Growth Spurts Child Learning Center LLC
CHILD'S INFORMATION

Child's Name: _____ Primary Language: _____

Child's Address: _____
Street City/Town Zip Code

Date of Birth: _____/_____/_____ Child's Schedule: MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐

Parent/Guardian Information

Name:_____ Name:_____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

E-mail Address:_____ E-mail Address:_____

Phone:_____ Phone:_____

Parent/Guardian Business Information

Company Name:_____ Company Name:_____

Address: _____ Address: _____

_____ _____

Business Phone: _____ Business Phone: _____

Business E-mail Address: _____ Business E-mail Address: _____

Others in Family Relationship/Emergency Contacts

Name:_____ Name:_____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone:_____ Phone:_____

Medical Information

Identified Allergies: _____

Health Insurance Provider: _____

Physician Information

Name of Physician/Clinic: _____ Phone: _____

Physician Address: _____
Street City/Town Zip Code

Dentist Information

Name of Dentist/Clinic: _____ Phone: _____

Dentist Address: _____
Street City/Town Zip Code

Parent/Guardian Signature: _____ Date: _____

FOR CENTER USE

Center: _____ Date of Admission_____ Age of Admission: _____

Date Registration Fee Rec'd:_____ Director's Initials: _____

Growth Spurts Child Learning Center® Informed Consent

Child's Name: ____

ACCESS

I will have access to the center without notice when my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

CHILD RELEASE

For a child's safety, Growth Spurts Child Learning Center will release a child only to parent(s)/legal guardian(s) or to the third parties I authorized below. Parents/guardians are required to provide a current copy of any relevant Custody Order.

Third party pick-up is subject to the following rules:

- At least two people other than the parents/guardians must be listed and designated as emergency contacts by checking the corresponding box below. Emergency contacts will be contacted if parents/guardians cannot be reached.

- If the person picking up is listed below, but does not pick up the child regularly, I will notify the center verbally, in advance. Verbal authorization is not permitted for any person not listed on this form.

- If the person picking up is NOT listed below, I must notify the center/school in writing, in advance.

- Photo identification will be required if the third party does not pick up the child regularly or is unknown to the staff member releasing the child.

THE FOLLOWING PEOPLE (WHO ARE NOT PARENTS/GUARDIANS) ARE AUTHORIZED TO PICK UP MY CHILD.

Name: ____________________	Name: ____________________
Relationship: ____________________	Relationship: ____________________
Address: ____________________ ____________________	Address: ____________________ ____________________
Daytime Phone: ____________________	Daytime Phone: ____________________
Cell Phone: ____________________	Cell Phone: ____________________
E-mail Address: ____________________	E-mail Address: ____________________
Contact In Case of Emergency YES ☐ NO ☐	Contact In Case of Emergency YES ☐ NO ☐
Name: ____________________	Name: ____________________
Relationship: ____________________	Relationship: ____________________
Address: ____________________ ____________________	Address: ____________________ ____________________
Daytime Phone: ____________________	Daytime Phone: ____________________
Cell Phone: ____________________	Cell Phone: ____________________
E-mail Address: ____________________	E-mail Address: ____________________
Contact In Case of Emergency YES ☐ NO ☐	Contact In Case of Emergency YES ☐ NO ☐

Growth Spurts Child Learning Center will not release a child to anyone who appears impaired. If an impaired person attempts to pick up your child, pick-up will be refused and we will attempt to contact the other parent/guardian or authorized persons. If alternative arrangements cannot be made, the local child protective services agency and/or the local police will be called, as required by state licensing.

PARENT/GUARDIAN INITIALS: ____________ Date: ______________

WALK PERMISSION

Weather permitting, children may go on walks supervised by staff in the surrounding area. Infants and young toddlers are transported in a buggy or stroller.

I give permission for my child to participate in walks. YES ☐ NO ☐
Preschool and school-age children may take field trips. A Blanket Field Trip Permission Slip will be included in this application for signature. Scheduled trip calendar describing trips will be sent home in advance.

PARENT/GUARDIAN INITIALS: _____ Date: _____

PHOTOGRAPHY & VIDEO PERMISSION

Growth Spurts Child Learning Center regularly takes photographs and videos of children enrolled for its business purposes. Growth Spurts Child Learning Center retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment. They may be shared with you and other families on a Growth Spurts Child Learning Cen-ter' website, by e-mail, by posting in the center, or in a parent newsletter. They may be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. They may be used for other center, general business, and marketing purposes, including Online. Growth Spurts Child Learning Center takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner.

I give permission for Growth Spurts Child Learning Center to take photographs and videos of my child and use these materials for its business purposes. YES ☐ NO ☐

PARENT/GUARDIAN INITIALS: _____ Date: _____

CHILD ILLNESS

If my child becomes ill, I will be called. I may be required to pick up my child as soon as possible (within 90 minutes at most). A child must remain out of the center until he/she is symptom free for 24 hours, unless a doctor's note is provided which states that the child is 1) not contagious; and 2) can participate in group care. The Parent Handbook contains Growth Spurts Child Learning Center full Child Illness Policy.

CHILDREN'S INJURIES

If my child sustains a minor injury during care, I will receive an injury report when I pick-up describing the incident. I will be contacted immediately if the injury produces any swelling, is on the face or head, or requires medical attention.

EMERGENCY MEDICAL CARE

If emergency medical attention is needed for my child, the center will attempt to contact me or the emergency contacts listed (if I cannot be reached). I authorize Growth Spurts Child Learning Center to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility, or to my preferred facility, if possible. Staff is trained in pediatric first aid and CPR and I authorize staff to administer the same. My child's health information may be viewed by staff, on a need to know basis, and state licenser for compliance.

CHILD'S HEALTH INSURANCE PROVIDER _____
NAME OF INSURED _____
POLICY NUMBER _____

PARENT HANBOOK ACKNOWLEDGEMENT Child Name _____

By signing below, I acknowledge and agree that: 1) in addition to this Informed Consent, I received the Growth Spurts Child Learning Center Parent Handbook or client equivalent, as well as any center-specific information and relevant state policies; 2) it is my responsibility to read and familiarize myself with all these materials and address any questions with center management; and 3) I will abide by these materials.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

Annual parent/guardian review and signature is required by Growth Spurts Child Learning Center and some state licensing agencies. If any changes are necessary, a new form will be completed.

PARENT/GUARDIAN SIGNATURE: _____ Date:_____
PARENT/GUARDIAN SIGNATURE: _____ Review Date: _____

Growth Spurts Child Learning Center LLC

Sunscreen Insect Repellent and Diaper Rash

Sunscreen, insect repellent and diaper rash creams and lotions should be applied to a child at least once at home to test for any allergic reaction. Aerosol sprays are prohibited.

Sunscreen/sun block must provide UVB and UVA protection with an SPF of 15 or higher. Sunscreen may not be used on infants under 6 months of age unless accompanied by a doctor's note. Insect repellent may only be used if recommended by public health authorities or requested by a parent/guardian. The repellent must contain a concentration of 30% DEET or less. Insect repellant may not be used on infants under 2 months of age. Oil of lemon eucalyptus and para-methane products may not be used on children under the age of three. All sunscreen/sun block and insect repellent provided by a parent/guardian must be:

- provided in the original container;
- clearly labeled with the child's full name;
- within the expiration date;
- appropriate for the age of the child; and
- free of nut ingredients.

I give Growth Spurts Child Learning Center permission to apply (name of sunscreen) _____ and/or (name of insect repellant) _____ when outdoor conditions warrant and consistent with package instructions (subject to any special instructions below) to my child, _____>

From: _____/_____/_____ To: _____/_____/_____ (not to exceed one year)

Special Instructions

Sunscreen/Sun Block: _____

_____

Insect Repellent: _____

_____

_____ _____

(Parent/Guardian Signature) (Date)

Growth Spurts Child Learning Center LLC

Permission Topical Ointment Administration

Child's Name: _____

I understand that topical ointments, such as lotion, lip balm or diaper cream, can be applied only as a preventive measure and cannot be used if the skin is broken or bleeding, unless I provide a Medication Authorization Form signed by me and my child's physician.

I understand that the topical ointment provided by me must:

- be appropriate for use on a child;
- be applied according to instructions on the label;
- be labeled with the child's full name; and
- be handed to a staff member and not left in a diaper bag or cubby.

I give my permission for the staff at Growth Spurts Child Learning Center to apply

- _____
- _____
- _____

as needed from: _____/_____/_____ to: _____/_____/_____ (not to exceed one year).

_____ _____

(Parent/Guardian Signature) (Date

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: ☐ Male ☐ Female
Last First M.I.

Date of Birth: _____ Home #: _____ Language Spoken At Home _____

Home Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

_____
Last First M.I.

_____
Last First M.I.

_____
Last First M.I.

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Date of Admission: _____

Date of Withdrawal: _____ **Reason:** _____

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
(Update Annually)

If my child _____, born on _____/_____/_____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to Growth Spurts Child Leaning Center , located at
Name of Facility or Caregiver
_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ❑ DC ❑MD ❑VA

Child's known Allergies or Physical Conditions: _____
_____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____ _____ _____
Home Business Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year

Place in child's folder/record.

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

TRAVEL AND ACTIVITY AUTHORIZATION

❑ Special one time permission for this activity only ❑ Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian

_____ give my permission
Name of Child

_____ for my child to participate in the following activities:

Trips in the van/automobile (facility or parent - owned)

Growth Spurts Child Learning Center Field Trips & Transportation
Explain planned activity - where and when

Field trips away from the facility

Growth Spurts Child Learning Center @
Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devises and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

❑ I will allow my child to play outside the fenced area; or

❑ I will not allow my child to play outside the fenced area.

This authorization is valid from _____/_____/_____ to _____/_____/_____

_____ _____
Parent/Guardian Signature Date Signed

PLEASE KEEP A COPY IN THE CHILD'S FILE.

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility. This is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4. Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ❑ Male ❑ Female ❑ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)*	❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer	
Race: *(check all that apply)*	❑ American Indian/ Alaska Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer	
Parent/Guardian Name:	**Parent/Guardian Phone:**	
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ❑ Yes ❑ No		

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ **Date:** _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ____ /_____ ❑ NML ❑ ABNL	**Weight:** ❑ LB ❑ KG	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ❑ Corrected ❑ Uncorrected ❑ Wears glasses ❑ Referred ❑ Not tested

Hearing Screening: *(check all that apply)* ❑ Pass ❑ Fail ❑ Not tested ❑ Uses Device ❑ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ❑ Asthma
- ❑ Autism
- ❑ Behavioral
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Developmental
- ❑ Diabetes
- ❑ Failure to thrive
- ❑ Heart failure
- ❑ Kidney failure
- ❑ Language/Speech
- ❑ Obesity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle cell
- ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ❑ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB?

❑ High → *complete skin test and/or Quantiferon test*

❑ Low

Skin Test Date: / **Quantiferon Test Date:**

Skin Test Results: ❑ Negative ❑ Positive, CXR Negative ❑ Positive, CXR Positive ❑ Positive, Treated

Quantiferon Results: ❑ Negative ❑ Positive ❑ Positive, Treated

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or fax 202-535-2607.

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ❑ Normal ❑ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ❑ Normal ❑ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**

HGB/HCT Test Date: / **HGB/HCT Result:**

Part 3: Immunization Information | To be completed by licensed health care provider.

Child Last Name:	Child First Name:	Date of Birth:

Immunizations	In the boxes below, provide the dates of immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year): Verified by: _____ (name & title)				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other	1	2	3	4	5	6	7

☐ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Is this medical contraindication permanent or temporary? ☐ Permanent ☐ Temporary until: _____ (date)

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

☐ Diphtheria ☐ Tetanus ☐ Pertussis ☐ Hib ☐ HepB ☐ Polio ☐ Measles
☐ Mumps ☐ Rubella ☐ Varicella ☐ Pneumococcal ☐ HepA ☐ Meningococcal ☐ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ☐ No ☐ Yes

This child is cleared for **competitive sports.** ☐ N/A ☐ No ☐ Yes ☐ Yes, pending additional clearance from: _____
_____

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	Provider Name:	
	Provider Phone:	
	Provider Signature:	Date:

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	Signature:	Date:
Health Suite Personnel Name:	Signature:	Date:

District of Columbia Oral Health (Dental Provider) Assessment Form

Parent/Guardian Instructions:
Part 1: Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address, list primary care provider, dental provider, and type of dental insurance. If the child has no dental provider and is uninsured, then please write "None" in each box.
Part 2: By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity representing this document. All information will be kept confidential. **This form will not be completed without parent/guardian signature. The parent/guardian must sign, print and date this part.**

Part 1: Child's Personal Information (to be completed by the parent/guardian)

Child's Last Name:	Child's First & Middle Name:	Date of Birth: MM/DD/YYYY	Gender: ☐M ☐F	School or Child Care facility: Grade:
Parent/Guardian Name 1:	Telephone 1: ☐Home ☐Cell ☐Work	Home Address:		Ward:
Parent/Guardian Name 2:	Telephone 2: ☐Home ☐Cell ☐Work	Emergency Contact:		Telephone:
Race Ethnicity: ☐White Non-Hispanic ☐Black Non-Hispanic ☐Hispanic ☐Asia or Pacific Islander ☐Other				
Primary Care Provider (Medical):	Dentist/Dental Provider:	Type of Dental Insurance: ☐Medicaid ☐Private Insurance ☐None ☐Other		

Part 2: Required Parent/Guardian Signatures

Parent/Guardian Release of Health Information:
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health.

PRINT NAME of parent/guardian: SIGNATURE of parent/guardian: Date:

Dental Provider Instructions:
Part 3: Indicate Circle Yes or No in finding column. For Yes, please explain in Comments Section.
Part 4 Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete, refer patient for follow up care. Dentist must sign, date, and provide required information.

Part 3: Child's Findings and Parent Recommendations (please indicate in finding column)

CONFIDENTIAL FORM

	Findings	Comments
Gingival inflammation	Y N	
Plaque and/or calculus	Y N	
Abnormal gingival attachments	Y N	
Malocclusion	Y N	
Treated Dental Caries	Y N	
Untreated dental caries	Y N	☐Check box if Urgent
Sealants on permanent molars	Y N	
Cleft lip and palate	Y N	
Preventative services completed	Y N	What kinds of preventative services were completed? ☐Prophy ☐Fluoride ☐Oral Hygiene

Part 4: Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. Treatment ☐is completed ☐is not completed ☐under treatment ☐refused treatment ☐no necessary.
The child has ongoing ☐urgent ☐non-urgent treatment needs and is under treatment ☐by me or ☐has been referred to:

DDS/DMD Signature: Print Name:

Address: Fax: **Phone:** **Date:**

District of Columbia Health Certificate:
This Form replaces the previous version of the District of Columbia Oral Health (Dental Provider) Assessment Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, all school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was approved by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examination. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that children 3 years of age or older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC Schools and other providers.

The Child and Adult Care Food Program
Enrollment Form / Income Eligibility Statement for Children

CENTER NAME: _____ FISCAL YEAR: 2024

PART 1 – ENROLLMENT INFORMATION

You must complete ALL five columns of Part 1.

Name(s) of Enrolled Child(ren)	Date of Birth	Before & After Care	Circle Normal Days of Care / Print Normal Hours of Care	Circle the Meals the Child Normally Receives while in Care
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper
		YES NO	SUN MON TUE WED TH FRI SAT Normal hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper

INCOME ELIGIBILITY INFORMATION

Please check all that apply and then fill out the parts specified.

- ☐ A member of my household receives SNAP (formerly Food Stamps) and/or TANF benefits. → Please complete Part 2 and Part 6.
- ☐ One or more of my children participates in Head Start / Early Head Start at this center. → Please complete Part 3 and Part 6.
- ☐ My household includes one or more foster children → Please complete Part 4 and Part 6.
- ☐ My child(ren) may qualify for Free or Reduced-Price meals based on household income. → Please complete Part 5 and Part 6.
- ☐ My child(ren) will not qualify for Free or Reduced-Price meals. → Please complete Part 6 only.

PART 2 – HOUSEHOLD MEMBER(S) RECEIVING SNAP and/or TANF BENEFITS

If any household member gets SNAP (Food Stamps) and/or TANF benefits, list the recipient's name, circle the benefit type(s), and give the case number.

Name of Benefit Recipient	Circle One or Both (if applicable)	SNAP / TANF Case Number **(required—not SSN or EBT #)**
	SNAP TANF	

PART 3 – CHILD(REN) ENROLLED IN HEAD START

If the enrolled child(ren) participates in Head Start/Early Head Start, write the name(s) below.

Name of Child	Name of Child	Name of Child

PART 4 – FOSTER CHILDREN

Name of Foster Child

Households with foster children only: Write the child(ren)'s name(s) here, then skip to Part 6.

Households with foster & non-foster children: Write foster child(ren)'s name(s) here. If you did **not** complete Part 2, you must complete Part 5 to qualify non-foster child(ren) for free/reduced-price meals. You may include foster child(ren) in Part 5 with non-foster child(ren). This makes it easier for non-foster child(ren) to qualify for free/reduced-price meals. If you choose to list the foster child(ren) in Part 5, you must report any personal income received by the foster child(ren). You do **not** have to report payments that you receive from the placement agency to support the foster child(ren). If you completed Part 2, skip Part 5. **All complete Part 6.**

PART 5 – TOTAL HOUSEHOLD INCOME – *Not required if Part 2 or Part 3 is completed.*

Write how much income **and** how frequently that amount is received: weekly, every two weeks (biweekly), twice a month (semimonthly), once a month (monthly), or annually.

List Names (First and Last) of **Everyone** In Your Household	Gross Income (before Taxes or Deductions) from Last Month (if none, write "0")							
	Earnings From Work Before Deductions		Alimony, Child Support, Welfare, etc.		Pensions, Retirement, Social Security, VA, etc.		Second job or any other income	
NAME	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY	INCOME	FREQUENCY
1.								
2.								
3.								
4.								
5.								

PART 6 – CERTIFICATION, SIGNATURE, AND SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

The adult household member who fills out this form must sign below. If Part 5 is completed, the adult signing the form must provide the **last four (4) digits ONLY** of his/her Social Security Number (SSN), or check "I do not have a Social Security Number." (See Privacy Act Statement on the back of this page.) **The last four digits of your SSN are NOT needed if you have checked "My child(ren) will not qualify for Free/Reduced-Price meals" or if you have listed a TANF or SNAP case number or are applying for Head Start or foster child(ren) only. CERTIFICATION:** 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; that institution official(s) may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

PRINTED NAME OF PARENT / GUARDIAN	**(LAST 4 DIGITS ONLY)**: XXX – XX – ____ ____ ____ ____ SOCIAL SECURITY NUMBER (SSN) OF PARENT/GUARDIAN	
SIGNATURE OF PARENT / GUARDIAN	DATE	☐ I do not have a Social Security Number
STREET ADDRESS, CITY, STATE , ZIP CODE		DAYTIME PHONE

PART 7 – CIVIL RIGHTS INFORMATION: ENROLLED CHILD(REN)'S ETHNICITY & RACE (OPTIONAL)

Check the ethnic and racial identity of your child(ren).

Ethnicity (mark one ethnic identity):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more racial identities):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this Program is administered without discrimination.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, income derived all or in part from any public assistance programs, or protected genetic information in employment or any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete a USDA Program Discrimination Complaint Form, found online at http://ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410, by fax at (202) 690-7442, or by email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 977-8330 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

In conjunction, the District of Columbia Human Rights Act, approved December 13, 1977 (DC Law 2-38; DC Official Code §2-1402.11(2006), as amended) prohibits discrimination on the basis of marital status, personal appearance, sexual orientation, gender identity or expression, family responsibilities, familial status, source of income, place of residence or business, genetic information, matriculation, or political affiliation of any individual. Additional protected traits can be found at https://ohr.dc.gov/protectedtraits. To file a complaint alleging discrimination on one of these bases, please contact the District of Columbia's Office of Human Rights at (202) 727-4559 or https://ohr.dc.gov/service/file-complaint.

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 list a case number for the Supplemental Nutrition Assistance Program (SNAP) and/or the Temporary Assistance for Needy Families (TANF) Program, submit an application on behalf of a foster child only, 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. Verification efforts may be carried out through program reviews, audits, and investigations and may include contacting the Child and Family Services Agency to verify foster child status; contacting the Income Maintenance Administration office to confirm receipt of SNAP and/or TANF benefits; contacting employers to determine income; and/or checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY – IES CLASSIFICATION

Reimbursement classification category for foster children

Check if one or more foster children are reported on this form:

- ☐ Free

Reimbursement classification category for non-foster children

Check one classification for all non-foster children reported on this form:

- ☐ Free (TANF, SNAP, Income Eligible, Head Start)
- ☐ Reduced-price
- ☐ Paid (household income above free or reduced-price level)
- ☐ Paid (incomplete information)

Total Household Income:

If necessary, use the correct income conversion formula before adding incomes reported with different frequencies. Once total monthly income is determined, write "monthly" as the frequency and use the "monthly" column of the Income Eligibility Guidelines.

To find monthly income:

Weekly income X 4.33 / **every 2 weeks** X 2.15 / **twice a month** X 2

Total income: $ _____ Frequency: _____

Number of household members: _____

The institution's Determining Official MUST sign and date the IES to complete it. Signature of a Verifying Official is recommended.

_____ _____

Signature of Determining Official Date

_____ _____

Signature of Verifying Official Date

Date child(ren) withdrew or terminated: _____