_\_\_ Yes \_\_\_ No

Does your child like or dislike the water? \_\_\_ Like Water \_\_\_ Dislike Water

What are your goals for your child while in this program? \_\_\_\_\_

Are there any situations or circumstances involving your child that the staff should be informed of? \_\_\_\_\_

(The above information will help us better understand your child's need.)

**Additional Comments**

**For Office Use Only**

Age at Admission: \_\_\_\_\_

Membership Type: \_\_\_\_\_ Membership #: \_\_\_\_\_

YMCA Program/Classroom: \_\_\_\_\_

Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Transportation Plan**

My child will arrive at the program with a parent or his/her designee and will depart from the program with a parent or his/her designee. Teachers will ask for a photo identification card until they become familiar with person(s) picking up.

THE COMMONWEALTH OF MASSACHUSETTS  
Department of Early Education and Care

**Small Group and Large Group Transportation Plan and Authorization**

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

My child will be attending the following days and times:  
(not exceeding 10 hrs per day Full Time or 6 hrs per day Part Time)

| <u>Day</u> | <u>Arrive</u> | <u>Depart</u> |
|------------|---------------|---------------|
| Monday     | _____ am/pm   | _____ am/pm   |
| Tuesday    | _____ am/pm   | _____ am/pm   |
| Wednesday  | _____ am/pm   | _____ am/pm   |
| Thursday   | _____ am/pm   | _____ am/pm   |
| Friday     | _____ am/pm   | _____ am/pm   |

**MY CHILD WILL ARRIVE AT THE PROGRAM:**

\_\_\_ PARENT/DESIGNEE DROP OFF

\_\_\_ PUBLIC or PRIVATE SCHOOL

\_\_\_ \*PRIVATE TRANS. ARRANGED BY PARENT

**MY CHILD WILL DEPART FROM THE PROGRAM:**

\_\_\_ PARENT/DESIGNEE PICK UP

\_\_\_ PUBLIC or PRIVATE SCHOOL

\_\_\_ \*PRIVATE TRANS. ARRANGED BY PARENT

\*Please provide name of company, phone #, and copy of agreement

\_\_\_\_\_

PARENT /GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION**

Must be updated annually or if parent makes any changes regarding the transportation to and from the center or if their schedule changes.



## Parent Statement of Understanding

The following information is important for the safety and protection of your child. Please read the information and sign this form to acknowledge your receipt and understanding of the Merrimack Valley YMCA's procedures governing the safety of children in our programs.

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

I understand that at no time may a staff person be alone with a single child where they cannot be observed by others. This means no one-on-one supervision of children.

I understand that my child will not be allowed to leave a licensed program with an unauthorized person. Any person authorized to pick up your 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. Persons who pick up your child must have a photo ID to verify identity.

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. Please do not put staff in a position where they have to make this judgment call.

I understand that the YMCA prohibits inappropriate talk, jokes, or sharing details of one's personal life and any kind of harassment in the presence of children, parents, and members.

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

A Resolution of the Merrimack Valley YMCA Board of Directors:

"To commit to diversity, inclusion and global efforts that increase access and engagement with our Y for everyone in our community regardless of race, gender, national origin, faith, age, income levels, sexual orientation, immigration status, varying abilities or other protected status."

**I have read and understand the statements above and have received a copy of the Pre School Child Care Parent Handbook.**

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Parent / Guardian Signature

Date



MERRIMACK VALLEY YMCA  
CODE OF CONDUCT  
For Staff and Volunteers

1. To protect YMCA staff, volunteers, and program members, at no time during a YMCA program may a staff person be alone with a single child where he or she cannot be observed by others. As staff supervise children, they should space themselves in such a way that other staff can see them.
2. Staff shall never leave a child unsupervised.
3. Rest-room supervision: Staff will make sure the restroom is not occupied by suspicious or unknown individuals before allowing children to use the facilities. Staff will stand in the doorway of the restroom while children are using the restroom. This policy allows privacy for the children and protection for the staff (not being alone with a child). If staff is assisting younger children, doors to the facility must remain open. No child, regardless of age, should ever enter a bathroom alone on a fieldtrip or at other off-site locations. Always send children in pairs (known as the rule of three) with a staff.
4. Staff should conduct or supervise private activities in pairs (one staff with 2 children) – diapering, putting on bathing suits, taking showers, and so on. When this is not feasible, staff should be positioned so that they are visible to others.
5. Staff should not abuse children in any way, including:
  - Physical abuse – striking, spanking, shaking, slapping, and so on.
  - Verbal abuse – humiliating, degrading, threatening, and so on.
  - Sexual abuse – touching or speaking inappropriately.
  - Mental abuse – shaming, withholding kindness, being cruel, and so on.
  - Neglect – withholding food, water, or basic care.No type of abuse will be tolerated and may be cause for immediate dismissal.
6. Staff must use positive techniques of guidance, including redirection, positive reinforcement, and encouragement rather than competition, comparison, and criticism. Staff will have age-appropriate expectations and set up guidelines and environments that minimize the need for discipline. Physical restraint is used only in predetermined situations (when necessary to protect the child or other children from harm), administered only in a prescribed manner, and must be documented in writing.
7. Staff will conduct a health check of each child upon his or her arrival each time the program meets, noting any fever, bumps, bruises, burns and so on. Questions or comments will be addressed to the parent or child in a nonthreatening way. Staff will document any questionable marks or responses.
8. Staff will respond to children with respect and consideration and treat all children equally, regardless of sex, race, religion, culture, economic level of the family, or disability.
9. Staff will respect children’s rights not to be touched or looked at in ways that make them feel uncomfortable, and their right to say no. Other than diapering, children are not to be touched on areas of their bodies that would be covered by a bathing suit.
10. Staff will refrain from intimate displays of affection toward others in the presence of children, parents, and staff.

11. Staff is not to transport children in their own vehicles or allow youth participants old enough to drive to transport younger children in the program.
12. Staff must appear clean, neat, and appropriate attired.
13. Using, possessing, or being under the influence of alcohol or illegal drugs during working hours is prohibited.
14. Smoking or use of tobacco in the presence of children or parents during working hours is prohibited.
15. Possession or use of any type of weapon or explosive device is prohibited.
16. Using YMCA computers to access pornographic sites, send e-mails with sexual overtones or otherwise inappropriate messages, or develop online relationships is not allowed.
17. Profanity, inappropriate jokes, sharing intimate details of one's personal life, and any kind of harassment in the presence of children, parents, volunteers, or other staff is prohibited.
18. Staff may not be alone with children they meet in YMCA programs outside the YMCA. This includes babysitting, sleepovers, driving or riding in cars, and inviting children to their homes. Any exceptions require a written explanation before the fact and are subject to prior administrator approval.
19. Staff must be free of physical and psychological conditions that might adversely affect children's physical or mental health. If in doubt, an expert should be consulted.
20. Staff will portray a position role model for youth by maintaining an attitude of loyalty, patience, courtesy, tact, and maturity.
21. Staff should not give excessive gifts (e.g., TV, video games, jewelry) to youth.
22. Staff may not date program participants who are under the age of 18.
23. Under no circumstances should staff release children to anyone other than the authorized parent, guardian,
24. or other adult authorized by the parent or guardian (written parent authorization on file with the YMCA).
25. Staff is to report to a supervisor any other staff or volunteer who violates any of the policies listed in this Code of Conduct.
26. Staff is required to read and sign all policies related to identifying, documenting, and reporting child abuse and attend trainings on the subject, as instructed by a supervisor.
27. Staff will act in a caring, honest, respectful, and responsible manner consistent with the mission of the YMCA.

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Parent / Guardian Signature

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Date



**MERRIMACK VALLEY YMCA  
CHILD CARE PROGRAM  
AUTOMATIC WITHDRAWAL AUTHORIZATION**

**Automatic (Debit/Credit card or EFT) Withdrawal Information**

Name of Child/Children: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Parent Email: \_\_\_\_\_

**Please check one of the following:**

Visa  MasterCard  American Express  Discover  EFT – **MUST** attach a voided check

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ CVV: \_\_\_\_\_

Name as it appears on the credit card: \_\_\_\_\_

Cardholder Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Cardholder Daytime Phone: \_\_\_\_\_

- I (we) authorize the YMCA to initiate recurring debit entries/credit card charges to the above referenced bank/credit card account. I understand that the charges will be based on fees that are due and payable at the time of the transaction and prior to services rendered.
- I (we) authorize the YMCA to withdraw sufficient funds to pay my (our) regular child care tuition and/or other related fees which are due and payable. I (we) understand that the YMCA may at its discretion; adjust the debits/charges according to the fees incurred.
- Should a draft not be honored by my (our) bank/credit card for any reason, I (we) understand that the YMCA will automatically resubmit the draft for payment.
- I (we) understand that after two unpaid drafts, the YMCA will immediately terminate child care until I (we) have brought all payments up to date. EFT returns are subject to \$20 banking fee.
- I (we) understand that if I (we) wish to terminate or change my (our) E-pay, I must give the YMCA a two week written notice.
- Automatic withdrawals will be processed on the **Due Date**. The first withdrawal will be processed on \_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## YMCA Preschool/Toddler SUNBLOCK PERMISSION FORM



I give the Methuen YMCA Preschool/Toddler Staff permission to put \_\_\_\_\_ sun  
brand name; if no preference state "any"  
 block on my child, \_\_\_\_\_, as needed. I will bring in replacement sun block if or  
 when requested by the schools educators.

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 Parent/guardian Signature

Date

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## YMCA Preschool/Toddler Door Access Code Form

Every family, whose child attends child care, will select a 4-digit family pin code to enter/gain access the child care wing. You and your child's emergency adult pick-ups will use your individual pin code to enter the child care wing. When you designate an alternative adult pick-up, please share your updated code with them so that they can access the classrooms for pick-up. Please do not hand out pin code to unauthorized pick-ups. The pin code will deactivate after the closure of the program, weekdays and weekends cutting off access to the child care entrance, and will reactivate when the program reopens.

Your self-selected 4-digit family pin: \_\_\_\_\_

---

 Parent/Guardian Signature

Date



Parent Handbook Sign OFF/RELEASE FORM

I have received a copy of the Parent Handbook, Health Care Policy and Holiday Closure Listing for the Year.

\_\_\_\_\_ Parent Handbook

\_\_\_\_\_ Health Care Policy

\_\_\_\_\_ Holiday Closure Listing for the Year

\_\_\_\_\_ Code of Conduct

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Child Care Closures 2020

|                   |           |                                 |
|-------------------|-----------|---------------------------------|
| January 1, 2020   | Wednesday | <b>New Year's Day</b>           |
| January 20, 2020  | Monday    | Martin Luther King Jr. Day      |
| February 17, 2020 | Monday    | <b>President's Day</b>          |
| April 10, 2020    | Friday    | Good Friday                     |
| April 20, 2020    | Monday    | Patriots Day                    |
| May 25, 2020      | Monday    | Memorial Day                    |
| July 3, 2020      | Friday    | Independence Day                |
| September 7, 2020 | Monday    | Labor Day                       |
| October 12, 2020  | Monday    | Columbus Day                    |
| November 11, 2020 | Wednesday | Veterans Day                    |
| November 26, 2020 | Thursday  | Thanksgiving Day                |
| November 27, 2020 | Friday    | Day After Thanksgiving          |
| December 24, 2020 | Thursday  | Christmas Eve<br>Open until 1pm |
| December 25, 2020 | Friday    | Christmas                       |
| January 1, 2021   | Friday    | <b>New Year's Day</b>           |



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### Part 1. All Household Members

Name of Enrolled Child(ren): \_\_\_\_\_

| Names of all household members<br>(First, Middle Initial, Last) | CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT)<br>* IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM. | CHECK IF NO INCOME       |
|---|--|--------------------------|
|   | <input type="checkbox"/>   | <input type="checkbox"/> |
|   | <input type="checkbox"/>   | <input type="checkbox"/> |
|   | <input type="checkbox"/>   | <input type="checkbox"/> |
|   | <input type="checkbox"/>   | <input type="checkbox"/> |
|   | <input type="checkbox"/>   | <input type="checkbox"/> |
|   | <input type="checkbox"/>   | <input type="checkbox"/> |

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

NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

### Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the Child Care Sponsor at Phone #: \_\_\_\_\_

Homeless  Migrant  Runaway

### Part 4. Total Household Gross Income—You must tell us how much and how often

| A. Name<br>(List only household members with income) | B. Gross income and how often it was received |                                    |  |                     |
|--|---|------------------------------------|--|---------------------|
|  | 1. Earnings from work before deductions       | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All Other Income |
| <i>(Example)</i><br>Jane Smith                       | \$200/weekly _____                            | \$150/twice a month _____          | \$100/monthly _____  | \$ _____ / _____    |
|  | \$ _____ / _____                              | \$ _____ / _____                   | \$ _____ / _____   | \$ _____ / _____    |
|  | \$ _____ / _____                              | \$ _____ / _____                   | \$ _____ / _____   | \$ _____ / _____    |
|  | \$ _____ / _____                              | \$ _____ / _____                   | \$ _____ / _____   | \$ _____ / _____    |
|  | \$ _____ / _____                              | \$ _____ / _____                   | \$ _____ / _____   | \$ _____ / _____    |

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

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

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

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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



## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

Mark one ethnic identity:

Mark one or more racial identities:

Hispanic or Latino  
 Not Hispanic or Latino

Asian  
 White

Black or African American

American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander

### Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_ Eligibility: Free \_\_\_ Reduced \_\_\_ Denied \_\_\_

Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

| Effective July 1, 2019 to June 30, 2020 |        |
|---|--------|
| Household size                          | Yearly |
| 1                                       | 23,107 |
| 2                                       | 31,284 |
| 3                                       | 39,461 |
| 4                                       | 47,638 |
| 5                                       | 55,815 |
| 6                                       | 63,992 |
| 7                                       | 72,169 |
| 8                                       | 80,346 |
| Each additional person:                 | +8,177 |

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** 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, audiotope, 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](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:

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

(2) fax: (202) 690-7442; or

(3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.



**MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR  
ACCOMMODATIONS  
CHILD NUTRITION PROGRAMS**

**INSTRUCTIONS**

**Note:** According to 7 CFR, part 226.20 food substitutions for medical reasons can be made only when there is a written statement from a medical authority. This written statement must include the medical reason and recommended alternate foods.

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person completing the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition is affected by the disability. For example: "Allergy to peanuts causes a life-threatening reaction."
10. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
11. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
- 12A. **Foods to Be Omitted:** List specific foods that must be omitted. For example, "exclude peanut butter."
- 12B. **Available/Acceptable Substitutions:** List the available or acceptable substitution foods to include in the diet. For example, "sunflower seed spread."
13. **Modifications to Meal Service:** Describe specific equipment required, or modifications necessary to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, one-on-one support, etc.)
14. **Signature of Preparer:** Signature of person completing form.
15. **Printed Name:** Print name of person completing form.
16. **Telephone Number:** Telephone number of person completing form.
17. **Date:** Date preparer signed form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
19. **Printed Name:** Print name of medical authority.
20. **Telephone Number:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

The American with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. **(For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act Amendments Act of 2008).** Information regarding the ADAAA, which expanded the definition of disability, can be found at:

<http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf>

**MEDICAL STATEMENT TO REQUEST  
CHILD NUTRITION PROGRAMS  
SPECIAL MEALS AND/OR ACCOMMODATIONS**

|  |  |                          |          |                               |  |       |       |       |       |       |       |       |       |
|--|--|--------------------------|----------|-------------------------------|--|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. School/Agency Name  | 2. Site Name                                 | 3. Site Telephone Number |          |                               |  |       |       |       |       |       |       |       |       |
| 4. Name of Participant   |  | 5. Age or Date of Birth  |          |                               |  |       |       |       |       |       |       |       |       |
| 6. Name of Parent or Guardian  |  | 7. Telephone Number      |          |                               |  |       |       |       |       |       |       |       |       |
| <p><b>8. Check One:</b></p> <p><input type="checkbox"/> Participant has a disability, which may include a <b>food allergy</b>, and <u>requires a special meal or accommodation</u>. Schools and agencies must make reasonable modifications to the meal to accommodate a disability which restricts a participant's diet. Modifications during and for food service may be required. Schools and agencies participating in federal nutrition programs must comply with requests for special meals. <b>A licensed physician, physician's assistant, or nurse practitioner must sign this form.</b></p> <p><input type="checkbox"/> Participant does not have a disability, <u>but is requesting a special accommodation</u> for a <b>fluid milk substitute</b> that meets the nutrient standards for non-dairy beverages offered as milk substitutes. <b>Food preferences are not an appropriate use of this form.</b> Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. <b>A licensed physician, physician's assistant, nurse practitioner, parent, or guardian may sign this form.</b></p>                            |  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| 9. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:   |  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| 10. DIET PRESCRIPTION AND/OR ACCOMMODATION: <i>(please describe in detail to ensure proper implementation-use extra pages as needed)</i>   |  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| <p><b>11. Indicate texture:</b></p> <p><input type="checkbox"/> Regular                      <input type="checkbox"/> Chopped                      <input type="checkbox"/> Ground                      <input type="checkbox"/> Pureed</p>  |  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| <p><b>12. Schools and agencies are not required to provide the exact substitution or other modification requested. However, must offer a reasonable modification that effectively accommodates the participant's disability and provides equal opportunity to participate in or benefit from the federal nutrition programs.</b></p> <p><b>Foods to be omitted and available/acceptable substitutions: <i>(please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed)</i></b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border: none;"><b>A. Foods To Be Omitted</b></td> <td style="width: 50%; vertical-align: top; border: none;"><b>B. Available/Acceptable Substitutions</b></td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table> |  |                          |          | <b>A. Foods To Be Omitted</b> | <b>B. Available/Acceptable Substitutions</b> | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| <b>A. Foods To Be Omitted</b>  | <b>B. Available/Acceptable Substitutions</b> |                          |          |                               |  |       |       |       |       |       |       |       |       |
| _____  | _____  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| _____  | _____  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| _____  | _____  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| _____  | _____  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| 13. Modifications to meal service:   |  |                          |          |                               |  |       |       |       |       |       |       |       |       |
| 14. Signature of Preparer*   | 15. Printed Name                             | 16. Telephone Number     | 17. Date |                               |  |       |       |       |       |       |       |       |       |
| 18. Signature of Medical Authority**   | 19. Printed Name                             | 20. Telephone Number     | 21. Date |                               |  |       |       |       |       |       |       |       |       |

\*Parent/legal guardian signature is acceptable for fluid milk substitution for a child with dietary needs other than a disability.

\*\*Medical Authority's signature is required for participants with a disability.

The information on this form should be updated to reflect any changes to the current medical and/or nutritional needs of the participant, and updated annually.