



**CHILDCARE ENROLLMENT CHECKLIST**

Parents,

This is a checklist of all the items that are required before your child can start his/her first day at Bright Stars Primary Learning Academy, LLC. You must fill out, date & sign the checklist.

- \_\_\_\_\_ \$65 registration fee (paid at time of enrollment)
- \_\_\_\_\_ First week's tuition (paid at time of enrollment)
- \_\_\_\_\_ Birth certificate
- \_\_\_\_\_ Most current Immunization records (Form 3231)

**COMPLETED ENROLLMENT PACKET:**

- \_\_\_\_\_ Parent Handbook (Please sign pages 17-18 and return with Enrollment Packet)
- \_\_\_\_\_ Enrollment form
- \_\_\_\_\_ **Copy Parent(s) D.L. and SSN Card**
- \_\_\_\_\_ Tuition Fee Agreement
- \_\_\_\_\_ Fee Schedule
- \_\_\_\_\_ Authorization for Pick-Up
- \_\_\_\_\_ Parental and Facility Agreement (BSPLA)
- \_\_\_\_\_ Child Medical Treatment Form
- \_\_\_\_\_ Family and Development History
- \_\_\_\_\_ Food Allergy Action Plan
- \_\_\_\_\_ Infant Feeding Plan
- \_\_\_\_\_ Infant Affidavit
- \_\_\_\_\_ Preventative Products Approval
- \_\_\_\_\_ Benefit Income Eligibility Forms (2 pages)
- \_\_\_\_\_ Community Childcare Food Supplement Distribution Log
- \_\_\_\_\_ WIC
- \_\_\_\_\_ Parental Enrollment Agreement with Child Care Facility (CCFS)
- \_\_\_\_\_ Household Letter Instructions
- \_\_\_\_\_ No Liability Insurance Parent Acknowledgement
- \_\_\_\_\_ Official start date: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature (Mom) \_\_\_\_\_  
Date

\_\_\_\_\_  
Parent(s) Signature (Dad) \_\_\_\_\_  
Date



## Discipline and Behavior Policy

Praise and positive reinforcement are effective methods of behavior management of children. When children receive positive, nonviolent, and understanding interactions from adults and others, they develop good self-concepts, problem solving abilities, and self-discipline. Based on this belief, Bright Stars Primary Learning Academy uses a positive approach to discipline and practices the following discipline and behavior management techniques.

### **WE DO**

- Communicate to children using positive statements on their level.
- Talk with children in a calm quiet manner.
- Explain unacceptable behavior to children.
- Give attention to children for positive behavior.
- Praise and encourage the children.
- Reason with and set limits for the children.
- Apply rules consistently.
- Model appropriate behavior.
- Provide alternatives and redirect children to acceptable activity.
- Give children opportunities to make choices and solve problems.
- Help children talk out problems and think of solutions.
- Listen to children and respect the children's needs, desires and feelings.

### **WE DO NOT**

- Inflict corporal punishment in any manner upon a child.
- Use food as a form of reward or punishment.
- Use or withhold physical activity as a punishment.
- Shame or punish a child if a bathroom accident occurs.
- Embarrass any child in front of others.
- Compare children.
- Leave any child alone, unattended or without supervision.
- Allow discipline of a child by other children.
- Criticize, make fun of, or otherwise belittle a child's parents, families, or ethnic groups.

Conferences will be scheduled with parents if particular disciplinary/behavior problems occur. If your child's behavior consistently endangers the safety of the children around him/her, then the Director has the right, after meeting with the parents and documenting behavior problems and interventions, to terminate child care services for that particular child.

Note: If, at any point, there is an indication/suspicion that a child may have special needs, Bright Stars Primary Learning Academy will inform the child's family and make contact with Baby Babies Can't Wait or EAP for assessment and assistance.

*My signature below indicates that I have received a copy of the discipline policy, it has been reviewed with me, and I have read and understand this policy.*

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Please circle as appropriate: PARENT, GUARDIAN, FOSTER PARENT  
Name of child \_\_\_\_\_



**Policy Agreement Form**

Child's Name \_\_\_\_\_  
Start Date \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

Bright Stars Primary Learning Academy, LLC Parent Handbook was created to promote an understanding of the policies and procedures at Bright Stars Primary Learning Academy, LLC. The information in the Parent Handbook applies to all enrolled children at Bright Stars Primary Learning Academy, LLC. It is important that parents and children are familiar with these expectations.

Please be sure to read the Parent Handbook in its entirety, complete this form, and return it with the other required forms to the center. Your child will not be allowed to start at Bright Stars Primary Learning Academy, LLC without having completed and returned this form. Your signature means that you have received, read, and understand the policies and procedures of Bright Stars Primary Learning Academy, LLC.

I have read and understand the policies and procedures in the Bright Stars Primary Learning Academy, LLC Parent Handbook. I agree to abide by them as will my child (ren).

Parent Name (PRINT) \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_

Parent Name (PRINT) \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_



**CHILDREN'S ENROLLMENT FORM**

Entrance Date: \_\_\_\_\_ Withdrawal Date: \_\_\_\_\_

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Home Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Mother's Email \_\_\_\_\_ Social Security Number \_\_\_\_\_

Mother's Home Address (if different from child's) Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Father's Email \_\_\_\_\_ Social Security Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child's Living Arrangements: (check one)  Both Parents  Mother  Father  Other

Child's Legal Guardian(s): (check one)  Both Parents  Mother  Father  Other



**RELEASE AUTHORIZATION/EMERGENCY CONTACT FORM**

The child may be released to the person(s) signing this agreement or to the following:

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_

Other identifying information (if any) \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone Number \_\_\_\_\_ Relationship to child \_\_\_\_\_

Other identifying information (if any) \_\_\_\_\_

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_



**MEDICAL INFORMATION**

Doctor/Clinic Name \_\_\_\_\_

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

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

Dentist Name \_\_\_\_\_

Dentist Address \_\_\_\_\_ Phone Number \_\_\_\_\_

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

My child has the following special needs \_\_\_\_\_

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:

\_\_\_\_\_  
\_\_\_\_\_

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List allergies to the following: (Input N/A on each line if not applicable)

Medications: \_\_\_\_\_

Food: \_\_\_\_\_

Environment: \_\_\_\_\_



**EMERGENCY MEDICAL AUTHORIZATION**

Should (child's name) \_\_\_\_\_ Date of birth \_\_\_\_\_

suffer an injury or illness while in the care of Bright Stars Primary Learning Academy, LLC and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

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

Signature \_\_\_\_\_

Date \_\_\_\_\_

Facility Administrator/Person-In Charge \_\_\_\_\_

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

**MEDICAL AUTHORIZATION AGREEMENT**

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

Parent/Guardian: \_\_\_\_\_

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

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

## Tuition Fee Agreement

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

**Date of Enrollment:** \_\_\_\_\_  Full Time  Part Time M T W Th F

Child's Arrival Time: \_\_\_\_\_ Child's Departure Time: \_\_\_\_\_

**Tuition Fee(s):** \_\_\_\_\_

**Weekly Tuition** – weekly tuition is due each Monday before services are provided for the current week.

**Monthly Tuition** – monthly tuition is due on the 1st day of each month before services are provided.

**Identification** – provide copy of State issued ID card.

1. An annual, non-refundable family Registration Fee is to be paid at time of Enrollment. Registrations Fees are renewed September 1st each year and must be paid in full by September 30th.

2. The Center is open from **6:00 a.m.** to **7:00 p.m.** Monday thru Friday. A Late Pick-Up fee of \$5 per minute per child will be charged when a child is left past the center's closing time. If I or other authorized persons do not pick up my child and/or do not contact the center, and after the center staff exhaust all attempts to reach authorized persons, as per state child care licensing regulation, the center staff may release children to the custody of child protective services or local authorities within thirty minutes after closing time.

3. Tuition fees are not pro-rated for illness, holidays, or emergency closures of the center. Each family receives 2 credit weeks per enrollment year for vacations or time off. Vacation credits should be requested in writing and consists of Monday-Friday period of time. (This does not apply for Subsidized Families based on CAPS policies and procedures)

4. Tuition is due in advance of services provided. Tuition payments received after the close of business on Friday will be subject to a \$20 Late Fee.

5. Accounts that are two weeks behind may result in immediate termination of service; however, once balance is paid, the child may return into care

6. Two week written notice is required prior to withdrawing. All balances must be paid in full by last day of attendance. Any outstanding balance will be referred to a collection agency and subsequent legal action. All fees associated with collections or attorney charges will be added to the collection account.



7. I agree to notify the center by **9:00am** when child is absent. I must notify center staff if my school age child does not need to be picked up from school or will not arrive at their designated bus stop.

8. If my child attends our school age program and school is not in session due to public school closing or snow. If school is not in session for the entire week and my child attends Monday - Friday, the weekly tuition will be applied to my account.

9. The terms of this Agreement, including tuition, fees and policies are able to be changed by Bright Stars Primary Learning Academy with 30 days' notice. This agreement can be terminated by the center at any time.

10. Bright Stars Primary Learning Academy reserves the right to dis-enroll any child without notice if it is in the best interest of the child or the program. This will not occur without appropriate attempts being made to resolve any issues or concerns.

I certify that I have read, understand and accept all of the terms and conditions in the Parent/Guardian Agreement.

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

\_\_\_\_\_  
Date

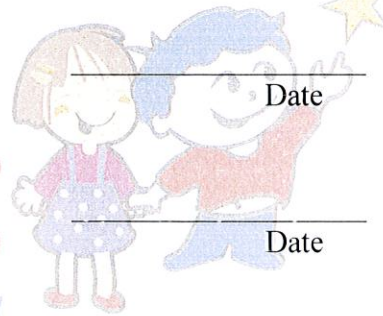
\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Director Signature

\_\_\_\_\_  
Date

Bright  
Stars  
Primary Learning Academy



# Bright Stars Primary Learning Academy

## 2019 – 2020

### Fee Schedule

**Registration Fee** \$65.00  
\$25.00 each additional child

**Weekly Rates:**

Ages 6 weeks thru 24 months: \$165.00  
Advanced 2 years thru 35 months: \$160.00  
Ages 3 years old: \$150.00  
Ages 4yrs. – 5yrs.: \$140.00

After School Care: \$75.00

Before & After School Care: \$85.00

Drop-In Care per day: \$45.00

Weekly Rate for School Age: \$130.00

**Related fees:**

Late Pick-up charge is \$5.00 per minute, per child, for children picked up after Closing time of 7:00pm

**Tuition payments are due every Monday when dropping off for the first day of the week or in advance.**

A \$20.00 late payment fee will be assessed on **ALL** accounts not paid on time.

**WE DO NOT ACCEPT PERSONAL CHECKS. NO EXCEPTIONS!**

**Policy:**

There is a 15% tuition discount off the older child's tuition.

I have read and understand all policies and fees described in this fee schedule.

Parent's Signature: \_\_\_\_\_

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





## Authorization for Pick-Up

**We will not release your child to anyone without parent or guardian authorization.**

The individuals listed below, as well as those listed on the Medical Treatment Permission form have my permission to pick up my child, \_\_\_\_\_ from Bright Stars Primary Learning Academy. These people must show photo ID in order to pick up the child.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

### **Special Circumstances:**

If a child's parent, is denied contact with the child, it is necessary to have a copy of the court document that grants full custody or orders a restraint against the parent. It is your responsibility to notify BSPLA in writing if the situation changes.



The following individuals are specifically denied permission to pick up my child:

\_\_\_\_\_  
Name Relationship to Child

\_\_\_\_\_  
Address Phone #

\_\_\_\_\_  
Name Relationship to Child

\_\_\_\_\_  
Address Phone #

I agree and by my signature give consent that in case of an accident, injury, or illness, my child \_\_\_\_\_, will be given emergency medical care. Basic first aid will be administered by a certified staff member. If the accident/injury is of a more serious nature, 911 will be called and transportation will be provided by ambulance to the Southern Regional Hospital or the closest hospital. I will be contacted immediately; if for any reason I am not able to be reached in a timely manner my emergency contact will be called.

\_\_\_\_\_  
Parent or Legal Guardian Signature Date

\_\_\_\_\_  
Director or Designee Signature Date



**PARENTAL & FACILITY AGREEMENT**

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

Bright Stars Primary Learning Academy, LLC agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize Bright Stars Primary Learning Academy, LLC to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for Bright Stars Primary Learning Academy, LLC.

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

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

(Parent/Guardian)

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

(Facility Administration)



## Child Medical Treatment Form

The following information will be kept on file for one year from the date signed. If any information changes, the parents or guardians need to promptly inform Bright Stars Primary Learning Academy in order for proper care to be given.

Physician's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Allergies to: Medications: \_\_\_\_\_  
Food: \_\_\_\_\_  
Environment: \_\_\_\_\_

Medications presently being taken and why: (Doctor's note is needed for medication administration by Bright Stars Primary Learning Academy staff).

History of illness we need to be aware of:

\_\_\_\_\_  
\_\_\_\_\_

In the event your child becomes ill or injured while in the care of Bright Stars Primary Learning Academy, you the parent will be contacted first. Please name two individuals whom are able to act for you in case you cannot be contacted.

Name: \_\_\_\_\_ Relationship to the Child: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to the Child: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_



## Family and Development History

Child's Name \_\_\_\_\_ Child's Age \_\_\_\_\_

Has child had previous Child Care/Preschool experience? \_\_\_\_\_

Describe briefly type of care child has been accustomed to (home, relatives, babysitters, foster home, day care home, etc.)

\_\_\_\_\_

### Previous Development

Age he/she began sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_

Is he/she a good climber? \_\_\_\_\_ Does he/she fall easily? \_\_\_\_\_

Age he/she began talking \_\_\_\_\_ Does he/she speak in words? \_\_\_\_\_

Does he/she speak sentences \_\_\_\_\_

Does he have any difficulties in speaking?

\_\_\_\_\_

### Eating

Is child usually hungry at Mealtimes? \_\_\_\_\_

What are his/her favorite foods? \_\_\_\_\_

What foods are refused? \_\_\_\_\_

Does child eat with a utensil? \_\_\_\_\_ hands? \_\_\_\_\_

Are there religious restrictions? \_\_\_\_\_ If so explain: \_\_\_\_\_

\_\_\_\_\_

Any special food considerations? \_\_\_\_\_

### Bathroom Habits

Is your child potty trained? Yes \_\_\_ No \_\_\_

Does your child need any type of assistance (buttoning, wiping, etc.)?

\_\_\_\_\_



What word is used for urination? \_\_\_\_\_ Bowel movements? \_\_\_\_\_

How does child react to accidents? \_\_\_\_\_

### **Sleeping**

What time does child go to bed? \_\_\_\_\_ Awaken? \_\_\_\_\_

Any special naptime needs (blanket, pull-up, etc.)? \_\_\_\_\_

### **Social Relations**

Has he/she had experience playing with other children? \_\_\_\_\_

By nature, is he/she friendly? \_\_\_\_\_ Aggressive? \_\_\_\_\_ Shy? \_\_\_\_\_ Withdrawn? \_\_\_\_\_

How does child get along with his/her brothers and sisters? \_\_\_\_\_ Adults \_\_\_\_\_

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

What makes child mad or upset? \_\_\_\_\_

How does child show his/her feelings? \_\_\_\_\_

What do you find is the best way to discipline? \_\_\_\_\_

How does child react to that discipline? \_\_\_\_\_

Does your child have any fears? (Animals, dark, noises, etc.) \_\_\_\_\_

Favorite toys or activities? \_\_\_\_\_

Does your child like to play outdoors? \_\_\_\_\_

### **Additional Needs**

In what particular way can we help your child grow and develop: Socially, emotionally, physically, and cognitively? \_\_\_\_\_

\_\_\_\_\_



# Food Allergy Action Plan

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

Place  
Child's  
Picture  
Here

ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

### Symptoms:

### Give Checked Medication\*\*:

(To be determined by physician authorizing treatment)

- |  |                                      |  |
|--|--------------------------------------|--|
| ▪ If a food allergen has been ingested, but <i>no symptoms</i> :         | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth            | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ Skin Hives, itchy rash, swelling of the face or extremities            | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ Gut Nausea, abdominal cramps, vomiting, diarrhea                       | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ Throat† Tightening of throat, hoarseness, hacking cough                | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ Lung† Shortness of breath, repetitive coughing, wheezing               | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ Heart† Thready pulse, low blood pressure, fainting, pale, blueness     | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ Other† _____   | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| ▪ If reaction is progressing (several of the above areas affected), give | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. †Potentially life-threatening.

### DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

3. Emergency contacts:

Name/Relationship	Phone Number(s)
a. _____	1.) _____ 2.) _____
b. _____	1.) _____ 2.) _____
c. _____	1.) _____ 2.) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

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

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Required)

**TRAINED STAFF MEMBERS**

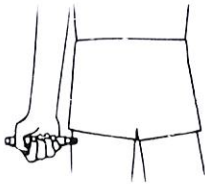
- |          |            |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |

**EpiPen® and EpiPen® Jr. Directions**

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

**Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions**



- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.



**SECOND DOSE ADMINISTRATION:**

If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

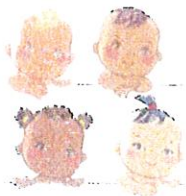


Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

*\*\*Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*





# Infant Affidavit



Name of Sponsor: \_\_\_\_\_ *Community Childcare Food Supplement, Inc.* \_\_\_\_\_

Name of Provider/Center \_\_\_\_\_

Name of Infant: \_\_\_\_\_

Infant Date of Birth: \_\_\_\_\_

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

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program must provide meals to all infants enrolled for care in the center/facility.

Center/provider will have available the following milk-based iron-fortified formula:

\_\_\_\_\_

Center/provider will have available the following iron-fortified infant cereal:

\_\_\_\_\_

Center/provider will have available the following brand of infant foods:

\_\_\_\_\_

Parents/Guardians,

Please check one of the following options below and sign this form:

\_\_\_\_\_ I would like the center/provider to serve ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

\_\_\_\_\_ I will provide the following meal component(s) to my infant and the center will provide all other meal components required:

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Formula*  | <input type="checkbox"/> Meat/Fish/Poultry/Eggs/Beans/Peas |
| <input type="checkbox"/> Cereal    | <input type="checkbox"/> Cheese/Cottage Cheese/Yogurt      |
| <input type="checkbox"/> Fruit     | <input type="checkbox"/> Bread/Crackers/Breakfast Cereal   |
| <input type="checkbox"/> Vegetable |  |

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

\_\_\_\_\_  
Date

\*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

## INFANT FEEDING PLAN

Child's full name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_

Does child take bottle? Yes [ ] No [ ]  
 Is the bottle warmed? Yes [ ] No [ ]  
 Does the child hold own bottle? Yes [ ] No [ ]  
 Can the child feed self? Yes [ ] No [ ]

Does the child eat: (Check all that apply)  
 Strained foods [ ] Whole milk [ ]  
 Baby foods [ ] Table foods [ ]  
 Formula [ ] Other [ ]  
 Breast Milk [ ]

What type of formula used? \_\_\_\_\_

Amount of formula/breast milk to be given? \_\_\_\_\_

Updated amounts of formula/breast milk: \_\_\_\_\_ Date: \_\_\_\_\_  
 Amount: \_\_\_\_\_ Date: \_\_\_\_\_  
 Amount: \_\_\_\_\_ Date: \_\_\_\_\_  
 Amount: \_\_\_\_\_ Date: \_\_\_\_\_  
 Amount: \_\_\_\_\_ Date: \_\_\_\_\_

Does the child take a pacifier? Yes [ ] No [ ] If yes, when? \_\_\_\_\_  
 \_\_\_\_\_

Food likes \_\_\_\_\_

Dislikes \_\_\_\_\_

Allergies? (Include any premixed formula) \_\_\_\_\_

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods \_\_\_\_\_  
 \_\_\_\_\_

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. \_\_\_\_\_  
 \_\_\_\_\_

**PARENTS' SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Preventative Products Approval

With parent's written approval, we may use preventative products, such as sunscreens, insect repellents, non-medicated powder, Petroleum jelly, and A&D ointment, without a physician's order: Child Care Rule: 290-2-3.11 (1)(e)

Please check each product below that you choose to use for your child. Please mark Sunscreen, we go outside daily. If you want your child to use these products, you are responsible for providing each. All items need to be labeled with your child's name and brought in a large Ziploc bag.

\_\_\_\_\_ Sunscreen

\_\_\_\_\_ Lotion

\_\_\_\_\_ Insect repellent

\_\_\_\_\_ Non-medicated Powder

\_\_\_\_\_ Petroleum jelly

\_\_\_\_\_ Non-prescriptive ointment (A&D, Desitin, etc.)

\_\_\_\_\_ Chopstick

\_\_\_\_\_ Band-Aids

\_\_\_\_\_ Neosporin, Bacitrim or similar ointment

\_\_\_\_\_ other (please specify): \_\_\_\_\_

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Parent's Printed Name

**Bright from the Start: Georgia Department of Early Care and Learning  
CACFP Meal Benefit Income Eligibility Statement\***

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

Phone# \_\_\_\_\_

Site# \_\_\_\_\_

**PART I: Child(ren) or Adult enrolled to receive day care**

Name: (Last, First, and Middle Initial)	DOB	AGE	SNAP, TANF, or EDCR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT number. Write case number and proceed to Part III	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAFD)				
				Head Start	Foster Child	Migrant	Runaway	Homeless
				<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"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)**

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

**A. Child Income:** Sometimes children in the household earn or receive income. Please indicate the TOTAL Child Income/How often?   
 income received by child household members listed in PART I here. \$ \_\_\_\_\_ / \_\_\_\_\_

**B. Other Household Members:** List all household members (including yourself) not listed in Part I even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write "0". If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often	2. Welfare, child support, alimony / How often	3. Social Security, pensions, retirement / How often	4. All other income / How often
1. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**C. Total Household Members (Adults and Children) listed in Part I and Part II** \_\_\_\_\_

**Social Security Number:** If income is listed on completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four digits of Social Security Number XXXX-\_\_\_\_  I do not have a Social Security Number

**PART III: Enrollment Information Children Only**

My child is normally in attendance at the facility between the hour of \_\_\_\_\_ (am/pm) to \_\_\_\_\_ (am/pm)  (Check here if only before/after school care is provided)

Circle the days your child normally attends the center: Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Circle the meals your child will normally receive while in care: Breakfast All Snacks Snacks P.M. Snacks Supper Evening Snacks

**PART IV: Signature**

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 give Federal/State data on the information I give. I understand that CACFP will also monitor the information I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefit and I may be prosecuted. My signature also certifies that the child(ren) or adult(s) listed on the form in Part I are enrolled for care. **If not completed fully and signed, the participant will be placed in the Paid category.**

Signature: X \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

\*This application is a revision of USDA's early childhood meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

**PART V: Participant's Ethnic and Racial Identities (optional)**

Check (✓) one ethnic identity:  Hispanic/Latino  Non-Hispanic/Latino   
 Check (✓) one or more racial identities:  Asian  White  Black or African American  Indian or Alaska Native  Hawaiian or other Pacific Islander

Official Use Only section for Provider: 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  Year Household Size: \_\_\_\_\_

Categorical Eligibility: check (✓) if applicable  Eligibility: check (✓) one Free  Reduced  Paid (Home)

Day Care Homes Only: check (✓) one Term  Term

**What is a Determining Official?** Determining Official (DO) is the person who determines if a participant is eligible for free or reduced meals. There must be at least two signatures on this form: one signature from the Determining Official (the address you determined when you applied for CACFP) and one signature from the confirming Official (the official who verifies the form's accuracy).

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

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

Follow Up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Community Childcare Food Supplement Inc.

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. [redacted] 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 Meal Benefit Income Eligibility Form. 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:** [redacted]

**2. Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits 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. **For more information on the Georgia's TANF and SNAP programs please call 1-877-423-4746 or visit [www.gateway.ga.gov](http://www.gateway.ga.gov).**

**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 this 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 everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. 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, TANF, FDPIR 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 [redacted]

**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 [redacted].

Sincerely,

Your Daycare Center Provider

# WIC

## A Special Food and Nutrition Education Program For Women, Infants and Children

### WHO IS ELIGIBLE?

- A pregnant woman
- A breastfeeding woman
- A woman who has recently been pregnant
- An infant or a child less than 5 years old

### SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

### TO BE ELIGIBLE, YOU MUST ALSO:

- Have a low or moderate income  
AND
- Have a special need that can be helped by WIC foods and nutrition counseling

### APPROVED WIC FOODS:

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.



# WIC

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- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.

I, \_\_\_\_\_, acknowledge receipt of the information about the WIC program. I understand that this information must be provided to every CACFP participant's family that completes an enrollment packet for the below named facility.

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

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

# Georgia WIC Program

Georgia WIC  
 Georgia Department of Public Health  
 2 Peachtree Street, NW  
 10<sup>th</sup> Floor  
 Atlanta, GA 30303  
 Telephone: 1-800-228-9173  
 Website: <http://dph.georgia.gov/WIC>

## INCOME ELIGIBILITY GUIDELINES (Effective from July 1, 2018 to June 30, 2019)

Household size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	22,459	1,872	936	864	432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
For each additional family member add	+ 7,992	+ 666	+ 333	+ 308	+ 154

### Parental Enrollment Agreement with Child Care Facility

The \_\_\_\_\_ agrees to provide child care for, \_\_\_\_\_ on  
(Facility's Name) (Child's Name)

Monday Tuesday Wednesday Thursday Friday  
(please circle)

from \_\_\_\_\_ a.m. to \_\_\_\_\_ p.m.  
(time during the day)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast Lunch Dinner  
Morning Snack Afternoon Snack Evening Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it. My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel. I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc. The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The facility agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep. I authorize the child care facility to obtain emergency medical care for my child when I am not available. I have received a copy and agree to abide by the policies and procedures for. I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

I also have received a Household Letter and WIC information along with my child's enrollment packet and have read and understand the resources in the state of Georgia available to myself and my family.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Parent/Guardian)

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Facility Administrator/Person-In-Charge)

Signature: \_\_\_\_\_  
(Facility Administrator/Person-In-Charge)

# HOUSEHOLD LETTER INSTRUCTIONS

## 2018-2019



Insert center name, address, and phone number in the highlighted portions of this letter.

1. Center Name: Bright Stars Primary Learning Academy

2. Center Name and Address: 8733 Tara Blvd. Jonesboro, GA 30236

3. Director/Owner's Name and Phone Number:

Jasmin Quillian / Rhonda Davis

4. Center Phone Number:

(770) 892-0160 (office) (770) 892-0161 (fax)

Please give this letter to all parents of children enrolled in your facility. All parents must sign your Distribution Log stating that they received a Household Letter. Please keep Distribution Logs current and file onsite. We will ask to see your Distribution Log quarterly to ensure that all items are distributed accordingly.

**NOTICE TO PARENTS AND**  
**GUARDIANS:**

**THIS FACILITY DOES NOT  
CARRY LIABILITY INSURANCE  
COVERAGE SUFFICIENT TO  
PROTECT YOUR CHILDREN IN  
THE EVENT OF AN INJURY, ETC.**

Posted per SB 24 (2004) requiring child care facility owners to post in a conspicuous place if it is not covered by liability insurance and to provide and retain written notice regarding no coverage to the parents and guardians.