BRIGHT DAYS CHILD DEVELOPMENT CENTER
NEW ENROLLMENT CHECKLIST

STUDENT NAME _____ TODAY'S DATE _____

PROJECTED ENROLLMENT DATE _____

- ☐ Student Data Form
- ☐ Child Developmental History Form
- ☐ Medical History Form
- ☐ Permission for Daily Release Form
- ☐ Emergency Information Form/Emergency Authorization
- ☐ Publicity Release Form
- ☐ Fee Payment Contract
- ☐ Current Immunization Form
- ☐ Parent Handbook/Policy Guidelines Form

Funding Forms

- ☐ Food Form (CCAFP)
- ☐ United Way
- ☐ State

BRIGHT DAYS CHILD DEVELOPMENT CENTER DATA FORM

Center Name _____ Today's Date _____ Enrollment Date_____

Child's Name_____ Nickname _____ Social Security #_____
Last First Middle

Gender_____ Race_____ Birth date_____ Age_____ Classroom_____

Street Address_____ County_____

City_____ State_____ Zip_____ Home Phone ( ) _____ - _____

Doctor's Name_____ Doctor's Phone Number ( )_____- _____

Parent/Guardian #1_____SS#_____ Date of birth_____

Place of Employment_____ Position _____ Work Hours _____

Work Phone ( ) _____ -_____ Cell Phone ( ) _____ - _____ Home Phone ( )_____-_____

e-mail address _____ Address of Employer _____

Marital Status ___Single ___Married ___Divorced Number in Household _____

Income Bracket: ___ Below $10,000 ___ $10,000-14,000 ___ $15,000-19,000
___ $20,000-29,000 ___ Over $30,000

Parent/Guardian#2_____SS#_____ Date of birth _____

Place of Employment_____ Position _____ Work Hours _____

Work Phone ( ) _____ -_____ Cell Phone ( ) _____ - _____ Home Phone ( )_____-_____

e-mail address _____ Address of Employer _____

Emergency Contact #1_____(_____)_____
Name Phone Number Relationship Address

Emergency Contact #2_____(_ _____)_____
Name Phone Number Relationship Address

Days Attending: M TU W TH F Arrival Time_____ Departure time_____

Employee/Student Status: ___Full Time ___Part time ___Seasonal

For Staff Use Only

Tuition_____ Date Received _____ Amount Cash___ Check___ Payment Type: ___Full fee ___Discount ___United Way ___State _____State Worker's Name _____ Income _____UW Co-Pay per day _____State Co-Pay per day ___CCFP (Food Program) ___Free ___Reduced ___Paid

Immunizations: Up-To-Date Certificate ___Yes ___No _____Date Received _____Exp. Date

Form Revised 2013

BRIGHT DAYS CHILD DEVELOPMENT CENTER
CHILD DEVELOPMENTAL HISTORY FORM

Child's Name_____ Date_____

Names and ages of siblings _____

Has your child been cared for by anyone other than parents?____Yes ____No By Whom?_____

Has your child previously attended a childcare center? ____Yes ___ No ____How Many? _____ For how long?

Where did he or she attend _____

Does your child use the restroom independently? _____Yes _____No

Does your child need help dressing or undressing? ____Yes ____No

Does your child have any special fears?____ Yes ____No Of what?_____

Your child's favorite games_____

Favorite toys_____

Favorite books_____

Does your child dislike any particular food(s)? _____

What form of discipline is used?_____

At what age did your child: Sleeping Habits:

Walk_____ Hours of sleep_____ Afternoon nap_____

Talk_____ Bedtime_____

Is your child toilet trained? ___ No ___Yes At what age? _____

BRIGHT DAYS CHILD DEVELOPMENT CENTER
MEDICAL HISTORY FORM

Child's Name_____ Date_____

Does your child require special medical care, please explain?_____

Does your child have any allergies?____Yes ____No What are they?_____

Does your child have a history of physical impairment? ____ Visual? ____Speech problems? ____
Hearing?

Current prescribed medications_____

Medical Doctor_____ Doctor's Phone # _____

Physician Group Name & Address _____

Does your child have a medical card or insurance? Name of insurance carrier
_____

Medical Card Number _____ Date Issued_____ Date of Expiration _____

Has you child even been to the dentist? ____Yes ____ No Dentist Name _____

Dentist Group Name & Address _____

Age of child at visit dentist visit? _____ Date of last visit to dentist _____

Dentist Phone Number _____ Any specific dental problems?_____

Please circle any of the following illness your child has had:

Measles Mumps Diphtheria TB Heart Disease Chicken Pox

German Measles Rheumatic Fever Polio Diabetes Kidney Disease

Whooping Cough Epilepsy Other_____

Has your child ever been hospitalized? If yes, explain_____

Other information we should know about medical or dental concerns

_____

Parent Signature _____ Date _____

Tell us about your child (socially, emotionally, special needs, etc.)

What are your hopes for your child as he or she participates in this program?

BRIGHT DAYS CHILD DEVELOPMENT CENTER
PERMISSION FOR DAILY RELEASE FORM

At the end of the day or during the day, my child_____

may be released only to the person(s) indicated below. **Any changes must be pre-approved through the office and provided by the parent/guardian. There will be no exceptions.**

	Name	Address	Phone	Relationship
1.				
2.				
3.				
4.				

At no time is my child, _____, to be released to the person(s) indicated below:

1. _____
2. _____
3. _____

_____ _____
Parent Signature Date

BRIGHT DAYS CHILD DEVELOPMENT CENTER
EMERGENCY INFORMATION FORM

Child's Name _____
Last First Middle

Date of Birth _____ Age _____

Emergency Contact

1. _____
Name Address Phone #s Relationship

2. _____
Name Address Phone #s Relationship

3. _____
Name Address Phone Numbers
Relationship

Child's Medical Doctor_____ Doctor's Phone # _____

Physician Group Name & Address _____

Preferred Hospital (if needed) _____

Bright Days Child Development Center Emergency Medical Authorization

Child's Name _____

The undersigned, who are parents or guardians having legal custody of the above-named minor, hereby authorizes the above-named school, into whose care the above–named minor has been entrusted, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to said minor under general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act, or to consent to an x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act. The undersigned further authorize the above named school to have the above-named minor released into the custody of its representative, should hospital care no longer be required. This medical authorization is to be used only in an extreme emergency, when said parents or guardians cannot be or are unavailable to be contracted.

Parent Signature _____ Date_____

BRIGHT DAYS CHILD DEVELOPMENT CENTER
FEE PAYMENT CONTRACT

General Enrollment Information

I, the parent/guardian of _____ understand that we are an enrollment based Center and agree to enroll my child based on the following attendance schedule:

Please circle all days child will be attending and indicate times below: M TU W TH F

___1/2 day ____Full day Time of arrival _____ Time of pickup _____

Self-Payment

I agree to pay the Center the fee of _____ per week, payable on Monday for the current week attending.

- I understand that if payment becomes two weeks behind my child my be disenrolled from the center.
- I understand that if I my child is absent due to sickness over five days a month, I am responsible to pay for any absence over five days. I also have to provide a statement detailing the sickness.
- I understand that if my child is absent for or vacation that I am still responsible for the fee.

Tuition Assistance Program

Number of family members: _____adults _____children Total (gross, not net) family income _____

_____I qualify for state funding.

_____I qualify for United Way funding.

- Note: I understand that if the state or United Way tuition assistance program refuses to provide payment for excessive absenteeism, I am responsible for any tuition balance that accrues.

_____ _____

Parent/Guardian Date

BRIGHT DAYS CHILD DEVELOPMENT CENTER
PUBLICITY RELEASE FORM

Dear Parent/Guardian,

From time to time, there are different organizations, newspapers, TV stations, non-profit agencies, or internal needs to take photos, film the agency or activities and children, or to visit or publicize the program and/or activities of the center.

_____

Name of child

I, the undersigned, hereby consent to the reproduction, publication, and other use of photographs or cinematic image and voice of my child by Children, Inc., in newspapers, TV stations, non-profit agencies or other organizations or businesses.

The undersigned grants the above-mentioned rights without compensation.

_____ _____

Parent/Guardian Signature Date

Revised FY2014-2015

KY Child and Adult Care Food Program Income Application

2014-2015 Child Care Centers

This form must have all sections complete in order for this center to qualify for reimbursement for meals served to your participants.
*For SNAP and K-TAP benefit information, please include the entire case number and skip section 3 then sign section 4.

1. CHILD INFORMATION (print) Name of Child (Last, first)	Birthdate	2. PROGRAM BENEFITS SNAP#	K-TAP#	Kinship	Foster
1.				☐	☐
2.				☐	☐
3.				☐	☐
4.				☐	☐
5.				☐	☐

3. **HOUSEHOLD MEMBERS AND MONTHLY INCOME:**

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above Last, First	GROSS MONTHLY Income From Work (Before Deductions	MONTHLY Income From Welfare Payments, Child Support, Alimony	MONTHLY Income From Pensions, Retirement, Social Security	Any Other MONTHLY Income Including Money Received from Kinship/Foster Child
1.	$	$	$	$
2.	$	$	$	$
3.	$	$	$	$
4.	$	$	$	$
5.	$	$	$	$

4. SIGNATURE AND SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X_____
Signature of Adult Household Member

X_____ ☐ No Social Security Number X_____
Last four digits Social Security Number* **Date**

Printed Name _____ Home Telephone No. _____ Work Telephone No._____

Street/Apt.No._____ City/State/Zip_____

5. Participant's ethnic and racial identities (optional) Mark one ethnic identity: ____Hispanic or Latino ____ Not Hispanic or Latino
Mark one or more racial identities: _____ Asian _____White ____Black or African American ____American Indian or Alaska Native
____ Native Hawaiian or Other Pacific Islander

*See Policy Memo

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

☐ SNAP/K-TAP Household

☐ Foster/Kinship Care

☐ Income Household:
Total Household Monthly Income: _____
Household Size: _____

Application approved for: ☐ Free Meals ☐ Reduced Price Meals ☐ Paid

_____ _____ _____ _____
Signature of Determining Official | Date | W/D Date | Re-enter Date

7 CFR 226.23(e)(4)

Revised FY2014-2015

Name of Site _____

CACFP ENROLLMENT FORM

1. Participant Information: (To be completed by Parent/Guardian)

Participant's Last Name	Participant's First Name	Date of Birth	Normal/Typical Hours of Care			Normal/Typical Days of Care (Circle all that apply)							Meals Normally Eaten (Circle all that apply)					
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN
				To		M	T	W	Th	F	Sa	Su	B	AM	L	PM	S	LN

***Parent/Guardian works multiple shifts and participants may be in care different days/hours ____yes ____no**

Guide:
Normal hours of care: Please insert the usual arrival time and the usual departure time. Indicate a.m. or p.m.
Normal days of care: Please circle the days of the week the participant(s) are usually in attendance at the facility
(M=Monday;T=Tuesday;W=Wednesday;Th=Thursday;F=Friday;Sa=Saturday;Su=Sunday)
Meals Normally Eaten-Please circle the meals the participants usually eat at the facility.
(B=Breakfast;AM=AM Supplement;L=Lunch;PM=PM Supplement;S=Supper;LN=Late Night Supplement)

2. Do you supply any food to the center for the participant's meals due to medical or religious reasons?
If **Yes**, please list foods supplied:

_____

3. Signature and Parent/Guardian Information:

_____

Parent/Guardian Signature **Date** ***(Parents date form)***

_____

Print Name: **Home Telephone Number:** **Work Telephone Number:**

_____

Address: **City:** **State:** **Zip Code:**

For Sponsor Use Only.

Signature of Determining Official:_____ **Date:** _____

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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 (in Spanish).
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**7 CFR 226.15 (e)(2)*

Date the participant withdrew:_____

Revised FY2014-2015
Child Care Income Application Letter

Dear Parent/Guardian:

Young children need healthy meals to learn. This letter is intended for parent or guardians of children enrolled at either a child care center or a family day care home. _____ 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 income application as soon as possible. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

The completed form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of federal funding received by the center. If your household's income is equal to or less than the amounts indicated for your household's size on the chart below, the center will receive a higher level of reimbursement.

1. **Do I need to fill out an income application for each of my children in day care?** Complete and submit one CACFP income application form for all children in your household only if they are enrolled in the same center or home. 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: _____.
2. **Who can get reduced priced meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, attached with this application.
3. **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 center.
4. **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.
5. **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. Once properly approved for free or reduced price benefits, whether through income or proof of benefits as supported by a current Supplemental Nutrition Assistance Program (SNAP) or K-TAP case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within eligibility standards.
6. **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.
7. **What if I have foster children?** In certain cases, foster children are eligible for free or reduced-price meals regardless of the income of the household with whom they reside. Fill out a separate application for each foster child in your care. However, if the foster children are siblings, each child may be listed on the same form. If this is a foster child, please indicate with a check mark on the application. Enter the foster child(ren's) personal use income (print "0" if the child has no income). Complete the form by proceeding to Part 4 and Part 5.
8. **The Kinship Care Program** operates under similar guidelines as that of foster care but the children are placed with family members. Under the Kinship Care Program, the state has custody of the child(ren) until permanent placement takes place (about 2 years later).
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. 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, nation origin, sex, age or disability.

If you have questions or need help, call _____ at _____.

Income Guidelines for Reduced Price Meals Effective July 1, 2014-June 30, 2015		
Family Size	**Reduced Price Meals**	
	Monthly	***Yearly***
1	**$1,800**	$21,590
2	**$2,426**	$29,101
3	**$3,051**	$36,612
4	**$3,677**	$44,123
5	**$4,303**	$51,634
6	**$4,929**	$59,145
7	**$5,555**	$66,656
8	**$6,181**	$74,167
For each additional family member add:	**+$626**	+$7,511

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

Non-discrimination Statement: "The U.S. Department of Agriculture (USDA) 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 if 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.)
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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 (in Spanish).
USDA is an equal opportunity provider and employer."

_____ _____

Sponsor Representative Phone Number

If you have questions about the CACFP and its administration, you may contact Deanna Tackett, Division Director at 502/564-5625 or at the following address: School and Community Nutrition, Kentucky Department of Education, 500 Mero Street, Frankfort, KY 40601.