

East Tenth United Methodist Children and Youth Center, Inc.

Parent Checklist

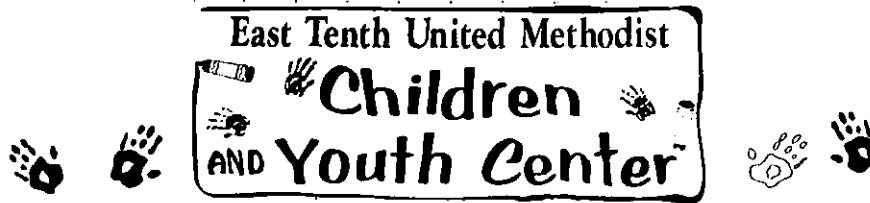
Please have the following documentation on file for your child's first day:

Tenga a mano la siguiente documentación en el expediente para el primer día de su hijo:

- _____ **Documentation of a Physical Exam**
La documentación de un examen físico
- _____ **Copy of Child's Social Security Card**
Copia de la tarjeta de Seguro Social del
- _____ **Copy of Child's Birth Certificate**
Copia del acta de nacimiento del niño
- _____ **Copy of Child's Current Immunization Records**
Copia de los registros de inmunizaciones actuales
- _____ **Completed Application**
Solicitud Completa
- _____ **Completed CACFP Enrollment Form**
CACFP Hoja de inscripción
- _____ **Completed CACFP Free/Reduced Lunch Form**
Completado CACFP Gratis / Reducido Almuerzo Forma
- _____ **Signed Receipt of Parent Handbook**
Firmado Recibo de Manual para Padres
- _____ **Signed Payment Contract**
Firmado contrato de venta
- _____ **Documentation of Special Needs (ie: IFSP, IEP, etc.)**
Documentación de las necesidades especiales
**Must be received prior to starting*
- _____ **Medication form and a doctor's signature if the child is taking medication.**
All medication must be sent in its original container with child's name, date and dosage clearly labeled.
Medicación forma y la firma de un médico si el niño está tomando medicamentos. Todos los medicamentos deben ser enviados en su envase original con el nombre del niño, la fecha y la dosis claramente etiquetados.
- _____ **For children attending the daycare ages 1-5 years, please provide the following** *(Para los niños que asisten a guarderías de las edades 1-5 años, proporcione lo siguiente):*
 - *Wear shoes with a hard bottom or sole. No flip flops, please.*
(Use zapatos con un fondo duro o única. No chanclas, por favor.)
 - *A complete change of clothes; including shirt, socks, pants/shorts and underwear (Una muda completa de ropa, incluyendo camisa, calcetines, pantalones / pantalones cortos y ropa interior)*
 - *A pillow and blanket for nap (Una almohada y una manta para dormir la siesta)*
- _____ **For infants please provide the following** *(Para los bebés por favor proporcione la siguiente información):*
 - *Formula fórmula*
 - *Diapers pañales*
 - *3 complete changes of clothes 3 mudas completas de ropa*
 - *Diaper rash cream if necessary (clearly labeled)*
Crema para la dermatitis del pañal si es necesario (claramente identificados)

Start Date: _____ Application Date: _____

Census Tract: _____ %FMI: (\$68,100/Annual) _____ %



Application Form

This application represents a request for admission. It is not binding upon the applicant or East Tenth UMCYC. Should the Center be able to accept the child, a place will be reserved. Furthermore, it is the parent's responsibility to return this application packet in a timely manner.
Esta aplicación representa una solicitud de admisión. No es obligatorio para el solicitante o UMCYC Oriente Décima. Si el centro de poder aceptar al niño, el niño podrá ser reservada. Además, es responsabilidad de los padres para que proporcione este paquete de solicitud en tiempo y forma.

How did you or your child hear about our program? Please check.

¿Cómo usted o su hijo entero de nuestro programa? Por favor, compruebe.

_____ East Tenth Youth Center _____ IPS _____ Online _____ Other (Otro) _____

Child Information *Información del Niño*

First Name _____ Last Name _____ Sex _____
Nombre Apellido Género
Birth Date _____ Nickname _____ Home # _____
Fecha de Nacimiento Apodo Teléfono de la casa
Address _____ City _____ Zip _____
Dirección Ciudad Código postal
School (if applicable) _____ Current Grade _____
Escuela (si aplica) Grado actual

() African-American () Caucasian () Hispanic () Bi-Racial () Other _____
African American Caucásico Hispano Bi-Racial Otro

Does your child have any special needs? Yes (Si) No
¿Su hijo tiene alguna necesidad especial?
If yes, please explain _____
En caso afirmativo, por favor explique

Does your child have any fears we should know about? Yes (Si) No
¿Su hijo tiene cualquier temor que deberíamos conocer?
If yes, please explain _____
En caso afirmativo, por favor explique

What is your child's first language? _____
¿Qué es la lengua materna de su hijo?

Does your child speak another language? _____
¿Su hijo habla otro idioma?

Parent Information

Parents: () Married () Divorced () Separated () Widowed () Single
 Los padres: Casado Divorciado Separado Viudo Solo

	Father Padre	Mother Madre
Name Nombre	_____	_____
Birth Date Fecha de nacimiento	_____	_____
Address Dirección	_____	_____
City, Zip Ciudad, Código postal	_____	_____
Email Address Dirección de correo electrónico	_____	_____
Home # Número de teléfono	_____	_____
Work # Teléfono del trabajo	_____	_____
Cell/Other Número de teléfono celular	_____	_____
Employer Empleador	_____	_____
Position Posición	_____	_____

Race (Raza): (M=Mother, F=Father)

() African-American () Caucasian () Hispanic () Bi-Racial () Other _____
 African American Caucásico Hispano Bi-Racial Otro

Child lives with: Both Parents Mother Father Legal Guardian
 El niño vive con: Ambos Padres Madre Padre Guardián Legal

Parent Marital Status: Married Divorced Separated Single
 Padres Estado Civil: Casado Divorciad Separado Solo

Are both parents on the Birth Certificate? Y N
 ¿Están ambos padres en el certificado de nacimiento?
 Were you married when the child was/were born? Y N
 ¿Estaba casada cuando nació el niño?
 If not, does the other parent have visitation rights? Y N
 Si no es así, ¿el otro padre tiene derechos de visita?

*If answered NO to any of these questions, please ensure both parents are added to the next section.

* Si respondió NO a cualquiera de estas preguntas, por favor asegúrese de que ambos padres se añaden a la siguiente sección.

Emergency Contacts *Contactos de Emergencia*

Emergency 1 Emergency 2 Emergency 3

Name	_____	_____	_____
<i>Nombre</i>			
Relationship	_____	_____	_____
<i>Relación</i>			
Address	_____	_____	_____
<i>Dirección</i>			
City, Zip	_____	_____	_____
<i>Ciudad</i>			
Home Phone	_____	_____	_____
<i>Teléfono de la casa</i>			
Other Phone	_____	_____	_____
<i>Otro número de teléfono</i>			

Child Pick-Up *Niño Pick Up Lista*

Pick-Up 1 Pick-Up 2 Pick-Up 3

Name	_____	_____	_____
<i>Nombre</i>			
Relationship	_____	_____	_____
<i>Relación</i>			
Phone	_____	_____	_____
<i>Teléfono</i>			

Pick-Up 4 Pick-Up 5 Pick-Up 6

Name	_____	_____	_____
<i>Nombre</i>			
Relationship	_____	_____	_____
<i>Relación</i>			
Phone	_____	_____	_____
<i>Teléfono</i>			

Are there any persons who are legally prohibited from contact with your child?
¿Hay personas que están legalmente prohibidas por el contacto con su hijo?

Yes No

If yes, please list: _____

Health Information *Información de la Salud*

Child's Doctor _____ Hospital Preference _____
Médico de su hijo Hospital de Preferencia
 Address _____ City _____ Zip _____
Dirección Ciudad Código postal
 Doctor's Telephone _____
Teléfono del médico

Does your child take medication? (please circle) YES NO
¿Su hijo toma medicamentos?

Please list medications (Por favor, enumere los medicamentos):

Medication <i>Medicación</i>	Reason for Medication <i>Motivo de la medicación</i>	Side Effects <i>Efectos secundarios</i>
_____	_____	_____

Does your child have any allergies? (please circle) YES NO
¿Su hijo tiene alergias?

If 'yes,' please list (En caso afirmativo, por favor indique): _____

What are the side effects? _____
¿Cuáles son los efectos secundarios?

Does your child have asthma? (please circle) YES NO
¿Su hijo tiene asma?

Does your child have physical limitations? YES NO
¿Su hijo tiene limitaciones físicas?

If 'yes,' please list (En caso afirmativo, por favor indique): _____

Is your child up to date on immunizations? YES NO
¿Está su niño al día con sus vacunas?

Does your child have health insurance? YES NO
¿Su hijo tiene seguro de salud?

If 'yes,' what is the name of the insurance company? _____
En caso afirmativo, ¿cuál es el nombre de la compañía de seguros?

Does your child receive mental health services? YES NO
¿Su hijo recibe servicios de salud mental?

If 'yes,' who is the mental health provider? _____
En caso afirmativo, ¿quién es el proveedor de salud mental?

Does your child generally exhibit any behaviors we should be aware of?
¿Tiene su niño generalmente presentan ningún comportamiento que debemos tener en cuenta? YES NO

If yes, please explain (En caso afirmativo, por favor explique):

***Please be aware that we will not administer over the counter medication to a child without doctor's approval and written consent. Tenga en cuenta que no vamos a administrar medicamentos de venta libre a un niño sin la aprobación de los médicos y el consentimiento por escrito.**

Household Information *Información del Hogar*

Number in household _____

Número de Personas en el Hogar

Number of children enrolled _____

Número de niños matriculados

Do you receive Food Stamps? _____

¿Usted recibe cupones de alimentos?

Do you receive TANF for your child? _____

¿Recibe dinero TANF para su hijo?

Does your child qualify free or reduced lunch? _____

¿Tiene su hijo califica almuerzo gratis oa precio reducido?

Household Configuration (hogar de configuración): (please check one)

Two-parent _____

Dos Padres

Single-parent (Female) _____

Solitera

Single-parent (Male) _____

Solitero

Grandparents _____

Abuelos

Other _____

Otro

Known Yearly Household Income: \$ _____

Conocido ingresos anuales del hogar

**Information used for reporting purposes. This information will be kept confidential. La información utilizada para la elaboración de informes. Esta información se mantendrá confidencial.*

If You Do Not Know... Please estimate by circling the amount that is closest to your yearly household income. *Si usted no sabe ... Por favor estimación encerrando en un círculo la cantidad más cercana a su ingreso anual.*

a. \$0 - \$5,999

b. \$6,000- \$11,499

c. \$11, 500- \$13,499

d. \$13,500- \$17,300

e. \$17,301- \$20,750

f. \$20,751- \$25,400

g. \$25,401- \$28,850

h. \$28, 851- \$34,600

i. \$34,601- \$39,750

j. \$39,751- \$46,150

k. \$46,151- \$51,300

l. \$51,301 or more

Tell us about your family. Is there any helpful information about your child you would like to share? *(Información útil acerca de su hijo):*

Are you or your children foreign born?

Yes

No

¿Está usted o sus hijos nacidos en el extranjero?

If yes, from which country? *En caso afirmativo, de qué país?* _____

Agreements Acuerdos

Emergency Medical Authorization Autorización Médica de Emergencia

I hereby give permission to secure emergency medical care for the child named in this application if I can not be contacted immediately. I understand that I will be contacted immediately, or as soon as possible, should I be away from the phone numbers given in this application. *(Yo doy permiso para obtener cuidado médico de emergencia para el niño nombrado en esta solicitud si no puedo ser contactado inmediatamente. Entiendo que seré contactado inmediatamente o tan pronto como sea posible, debería estar lejos de los números de teléfono que figuran en esta solicitud.)*

Signature (Firma) _____ Date (Fecha) _____

Transport Permit Permiso de Transporte

In the event of a field trip or other activity, I give my permission for my child to be transported by the Center in a motor vehicle. We further agree to release and hold harmless East Tenth United Methodist Children & Youth Center, Inc., their agents, officers, employees, and volunteers, from any and all liability, claims, suits, demands, judgements, costs, interest and expense (including attorneys' fees and costs) arising from such activities, including any accident or injury to the student and the costs of medical services. *(En el caso de un viaje de estudios u otra actividad, le doy mi permiso para que mi niño sea transportado por el Centro en un vehículo de motor. También estamos de acuerdo en liberar y eximir de responsabilidad a este Décimo United Methodist Children & Youth Center, Inc., sus agentes, oficiales, empleados, y voluntarios, de cualquier y toda responsabilidad, reclamos, demandas, demandas, juicios, costos, y gastos por intereses (incluyendo los honorarios de abogados y costas) que surjan de esas actividades, incluido cualquier accidente o daño para el estudiante y los costos de los servicios médicos.)*

Signature (Firma) _____ Date (Fecha) _____

Authorization for Child's Release Autorización para la Divulgación del niño

Children will be released only to a parent/guardian or a person designated by the parent/guardian. Parents/guardians or persons designated by the parent must make sure that a staff member is aware of the child's arrival and departure. Children must be signed in and out daily by a parent or designated adult. *(Los niños serán entregados solamente a un padre / tutor o una persona designada por el padre / tutor. Los padres / tutores o personas designadas por los padres deben asegurarse de que un miembro del personal está al tanto de la llegada del niño y de salida. Los niños deben ser firmados y salir a diario por un padre o un adulto autorizado.)*

Signature (Firma) _____ Date (Fecha) _____

Meals Comidas

Breakfast, lunch and an afternoon snack will be provided daily and served according to CACFP guidelines and standards. CACFP is a state funded program through the Department of Education and funded through the USDA. USDA is an equal opportunity provider and employer. *(El desayuno, el almuerzo y la merienda se sirve todos los días y se sirve de acuerdo con las directrices y normas del CACFP. CACFP es un programa financiado por el Estado a través del Ministerio de Educación y financiado por el USDA. USDA es un proveedor y empleador.)*
Initial (Iniciales) _____

Photographic Release *Publicación fotográfica*

I consent and authorize Little Dove Daycare to use and reproduce photographs taken of my child and to circulate them for advertising and publicity purposes of every description including our center website and facebook. *(Doy mi consentimiento y autorizo Daycare paloma a utilizar y reproducir fotografías tomadas de mi hijo y que los distribuyera con fines publicitarios y publicidad de todo tipo, incluyendo nuestro sitio web central y facebook.)*

Signature (*Firma*) _____ Date (*Fecha*) _____

Illness Policy *Enfermedad de Política*

I have read and understand the child illness policy in the parent handbook. In the event that my child becomes ill, I will make arrangements for my child to be picked up from the child care facility in a timely manner. Children who are sent home ill must stay home the next day as well unless a doctor's statement is provided stating the child is not contagious and able to return to care. *(He leído y entiendo la política de una enfermedad infantil en el manual de los padres. En el caso de que mi hijo se enferma, voy a hacer los arreglos para mi hijo que se recogió en el centro de cuidado infantil en el momento oportuno. Los niños que son enviados a casa enfermos deben quedarse en casa al día siguiente, así a menos que se proporcione una declaración de un médico que indique que el niño no es contagiosa y capaz de volver a la atención.)*

Signature (*Firma*) _____ Date (*Fecha*) _____

Payment Policy *Política de pago*

I understand that I am obligated to uphold the signed payment contract with East Tenth United Methodist Children and Youth Center. Furthermore, I understand that the weekly childcare fee is to be paid in full regardless of my child's attendance of center closings. *(Entiendo que estoy obligado a respetar el contrato firmado con el pago East Children Centro Metodistas Unidas y el Centro de la Juventud. Además, entiendo que la cuota semanal cuidado de los niños debe ser pagado en su totalidad, independientemente de la asistencia de mi hijo de cierre del centro.)*

Initial (*Iniciales*) _____

Safe Sleep Position Policy *De posición de política*

I have read and understand the center's safe sleep policy in the parent handbook. I understand that infants less than 12 months of age shall be placed on their backs on a firm, tight-fitting mattress for sleep in a crib, unless the child has a note from a physician stating otherwise. The infant's head will remain uncovered during sleep. *(He leído y entiendo la política del centro sueño seguro en el manual de los padres. Entiendo que los bebés menores de 12 meses de edad se deben colocar sobre la espalda en una superficie firme y bien ajustado colchón para dormir en una cuna, a menos que el niño tenga una nota de un médico que indica lo contrario. La cabeza del bebé se mantendrá descubierta durante el sueño.)*

Signature (*Firma*) _____ Date (*Fecha*) _____

Lost or Stolen Items *Artículos perdidos o robados*

Please note that the East Tenth United Methodist Children and Youth Center, Inc. cannot be held liable for any items lost, stolen or damaged while participating in events provided by East Tenth United Methodist Children and Youth Center. *(Tenga en cuenta que el Este Centro United Methodist Children y Youth Center Inc., no se hace responsable de los artículos perdidos, robados o dañados durante su participación en eventos proporcionados por East Los niños Décima Metodistas Unidas y el Centro de la Juventud.)*

Initial (*Iniciales*) _____

Written Emergency Plan Plan de emergencia por escrito

- ✓ Parents will be notified in writing and/or by phone should in the event of the illness of a staff member that may be contagious to others, or any emergency that prevents children from being cared for in the facility. *(Los padres serán notificados por escrito y / o por teléfono debería, en el caso de la enfermedad de un miembro del personal que puede ser contagiosa a otros, o cualquier otra emergencia que impide que los niños sean atendidos en las instalaciones)*
- ✓ Should our building become unsafe during business hours all children and staff members will be moved to the John H. Boner Community Center across the street and parents will be notified. *(En caso de nuestro edificio contaminarse durante el horario de todos los niños y miembros del personal se trasladará al Centro John H. Boner Comunidad lado de la calle y los padres serán notificados)*
- ✓ Parents must have a back up plan for care in place in the event that their child becomes ill or the facility is in able to care for the children. *(Los padres deben tener un plan de copia de seguridad de la atención en el lugar en caso de que su hijo se enferme o el establecimiento esté incapacitado para cuidar de los niños.)*
- ✓ A child or staff member may be excluded from care to prevent the spread of infection to other children and staff. Should a child show signs of a communicable illness they will be separated from the group and cared for in the office. Parent/guardian or emergency contacts will be notified by office staff and asked to pick up the child. *(Un niño o un miembro del personal puede ser excluido de la atención para evitar la propagación de la infección a otros niños y el personal. En caso de un menor muestra señales de una enfermedad contagiosa que se separó del grupo y atendidos en la oficina. Contactos con los padres / tutores o de emergencia serán notificados por personal de la oficina y le pidió a recoger al niño.)*
- ✓ In case of an emergency, alternative contacts will be called in the event that parent's can not be reached. Parents are responsible for keeping these numbers current. *(En caso de una emergencia, contactos alternativos será llamado en el caso de que los padres no puede ser alcanzado. Los padres son responsables de mantener estos números actuales.)*
- ✓ Fire drills are done every month to prepare staff and children for emergency evacuations. *(Simulacros de incendios se realiza todos los meses para preparar al personal ya los niños para evacuaciones de emergencia.)*
- ✓ Tornado drills will be held monthly during the spring and summer months. In severe weather the alarm will sound. Children will be gathered and lead to the basement level, away from glass and loose objects. Children will be asked to kneel on the floor, tuck their head between their legs and cover their head and neck with their hands. Children should remain in this position until the severe weather has passed and the warning has expired. *(Tornado simulacros se llevan a cabo mensualmente durante los meses de primavera y verano. En el mal tiempo la alarma sonará. Los niños serán recogidos y llevar al nivel del sótano, lejos de vidrio y objetos sueltos. Los niños se les pedirá a arrodillarse en el suelo, meter la cabeza entre las piernas y se cubren la cabeza y el cuello con las manos. Los niños deben permanecer en esta posición hasta que el mal tiempo ha pasado y el aviso ha expirado.)*

I have read and understand the center's written emergency plan in the parent handbook.

Yo he leído y entendido el centro del plan de emergencia escrito en el manual de los padres.

Parent Signature (Firma)

Date (Fecha)

Guidance & Discipline Policy

1, 2, 3 Magic Curriculum *Applies to children over 3 years of age.

1, 2, 3 Magic is an extremely popular and effective program that addresses the difficult task of child discipline with humor, keen insight and proven experience. Dr. Phelan, the program's author and an internationally renowned expert on child discipline and Attention Deficit Disorder, simplifies the job of disciplining in three straightforward steps:

Step 1: Controlling Obnoxious Behavior: A simple counting technique to get the kids to STOP doing what you don't want them to do (whining, arguing, tantrums, fighting, etc.)

Step 2: Encouraging Good Behavior: Effective methods to get your kids to START doing what you want them to do (cleaning up, homework, napping, etc.)

Step 3: Strengthening Your Relationship: Powerful techniques that reinforce the bond between teachers and students.

Here's how the program works: When a child does something a parent or caregiver doesn't like, the parent or caregiver says, "That's one." If the child continues the parent says, "That's two." If the child continues going, the parent says, "That's three. Take five." That means the child has to go to the time out area for a time-out that lasts about one minute for each year of the child's age. For really bad behavior, like hitting or cursing, the parent or caregiver goes straight to "That's three," and adds time depending on the severity of the misdeed. During the counting and after the time-out the caregiver can give a two or three word explanation but doesn't say anything else—no lecturing, no arguing, no yelling. The "no talking" and "no emotion" rules are essential. If teachers violate these cardinal rules the child can't clearly hear the warning, ("That's one") which gets mixed up with the rest of the caregiver's "verbal garbage." Many children take yelling, nagging and arguing as a challenge. Attempts at talking are guaranteed to take the child's focus off the possibility of an enjoyable argument. **Physically harmful or emotionally abusive discipline is not permitted.**

Infant and Toddler Policy:

Caregivers will not:

- Associate disciplinary action or rewards with rest
- Associate disciplinary action with food or use food as a reward.
- Associate disciplinary action or humiliate a child in regard to toileting.
- Use time out for any child less than three (3) years of age
- Use time out for any purpose other than to enable the child to regain control.
- Physically restrain a child except:
 - When it is necessary to ensure their own safety or that of others; and
 - Only for as long as is necessary for control of the situation.
- Use punishment to correct unacceptable behavior

If a child exhibits inappropriate behavior, we will give positive redirection within the activity area. Children may need a positive reminder of the appropriate behavior in the activity area. If an inappropriate behavior continues after a child has been positively redirected within an activity area, give positive redirection to another activity area.

We will take immediate, positive action when the behavior is socially unacceptable. Occasionally children lose control of their emotions or exhibit behavior that is socially

unacceptable (for example, biting, striking or kicking another child). When such behavior occurs, the child needs time to regain control of him or herself.

You should then:

- take the child to a neutral place in the room
- position yourself so that you have eye contact with the child
- use neutral words to state your expectation "You need to..."
- reinforce your expectation with a positive direction, for example, "Blocks are for building."
- accompany the child back to the group and redirect him or her to an appropriate activity
- praise any positive behavior you observe after your discussion; be especially positive about any performance that indicates the child has heard and understood, and is attempting to respond to the points of your one-to-one discussion
- emphasize the positive at all times

Disciplinary Reporting Procedures:

BEHAVIOR REPORT- this is a formal document that states the incident causing disciplinary action to be taken against the child.

WRITE-UP- this document is used in one of two causes; a.) the child has received multiple Behavior Reports or b.) the child's behavior has surpassed that of a behavior report and deserves more severe punishment than a behavior report. If a child has multiple problems in a single day, he/she may receive more than one write-up in that day; this includes the possibility of suspension.

SUSPENSION- this is given after three (3) write-ups have been issued to the child and guardian warning of behavior issues or the child strikes another child with malicious intent and can last 1-3 days. Please be aware, we DO NOT provide transportation to and from school for those students on suspension.

EXPULSION- a child may be removed from the program after three (3) suspensions, or if the Director feels the child may in any way endanger the health and safety of other students or staff. If your child(ren) have been suspended or expelled for any reason, you must find alternate care for that time period. The child(ren) will not be able to return until after the suspension or expulsion has been lifted.

If the child gets into a physical altercation with another student, the situation may result in immediate suspension. At this point, we will contact you by phone, alert you of the situation and it will be your responsibility to pick-up your child immediately.

A Note to Parent's about Striking Back

We understand that children grow up in a rough world. We also understand that it may be necessary to teach children to "strike back" and defend themselves when others are harassing them. This is often necessary when a child is walking down the street, through an alley, etc. Please understand however that this is a Safe Place for children and we do not tolerate the "strike backs" in our programs. Our rule is that a child must notify an adult if being harassed in any way. Our trained staff will handle the situation promptly and appropriately. If your child does "strike back" they will be punished as if they began the altercation.

I have read and understand the discipline policy stated above.

Legal Guardian's Signature

Date

Little Dove Daycare
East Tenth United Methodist
Children & Youth Center, Inc.
2327 E. 10th Street
Indianapolis, IN 46201
317-637-0841

Parent's Notice

I understand that this daycare ministry is not licensed under the laws of Indiana. However, I understand that this daycare ministry complies with the state rules concerning sanitation and fire safety for the primary use of the structure in which care is conducted. I also understand that it is my responsibility to ensure that the nutritional and health needs of my child are met while my child is at the Daycare ministry.

Notificación de los Padres

Entiendo que este ministerio guardería no tiene licencia bajo las leyes de Indiana. Sin embargo, entiendo que este ministerio guardería cumple con las normas estatales sobre el saneamiento y la seguridad contra incendios para el uso principal de la estructura en la que la atención se lleva a cabo. También entiendo que es mi responsabilidad asegurar que las necesidades nutricionales y de salud de mi hijo se conocieron cuando mi hijo está en el ministerio de la guardería.

Parent/Legal Guardian's Signature
Padre / Tutor Legal Firma

Name of Enrolled Child
Nombre del niño matriculado

This notice does not absolve a daycare ministry from the liability for injury to a child while the child is at the daycare ministry if the injury is negligence or intentional wrong doing on the part of the daycare ministry or an employee of the daycare ministry. *(Esta notificación no exime a un ministerio de la guardería de la responsabilidad por lesiones a un niño mientras el niño está en el ministerio de la guardería si la lesión es negligencia intencional o mala acción por parte del ministerio de la guardería o un empleado del ministerio de la guardería.)*



**HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD**

State Form 49969 (R3 / 11-11)

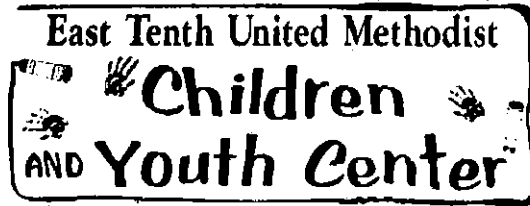
**BUREAU OF CHILD CARE
DIVISION OF FAMILY RESOURCES**

Name of child (last, first)		Date of birth (month, day, year)	Date of admission (month, day, year)
Address (number and street, city, state, and ZIP code)			
Child lives with (relationship)	Name	Telephone number ()	

MEDICAL HISTORY			
Communicable Disease	Month / Year	Condition	Explain if present
Measles		Allergies:
Rubella (German Measles)		
Chickenpox		Handicapping conditions:
Mumps		
Scarlet Fever		Other:
Whooping Cough		
Other:		

PHYSICAL EXAMINATION	
Date of exam (month, day, year)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:
Note any unusual findings:	
Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (including sports)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:	
Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Insert Center or Sponsoring Organization Letterhead



Little Dove Daycare Certified Registered Ministry
Before & After School Program
Summer Days for Youth

2327 East 10th Street, Indianapolis, IN 46201
637.0841 Phone
317.637.0849 Fax

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **East Tenth United Methodist Children and Youth Center, Inc.** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Application for Free and Reduced Price Meals. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household only if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: East Tenth United Methodist Children and Youth Center, Inc., 2327 East 10th Street, Indianapolis, Indiana 46201.**
2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) or Temporary Assistance for Needy Families (TANF) can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.
3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on the application. Children in households participating in WIC may be eligible for reduced price meals.
4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children who live with you. You also may include foster children who live with you.
6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP or TANF case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.
7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.
8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact [name, address, phone number].
9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call 317-637-0841.

Sincerely,

Center Director

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating

Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care Centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes:** Licensed or approved private homes.
- **After School Care Programs:** Centers in low-income areas provide free snacks to School-age children and youth.
- **Emergency Shelters:** Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in after school care programs in needy areas.

Contact

Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

East Tenth United Methodist Children and Youth Center, Inc. 2327 East 10 th Street Indianapolis, IN 46201 317-637-0841

Indiana Department of Education

CACFP Staff School & Community Nutrition 151 West Ohio Street Indianapolis IN 46204 800-537-1142 or 317-232-0850
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In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). The USDA is an equal opportunity provider and employer.

**INSTRUCTIONS FOR COMPLETING THE CACFP
APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)**

Follow these instructions, if your **household gets FOOD STAMPS OR TANF:**

Part 1: List all household members and birth dates for children.

Part 2: List the case number for any household member (including adults) receiving Food Stamps or TANF.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form and enter the contact information. The last four digits of a Social Security Number are not necessary.

Part 6: Answer this question if you choose to.

Part 7: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If all children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form and complete the contact information. A Social Security Number is not necessary.

Part 6: Answer this question if you choose to.

Part 7: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

If some of the children in the household are foster children.

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.

Part 2: If the household does not have a case number, skip this part.

Part 3: If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [sponsor contact and phone number]. If not, skip this part.

Part 4: Follow these instructions to report total household income from this month or last month:

Section A – Name: List only the first and last name of **each** person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.

In Box 1 - list the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

In Box 2 - list the amount each person got from the month from welfare, child support, alimony.

In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

INSTRUCTIONS FOR COMPLETING THE CACFP
APPLICATION FOR FREE AND REDUCED PRICE MEALS (Child Care)

Part 5: Adult household member must sign the form, complete the information, and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all household members. For any person, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month:

Section A–Name: List only the first and last name of each person living in your household with income, related or not (such as grandparents, other relatives, or friends who live with you). Include yourself and all children living with you. Attach another sheet of paper if you need to.

Section B – Gross Income and How Often it was Received: for each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.

In Box 1 - list the **gross income**, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

In Box 2 - list the amount each person got from the month from welfare, child support, alimony.

In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, under *Earnings From Work*, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: An adult household member must sign the form, complete the information, and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Sign this part if you do not want your application information shared with Medicaid or Hoosier Healthwise.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

ENROLLMENT FORM

IDOE/CACFP Name of Institution _____ Sponsor ID Number _____

July 2012 Name of Facility _____

Child's Name: _____ Birthdate: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (✓) the meals your child normally receives while in care.	Breakfast _____ AM snack _____ Lunch _____ PM snack _____ Supper _____ Night snack _____	Breakfast _____ AM snack _____ Lunch _____ PM snack _____ Supper _____ Night snack _____	Breakfast _____ AM snack _____ Lunch _____ PM snack _____ Supper _____ Night snack _____	Breakfast _____ AM snack _____ Lunch _____ PM snack _____ Supper _____ Night snack _____	Breakfast _____ AM snack _____ Lunch _____ PM snack _____ Supper _____ Night snack _____	Breakfast _____ AM snack _____ Lunch _____ PM snack _____ Supper _____ Night snack _____	Breakfast _____ AM snack _____ Lunch _____ PM snack _____ Supper _____ Night snack _____
If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc) Please check (✓) here _____							

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant, and must be updated annually.

Printed name of parent/guardian: _____ Phone Number: _____

Signature of parent/guardian: _____ Date: _____

CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

SPONSOR NAME:	PHONE NUMBER:
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CENTER:	FDC PROVIDER:
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PART 1. ALL HOUSEHOLD MEMBERS	BIRTH DATES OF CHILDREN	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 4 TO SIGN THIS FORM.	CHECK IF NO INCOME
NAMES OF ALL HOUSEHOLD (FIRST, MIDDLE INITIAL, LAST)			
		<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"/>
		<input type="checkbox"/>	<input type="checkbox"/>

PART 2. BENEFITS: IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVED [FOOD STAMPS] OR [STATE TANF 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 [INSERT CENTER CONTACT AND PHONE NUMBER]

HOMELESS MIGRANT RUNAWAY

PART 4. TOTAL HOUSEHOLD GROSS INCOME—You must tell us how much and how often

A. NAME (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> 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: XXX - XX - _____ I DO NOT HAVE A SOCIAL SECURITY NUMBER

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

CACFP APPLICATION FOR FREE AND REDUCED PRICE MEALS (CHILD CARE)

A CHILD ENROLLED IN THE DAY CARE FACILITY MAY QUALIFY FOR FREE OR REDUCED PRICE MEALS IF THE HOUSEHOLD INCOME FALLS AT OR BELOW THE LIMITS ON THIS CHART:

JULY 1, 2014 TO JUNE 30, 2015			
HOUSEHOLD SIZE	MONTHLY INCOME	HOUSEHOLD SIZE	MONTHLY INCOME
1	1,800	5	4,303
2	2,426	6	4,929
3	3,051	7	5,555
4	3,677	8	6,181
FOR EACH ADDITIONAL FAMILY MEMBER, ADD \$626			

PART 6. PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)	
MARK ONE ETHNIC IDENTITY: <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO	MARK ONE OR MORE RACIAL IDENTITIES: <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK OR AFRICAN AMERICAN

PART 7: OTHER BENEFITS: THE LAW ALLOWS US TO TELL MEDICAID AND HOOSIER HEALTHWISE THAT YOUR CHILDREN ARE ELIGIBLE FOR FREE OR REDUCED-PRICE MEALS. WE MAY SHARE YOUR APPLICATION INFORMATION WITH MEDICAID OR HOOSIER HEALTHWISE UNLESS YOU DO NOT WANT US TO. IF YOU DO NOT WANT US TO SHARE THIS INFORMATION, SIGN HERE:

FOR INFORMATION ABOUT HOOSIER HEALTHWISE HEALTH INSURANCE
CALL 1-800-889-9949

SIGNATURE OF PARENT OR LEGAL GUARDIAN

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.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

CHILD CARE REPRESENTATIVE USE ONLY

ANNUAL INCOME CONVERSION: ~~WEEKLY X 52~~ - ~~EVERY 2 WEEKS X 26~~ - ~~TWICE A MONTH X 24~~ - ~~MONTHLY X 12~~

<p>SECTION A MARK ONE OF THE BOXES BELOW TO SHOW HOW YOU ARE GOING TO DETERMINE ELIGIBILITY.</p> <input type="checkbox"/> FOOD STAMP OR TANF HOUSEHOLD —THE FOOD STAMP OR TANF NUMBER MEETS THE CRITERIA FOR AN ACCEPTABLE CASE NUMBER. COMPLETE SECTION B & C OR <input type="checkbox"/> FOSTER CHILD —COMPARE THE FOSTER CHILD'S PERSONAL INCOME TO THE GUIDELINES. COMPLETE SECTION B & C OR <input type="checkbox"/> HOUSEHOLD INCOME —COMPLETE THE INFORMATION BELOW AND COMPLETE SECTION B & C <p>TOTAL HOUSEHOLD SIZE: _____</p> <p>TOTAL HOUSEHOLD INCOME \$ _____ / _____ <i>EXAMPLE: \$100/WEEK</i></p> <p>COMPARE TOTAL HOUSEHOLD INCOME TO CURRENT USDA INCOME ELIGIBILITY GUIDELINES. WHEN THE HOUSEHOLD INCOMES ARE LISTED FOR DIFFERENT PAY PERIODS, YOU MUST CONVERT ALL INCOME TO MONTHLY OR ANNUAL INCOME. USE THE CONVERSION LISTED ABOVE.</p>	<p>SECTION B BASED ON THE INFORMATION PROVIDED, THIS APPLICATION WILL BE:</p> <input type="checkbox"/> APPROVED FREE <input type="checkbox"/> APPROVED TIER I <input type="checkbox"/> APPROVED REDUCED <input type="checkbox"/> APPROVED TIER II <input type="checkbox"/> PAID <p>USE THIS SPACE FOR INCOME CALCULATION.</p> <p>SECTION C</p> <p>_____ SIGNATURE OF SPONSOR REPRESENTATIVE</p> <p>_____ DATE OF APPROVAL</p> <p style="text-align: center;">THIS FORM EXPIRES ONE YEAR FROM THE DATE IT WAS APPROVED</p>
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Consent for the Use of ISTAR-KR

East 10th United Methodist Children and Youth Center

I give my consent for the agency listed above to use the ISTAR assessment tool to monitor my child's developmental progress. Use of this assessment will allow me to receive periodic reports on the skills that my child has demonstrated in the areas that build toward kindergarten readiness and eventual success in school.

I understand the ISTAR information will be stored in a secure Indiana Department of Education database that has been designed to be compliant with the Family Educational Rights and Privacy Act (FERPA-34 CFR Part 99). This data will never be released to the public, but may be used by my child's current program/facility in an aggregated way to analyze trends of factors that define effective programming for groups of children.

I understand that the assessment data specific to my child may only be accessed by the current program/facility serving my child. I also understand that this agency will have access to previous data collected in ISTAR. Without my written consent to release assessment data, future providers and educators at any accredited school my child attends once they are school-age will not be able to access my child's assessment.

I understand that granting consent for Use of ISTAR is voluntary and that my consent may be revoked at any time. I further understand that if I revoke consent, the revocation is not retroactive, that is, it does not negate an action that has occurred after the consent was given and before the consent was revoked.

Student's Name (print) _____ Student's Date of Birth _____

Parent/Guardian Name (Please Print)

Relationship to student

Parent/Guardian Signature

Date

THIS COMPLETED DOCUMENT MUST BE MAINTAINED AT THE CHILD'S FACILITY AND A COPY FORWARDED TO THE:

Indiana Department of Education
Sally Reed Crawford, ISTAR Specialist
Office of Student Assessment
151 W. Ohio Street
Indianapolis, IN 46204



Consent to Release ISTAR-KR Data

To Public School

I give my consent for the ISTAR progress data that has been collected during my child's developmental years in preschool be accessible to the public school where my child is or will be educated.

I understand the ISTAR information will continue to be stored in a secure Indiana Department of Education database that has been designed to be compliant with the Family Educational Rights and Privacy Act (FERPA-34 CFR Part 99). This data will never be released to the public, but may be used in an aggregated way to analyze trends of factors that define effective programming for groups of children.

I understand that the assessment data specific to my child may only be accessed by the local education agency that is serving my child. I also understand that this data will be available to future public schools that my child attends in the state of Indiana.

I understand that granting consent for Use of ISTAR is voluntary and that my consent may be revoked at any time. I further understand that if I revoke consent, the revocation is not retroactive, that is, it does not negate an action that has occurred after the consent was given and before the consent was revoked.

Student's Name (print) _____ Student's Date of Birth _____

Parent/Guardian Name (Please Print)

Relationship to student

Parent/Guardian Signature

Date

THIS COMPLETED DOCUMENT MUST BE MAINTAINED AT THE CHILD'S FACILITY AND A COPY FORWARDED TO THE:

Indiana Department of Education
Sally Reed Crawford, ISTAR Specialist
Office of Student Assessment
151 W. Ohio Street
Indianapolis, IN 46204
