HOPKINS HOUSE PRESCHOOL ACADEMIES
A CENTER FOR CHILDREN & THEIR FAMILIES

PRESCHOOL ACADEMY ENROLLMENT PACKAGE

ACADEMY:
☐ Helen Day (Alexandria City) ☐ Innovative (Herndon) ☐ McNeil (Fairfax South County)

PREFERRED START DATE: _____
Although we will work to accommodate your wishes, we cannot guarantee enrollment on your preferred date (please select a Monday only). You will receive an official enrollment date upon successful submission of this complete enrollment package and payment of the registration fee.

STUDENT INFORMATION
Please provide information about the child you wish to enroll in the Hopkins House Preschool Academy.
Name: _____ Nickname (if any): _____
Gender: ☐ Male ☐ Female Birthdate: _____

PARENT/GUARDIAN INFORMATION
Please provide information about one or both parents/guardians who have legal custody of the child.
PRIMARY CONTACT Name: _____ Relationship: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Employer *(leave blank if unemployed):* _____ Work Phone: _____
Employer Address: _____

SECONDARY CONTACT Name: _____ Relationship: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Employer *(leave blank if unemployed):* _____ Work Phone: _____
Employer Address: _____

EMERGENCY CONTACTS:
Please provide information for TWO persons OTHER than parent/guardian you authorize to pick your child up from Hopkins House in the event s/he becomes ill or has an emergency and you (parent/guardian) cannot be reached.
CONTACT #1 Name: _____ Relationship to Student: _____
Home Address: _____
Phone: _____ Email: _____

CONTACT # 2 Name: _____ Relationship to Student: _____
Home Address: _____
Phone: _____ Email: _____

AUTHORIZED PICK-UPS:
Please provide information for any additional persons you authorize to pick your child up from Hopkins House.
Name: _____ Relationship to Student: _____
Name: _____ Relationship to Student: _____
Name: _____ Relationship to Student: _____

OFFICE USE ONLY:
Form Verification Completed by: _____ Date: _____
Reg. Fee: $_____ Date: _____ 1st week's deposit: $_____ Date: _____
First date of attendance: _____ Last date of attendance: _____

STUDENT HEALTH & SPECIAL NEEDS INFORMATION

ALLERGIES - *Please list all known allergies and health conditions:*

_____

_____

HEALTH ACTIONS - *Please describe the action we should take in the event of an allergy/health condition emergency as listed above:*

_____

_____

_____

SPECIAL NEEDS - *Please list any special developmental, learning or physical needs that may require special accommodation:*

_____

_____

_____

OTHER INFORMATION

PREVIOUS SCHOOLS ATTENDED - *Please list any other day cares or schools your child has attended:*

_____

_____

_____

OUTSIDE SCHOOL PROGRAMS - *If your child will be enrolled in another school or program while attending Hopkins House, please provide the NAME and TYPE of the program/school:*

_____

_____

_____

PLANNED PAYMENT METHOD:

- ☐ Self-Pay (Check, Credit/Debit Card
- ☐ Office for Children (OFC) Subsidy. Case Worker Name & Contact #: _____
- ☐ Military & DoD Child Care Assistance
- ☐ Other Subsidy or Scholarship: _____

Enclosed Forms:

- ☐ **Form 1:** Identity Verification *(complete bottom of form in presence of preschool administrator)*
- ☐ **Form 2:** Authorization for Emergency Medical Care *(must be notarized)*
- ☐ **Form 3:** Statement of Parent Understanding
- ☐ **Form 4:** Permissions
- ☐ **Form 5:** School Entrance Health Form *(Part II & III should be completed by a Medical Provider)*
- ☐ **Form 6:** Virginia Child & Adult Care Food Program
- ☐ **Form 7:** Virginia CACFP Meal Benefit Income Eligibility Form for Child Care Centers
- ☐ **Form 8** *(optional):* EasyPay Sign-Up Form

HOPKINS HOUSE PRESCHOOL ACADEMIES
A CENTER FOR CHILDREN & THEIR FAMILIES

FORM #1

IDENTITY VERIFICATION

ACADEMY:

☐ Helen Day (Alexandria City)
☐ Innovative (Herndon)
☐ McNeil (Fairfax South County)

APPLICATION DATE: _____

Child's Name:	Nickname:
Mother/Guardian Name:	Father/Guardian Name:

This form must be completed in the presence of Preschool Principal or administrator.

Child's place of birth (City and State): _____

Birth date: _____

Birth certificate number: _____

Date certificate issued: _____

Principal/Administrator's signature verification: _____

Proof of your child's identity and age may include a certified copy of your child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of your child's identity from a child placing agency, record from a public school in Virginia, or certification by a principal or his/her designee of a public school in the U.S. that a certified copy of your child's birth record was previously presented.

Viewing your child's proof of identity is not necessary when the child attends a public school in Virginia *and* Hopkins House assumes the responsibility for your child directly from the school (i.e., after school program) or Hopkins House transfers responsibility of your child to the school (i.e., before school program). While programs are not required to keep the proof of your child's identity, documentation of viewing this information must be maintained in your child's record here at Hopkins House.

HOPKINS HOUSE PRESCHOOL ACADEMIES
A CENTER FOR CHILDREN & THEIR FAMILIES

FORM #2

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

ACADEMY:
☐ Helen Day (Alexandria City)
☐ Innovative (Herndon)
☐ McNeil (Fairfax South County)

APPLICATION DATE: _____

Child's Name:	Nickname:
Mother/Guardian Name:	Father/Guardian Name:

This authorization MUST be notarized.

If I cannot be contacted in an emergency affecting the health of my child, I authorize the preschool principal or designated staff to obtain emergency medical care for my child.

_____ _____
Parent/Guardian Signature Date

Subscribed and Sworn to before me this _____ day of _____ in the year _____.

(SEAL)

_____
Notary Public

Physician:	Telephone #:
Address:	
Health Insurance Company:	
Name of Policy Holder:	Relationship to Child:
Policy Number:	Coverage:
Medicaid Number:	State: ☐DC ☐MD ☐VA

HOPKINS HOUSE PRESCHOOL ACADEMIES
A CENTER FOR CHILDREN & THEIR FAMILIES

FORM #3

STATEMENT OF PARENT UNDERSTANDING

ACADEMY:
☐ Helen Day (Alexandria City)
☐ Innovative (Herndon)
☐ McNeil (Fairfax South County)

APPLICATION DATE: _____

Child's Name:	Nickname:
Mother/Guardian Name:	Father/Guardian Name:

Tuition and Fees

_____ _____ Guardian(s) Initials

1. I understand that I am solely responsible for payment of the Academy tuition and fees, when due and in full. I understand that if the Academy tuition is paid by a third party (i.e. government, employer, social services, or faith institution), I am solely responsible for ensuring that such payments are made when due and in full; and, that if such payment is not received on time or in full, I am personally liable for said payment.

_____ _____ Guardian(s) Initials

2. I understand that the Academy Registration Fee and/or Re-Registration Fee is non-refundable and must be paid at the time this Enrollment Package is submitted.

_____ _____ Guardian(s) Initials

3. I understand that, upon my child's enrollment in that Academy, I must pay a nonrefundable deposit in an amount equal to one week's tuition; and, that this deposit will be credited to my first week's tuition and is not refundable for any reason, including if I should elect not to enroll my child in the Academy.

_____ _____ Guardian(s) Initials

4. I understand that my child's Academy tuition is based on a yearly rate and that I am permitted to pay this tuition annually or in monthly or weekly installments. I also understand that my tuition payments, whether paid annually, monthly, or weekly are due in advance of service, and that I can make these payments by personal check, money order, or credit card (Discover Card, MasterCard, or Visa) and that cash is not accepted.

_____ _____ Guardian(s) Initials

5. I understand that there is no discount or adjustment to my tuition for my child's absences, or for holidays, staff development days, Winter/Spring Break, early withdrawal or emergency weather event when the Academy is closed. I also understand that no tuition or fees will be refunded, even in the case of extended absences or closure of the Academy.

_____ _____ Guardian(s) Initials

6. I understand that a late fee may be charged for late payment of tuition and that Hopkins House may decline to accept personal checks if my personal check is returned by the bank for insufficient funds, and that I will be charged any applicable bank fees associated with the returned check.

_____ _____ Guardian(s) Initials

7. I understand that failure to pay tuition in full, including any assessed late fees, within five business days after the due date, may result in the termination of my child's enrollment at the Academy and that re-enrollment of my child will be determined by available space and payment of all outstanding tuition due and the applicable re-registration fee.

_____ _____ Guardian(s) Initials

8. I understand that I will be assessed a late pick-up fee if I fail to pick-up or have picked-up my child after the usual preschool closing time.

_____ _____ Guardian(s) Initials

9. I understand that I am required to give written notice thirty (30) days prior to the withdrawal of my child from the Academy, and that I am liable for an amount equal to the annual tuition divided by twelve (12) if prior written notice of withdrawal is not given.

Health and Safety

_____ _____ Guardian(s) Initials

1. I understand that I am solely responsible for completing and submitting all forms required by the Academy and that these forms must be on file before my child can begin classes.

_____ _____ Guardian(s) Initials

2. I understand and agree that my child must be in attendance at the Academy daily, prior to 9 am, I also understand and agree that if my child is not in attendance at the Academy by 9 am, the Academy Principal may decline to allow my child to attend class that day and that I am still responsible for the tuition.

_____ _____ Guardian(s) Initials

3. I understand and agree that I am not to leave my child on the Academy campus without supervision. I also understand and agree that I am expected to walk my child into the preschool building each morning and release my child to the classroom teacher and sign my child in before exiting the building and sign him/her out at the end of the day.

_____ _____ Guardian(s) Initials

4. I understand and agree that my child will not be released to anyone except the parent/guardian of record without my written permission. I also understand and agree that the Academy will release my child to either parent unless a court order is obtained and shown to the Academy Principal designating a single parent/guardian as sole custodian of the child.

_____ _____ Guardian(s) Initials

5. I understand and agree that no medication will be administered to my child without my written permission, except in the case of an emergency and then only by a physician. I also understand and agree that prescription medication must be administered at home for 24 hours before my child can return to the Academy.

_____ _____ Guardian(s) Initials

6. I understand and agree that the Academy Principal will notify me whenever my child becomes ill and I understand and agree that I am expected to pick-up my child as soon as possible.

_____ _____ Guardian(s) Initials

7. I understand and agree that I will be given a Family Handbook which details the rules and procedures of the Academy and that I am expected to be knowledgeable of and to adhere to these rules and procedures.

_____ _____ Guardian(s) Initials

8. I understand and agree that my child's preschool enrollment may be terminated if my child's behavior threatens his or her own safety or that of other children or the staff.

_____ _____ Guardian(s) Initials

9. I understand and agree that my child cannot attend preschool if s/he has any illness that threatens the health of other children or the staff. I also understand and agree that health department regulations concerning periods of infection will be enforced, including that my child must be free of fever at least 24 hours before s/he will be permitted to return to preschool after an illness. And, I understand and agree that I inform the Academy within 24 hours or the next business day after my child or any member of my immediate household has any reportable, communicable disease.

AGREEMENT

By affixing my signature below, I affirm that I have read, understand, and agree with the several statements and agreements listed above:

_____ _____

Mother/Guardian Signature Date

_____ _____

Father/Guardian Signature Date

HOPKINS HOUSE PRESCHOOL ACADEMIES
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FORM #4

PERMISSIONS

ACADEMY:
☐ Helen Day (Alexandria City)
☐ Innovative (Herndon)
☐ McNeil (Fairfax South County)

APPLICATION DATE: _____

Child's Name:	Nickname:
Mother/Guardian Name:	Father/Guardian Name:

Field Trips

1. I understand that my child may participate in Preschool Academy local field trips and excursions, including but not limited to the surrounding neighborhood, local parks, and playgrounds, and distances of not more than three miles from the Academy campus.
2. I also understand that, from time-to-time, my child may be taken on day trips, including but not limited to the zoo, aquarium, or museum, and distances of more than three miles from the Academy campus. And, that in such instances, I will be given prior notice and that I may elect not to allow my child to attend such a trip and, in such instance, shall accept responsibility for alternative care for the child during the trip or for the full day.
3. I also understand that some trips or excursions, whether local or day, may require a fee for admissions or transportation, or incidental costs (e.g., souvenirs). In such case, I will be given prior notice of said fee or other cost and shall be responsible for providing my child with the required funding.

By my signature below, I acknowledge and agree to the Field Trips understandings stated above.

_____ _____
Parent/Guardian Signature Date

Photographs and Publications

1. I understand that my child may be photographed or recorded at Hopkins House Preschool Academy during normal hours, field trips, or activities, for purposes including but not limited to identification (e.g., clothing cubby ID), publicity for the Academy (e.g., media publication and advertising), public display (e.g., bulletin board), and publications (e.g., annual report, newsletter, website).
2. I understand that my child's name and other personal information will not be included with these photographs when published, without my express written permission.
3. I understand that there will be no payment or other compensation for the use of my child's image or likeness.
4. I understand that I can revoke this permission at any time, by submitting my wishes in writing to the Academy Principal.

By my signature below, I acknowledge and agree to the Photographs and Publications understandings stated above.

_____ _____
Parent/Guardian Signature Date

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/_____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school****. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____Date: _____/_____/ _____

Signature of person completing this form: _____Date:_____/_____/_____

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |____|____|____|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	**1**	**2**	**3**	**4**	**5**
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	**1**	**2**	**3**	**4**	**5**
*Tdap booster (6th grade entry)	**1**				
*Poliomyelitis (IPV, OPV)	**1**	**2**	**3**	**4**	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	**1**	**2**	**3**	**4**	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	**1**	**2**	**3**	**4**	
Measles, Mumps, Rubella (MMR vaccine)	**1**	**2**			
*Measles (Rubeola)	**1**	**2**	Serological Confirmation of Measles Immunity:		
*Rubella	**1**		Serological Confirmation of Rubella Immunity:		
*Mumps	**1**	**2**			
*Hepatitis B Vaccine (HBV) ❑ Merck adult formulation used	**1**	**2**	**3**		
*Varicella Vaccine	**1**	**2**	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	**1**	**2**			
Meningococcal Vaccine	**1**				
Human Papillomavirus Vaccine	**1**	**2**	**3**		
Other	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**___/___/____

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____
_____
_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

TB Screening: ☐ No risk for TB infection identified ☐ No symptoms compatible with active TB disease
☐ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result: ☐ Positive ☐ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

Stereopsis	❑ Pass	❑ Fail		❑ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):
☐ **Well child; no conditions identified of concern to school program activities**
☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____
_____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epinephrine auto-injector ☐ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ Date: ____/_____/_____

Practice/Clinic Name: _____ **Address**: _____

Phone: _____-_____-_____ **Fax**: _____-_____-_____ **Email:** _____

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF)FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES

1 All Household Members | 2 | 3

NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children]			FOSTER CHILD	SNAP, TANF or FDPIR CASE #
	First, Middle Initial, Last	Check if NO income	Ages of children in care	Skip to Part 6 if all are foster children.	Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. SNAP AND TANF MUST BE NINE (9) DIGITS
1		☐		☐	
2		☐		☐	
3		☐		☐	
4		☐		☐	
5		☐		☐	
6		☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison or Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How often	Amount	How often	Amount	How often	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, 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.

X X X – X X – _____
Social Security Number

☐ **I do not have a social security number.**

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.

_____ _____ _____
Date *Printed Name of Adult Household Member* *Signature of Adult Household Member*

7 Contact Information (Optional)

_____ (_____) _____
Work Telephone Number (Include Area Code) *Home Telephone Number (Include Area Code)* *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS* , the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS.

Date: _____ Sign here: _____

CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A **Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12**

Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per $_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

☐ **FREE** based on:			☐ **REDUCED** based on:	☐ **DENIED** reason:	
☐ foster child	☐ migrant	☐ SNAP, TANF, FDPIR	☐ household income	☐ income too high	☐ incomplete applicatio ı
☐ homeless	☐ runaway	☐ household income			☐ non-qualifying SNAP/TANF

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

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

This institution is an equal opportunity provider.

Virginia Child and Adult Care Food Program (CACFP)
Annual Enrollment Form (Child)

CENTER/PROVIDER COMPLETE THIS SECTION

Center/Provider Name			
		VA	
Street Address	*City*	*State*	*Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate Annual Enrollment Form for each child when enrolling their child(ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 5 below**.

This form is required for:	**This form is NOT required for:**
Child Care Centers, Family Day Care Homes	Outside School Hours Care Centers, Emergency Shelters

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK			4 MEALS RECEIVED
	☐ Monday	TIME IN	TIME OUT	SPORADIC SCHEDULE (no set schedule of days)	☐ Breakfast
Child's First Name	☐ Tuesday				☐ AM Snack
	☐ Wednesday				☐ Lunch
Child's Last Name	☐ Thursday				☐ PM Snack
	☐ Friday	NOTES:			☐Supper
Date of Birth (mm/dd/yyyy)	☐Saturday				☐ EV Snack
	☐ Sunday				
Age					

5 Parent/Guardian Signature and Date:

By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Annual Enrollment Form and that the information contained on this form is true and correct.

Printed Name:	*Signature:*
Street Address:	*City, State, Zip Code:*
Phone Number HOME / WORK / CELL (circle one):	*Date:*

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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(1) mail: U.S. Department of Agriculture
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(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Child Care Representative Use Only

Effective Date of This Enrollment Form:	***The effective date may be retroactive to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.***
(mm/dd/yyyy)	
Effective Withdrawal Date of This Enrollment Form:	
(mm/dd/yyyy)	
Printed Name of Center Representative	***This form is effective for 12 months from the date of parent signature.***
Signature of Center Representative	