



## Welcome to Kid's Castle

We are thrilled that you have chosen Kid's Castle preschool for your child/children! Our goal is to provide your child with quality care and an educational experience that will last a lifetime. The first day for the 2024-2025 preschool year is Tuesday, September 3<sup>rd</sup>, 2024.

Kid's Castle is open from 6:30 a.m. to 6:00 p.m. Monday through Friday. No children are permitted in the building prior to 6:30am. A late fee will be charged for children picked up after 6:00 p.m.

Communication is important! Make sure you get to know all of your child/children's teachers. The parent communication area is located at the front of the building by the main door. Each classroom also has a parent communication board with daily schedules and lesson plans displayed. The Procure Solutions app is our main way to communicate – please make sure to download the app upon enrollment.

Each month, you will receive a calendar and newsletter. Please pay close attention to these hand-outs, as they will inform you of important dates, activities and events that are happening here at Kid's Castle!

Tuition is automatically withdrawn on Tuesday each week. If you receive WI Shares subsidy, payment must be transferred on the first day of each month. You will be billed according to the weekly rate that you schedule your child/children in attendance for.

If your child will be late or absent for their scheduled day, please call Kid's Castle at 262-657-7413, within the hour after your child's scheduled start time. We will make every reasonable attempt to contact you if you do not call, but your child will be marked absent if we do not hear from you.

### **Our goals:**

- To have your child feel safe, secure, and loved in their classroom environment by all staff here at Kid's Castle.
- Your child will develop self-discipline and positive self-esteem along with intellectual and physical skills.
- Your child will develop friendships with their peers and teachers.
- Your child will learn respect for others and other's belongings.
- Your child will have opportunities to express their individualism and share ideas with their class.

**Paperwork MUST be turned in 2 business days prior to start date**

**This includes:**

Registration Packet and Fee \_\_\_\_\_  
Provider/Parent Payment Agreement Form \_\_\_\_\_  
Health History Form \_\_\_\_\_  
Immunization Report \_\_\_\_\_  
Intake Form (Under 2 years only) \_\_\_\_\_  
YoungStar Intake \_\_\_\_\_  
Facebook \_\_\_\_\_  
HSIS/CACFP Form (All Households) \_\_\_\_\_

**Due no later than 60 days after enrollment:**

Health Report (signed by doctor) \_\_\_\_\_

**What to bring:**

- **Nap Bedding** - Parents should bring a crib sheet and blanket or sleeping bag (an item for underneath and on top of the child). Nap items should be taken home at the end of every week to be washed and returned the following week. Bedding needs to be brought to school in an XL Ziploc bag (provided by Kid's Castle upon enrollment).
- **Extra clothing** - It is very important to provide extra clothing for your children in the event of an accident or spill. Please label your child's clothing. Extra clothing will be stored in a gallon sized Ziploc bag (provided by Kid's Castle upon enrollment).
- **Outdoor clothing** - In the winter months, the children still go outside to play twice per day. Please provide the appropriate outdoor attire for your children. This includes: coat, hat, mittens/gloves, snow pants and boots!
- **Diapering Materials** - If your child requires diapering materials, it is the parents' responsibility to provide diapers/pull-ups and wipes. If diaper cream is needed, please ask for a medication form to fill out so our teachers can administer the medication.
- **Children Under Two** - A sippy cup labeled with their name.
- **Children Under One** - 2 bottles labeled with their name, a sleep sack, formula/breast milk & baby food/snacks.

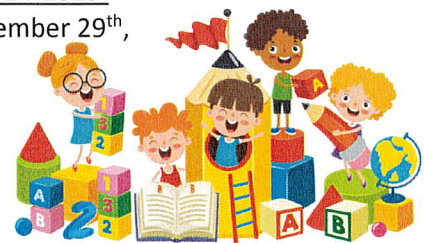
**Please label all your child's belongings. All children will be provided with a bag for extra clothes and a bag for nap items. Each child will also have a hook and cubby in the hallway for their items. Important paperwork will be sent home in their cubbies.**

**Kid's Castle Contact Info:**

**Financial Director:** Lindsey Fox  
**Curriculum Director:** Angelia Gallion  
**Main Phone Number:** 262-657-7413  
**Email:** [kckenosha@gmail.com](mailto:kckenosha@gmail.com)

**Preschool Year Calendar Days Off 2024-2025:**

September 2<sup>nd</sup>, November 28<sup>th</sup>, November 29<sup>th</sup>,  
December 24<sup>th</sup>, December 25<sup>th</sup>,  
January 1<sup>st</sup>, April 18<sup>th</sup>, and May 26<sup>th</sup>



# Kid's Castle Preschool Parent Participation Form 2024~2025

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

1. I understand that Kid's Castle is a state licensed facility and is open from 6:30am to 6:00pm. A late charge of \$5.00, every 5 minutes, per child will be applied to my account if I pick up after the closing time of 6:00pm.
2. I understand that chronic late pickups may be grounds for dismissal.
3. I understand that Kid's Castle does not provide breakfast for my child/children. I am aware that I may provide my child with breakfast to eat at Kid's Castle **before** 8:00a.m.
4. I understand that Kid's Castle will provide a lunch for my child. Participation in the lunch program is mandatory. The only supplements allowed to be brought in by parents will be for allergies and/or special needs. Also, if my child arrives after lunch has been served (11:30a.m. - 12:45p.m.) It is my responsibility to feed them before they arrive.
5. I understand that tuition will be automatically withdrawn on Tuesday each week and I will adhere to my Provider/Parent Payment Agreement Form.
6. I understand that after 2 weeks of missed payments, I will be required to set up a payment plan with administration, or my child will be withdrawn from the program. \_\_\_\_\_(Initials)
7. I understand that any card payments (credit or debit) made on my account will be charged a 3.5% service fee. \_\_\_\_\_(Initials).
8. I understand that if my payment is returned for any reason, I will be charged a returned item fee of \$30.00 for an ACH payment and \$10.00 for a credit card payment.
9. I understand that if my account is sent to collections, I will be charged **ANY** fees associated with the collection process.
10. I understand that if my account is delinquent for any reason, Kid's Castle reserves the right to terminate enrollment. Upon returning, if space is available, I will be charged a reenrollment fee of \$30.00 if within the same school year.
11. I understand that schedule changes are preferred in writing and submitted two weeks in advance. There is no "swapping" of days. I also understand that ANY changes to my child's schedule must be approved through the administration and is based on availability in that classroom.
12. I understand that tuition is based on my contracted schedule. I am required to pay for the days my child is scheduled for EVEN IF THEY DO NOT ATTEND.
13. I am aware that Kid's Castle has a built in week of vacation throughout the year (childcare week) over KUSD's Winter Break. Parents will be notified about this vacation time in advance and must turn in the appropriate "childcare week request off" form on time (as defined on the request form) to receive this week off at no charge. Parents may also choose up to 2 weeks of personal vacation per year for children attending **year-round**. Children who only attend for the **school year** will receive 1 week (Vacation "weeks" are based off of scheduled days- i.e. scheduled M,W,F=3 days vacation). This is an accrued vacation that you'll receive 6 months after enrollment. We ask that a vacation request form be completed and given to the office two weeks prior to the requested dates off.
14. I understand that I will be charged a weekly rate per my child's schedule; this includes holidays, days off and sick days. I will not be refunded for Kid's Castle closing due to severe weather. Kid's Castle will report closings via Procure and their Facebook page.
15. I am aware that I need to call Kid's Castle and report an absence within 1 hour of my child's scheduled arrival time. If no communication is made, my child will be marked absent for the day.
16. I understand that I need to notify the administration of any changes in address, phone numbers or places of employment as soon as these changes occur.
17. I understand that I will be notified of any pets (other than the fish) in the center.

# Kid's Castle Preschool Parent Participation Form 2024~2025

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18. I understand that I am responsible for paying a flat weekly rate regardless of when my child attends, if my child is enrolled in the KUSD 4-K program. The tuition cost for the 4-K program is a weekly Monday-Friday rate that includes a nutritious hot lunch and snacks.
19. I understand that my child may participate in field trips/outings (both walking and transported) sponsored and supervised by Kid's Castle. \_\_\_\_\_(Initials)
20. I understand that fieldtrips are a privilege and Kid's Castle reserves the right to **not** allow children to attend.
21. **I understand that enrollment fees are due prior to my child's enrollment and are nonrefundable.**
22. I understand that if I wish to dis-enroll my child from the program, a two week notice to administration is required, and I will be billed for those two weeks regardless of attendance. \_\_\_\_\_(Initials)
23. I understand Kid's Castle reserves the right to call 911 in case of an emergency. \_\_\_\_\_(Initials)
24. I hereby give consent for emergency medical care/treatment (911) to be used only if I cannot be reached immediately and aware that I will be held responsible for all fees associated. \_\_\_\_\_(Initials)
25. I understand that I need to review Kid's Castle's policy book, located outside of the front office, for additional fees and policies that may apply. I agree to abide by policies stated in the policy book regardless of whether or not I decide to read the policy book. \_\_\_\_\_(Initials)
26. I understand that it is my responsibility to provide and replenish my child with the items they'll need during care. This includes but is not limited to nap items and diapering materials. If I do not bring these particular items I will be charged a daily fee of \$2.00 per day for nap items, \$2.00 per diaper/pull-up, and a \$5.00 fee to replace a closeable storage bag. Children will receive an XL Ziploc bag for nap items, and a gallon Ziploc bag for extra clothes. \_\_\_\_\_(Initials)
27. I understand if I participate in WI Shares that it is my responsibility to pay my child's tuition on the first day of the month. A two day grace period will be given to make this payment. **After that a \$5.00 per day late fee will be added to my account until my payment is received.**
28. I understand that if my WI Shares payment is not applied **I will be held responsible** to pay my child's tuition. \_\_\_\_\_(Initials)
29. I understand that no refunds will be provided for any monies paid from MY WI Childcare EBT EDGE.
30. I understand that MY WI Childcare EBT EDGE card may not be used to pay any amount of my parent share payment.

Parent/Guardian or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian or Responsible Party: DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Four SSN: \_\_\_\_\_

**Kid's Castle LLC 2024-2025 School Year  
2 Years Old  
4211 GREEN BAY ROAD Suite 102  
KENOSHA, WI 53144  
(262) 657-7413**

<u>Office Use Only</u>	
Paperwork Given	_____
Reg. Fee PMT	_____
Procure Started	_____
Procure Completed	_____
Teachers Notified	_____

**REGISTRATION FEE \$60.00 (Due at the time of registration for new applicant - ACH or card payments only)**

STARTING DATE: \_\_\_\_\_

CHILD'S NAME (FIRST)	(MIDDLE)	(LAST)	(NICKNAME)	SEX	BIRTHDATE

FATHER/GUARDIAN NAME	OCCUPATION (NAME OF BUSINESS)	WORK PHONE	PERSONAL PHONE

HOME ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	Child lives with? Circle one	Y	N

EMAIL ADDRESS \_\_\_\_\_

MOTHER/GUARDIAN NAME	OCCUPATION (NAME OF BUSINESS)	WORK PHONE	PERSONAL PHONE

HOME ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	Child lives with? Circle one	Y	N

EMAIL ADDRESS \_\_\_\_\_

DOCTOR'S NAME	ADDRESS	PHONE

PERSONS TO BE CONTACTED IN AN EMERGENCY (OTHER THAN PARENT/GUARDIAN):	Authorized to pick up child:	
	Y	N

NAME (FIRST, LAST)	RELATIONSHIP	ADDRESS	PHONE	Y	N

NAME (FIRST, LAST)	RELATIONSHIP	ADDRESS	PHONE	Y	N

NAME (FIRST, LAST)	RELATIONSHIP	ADDRESS	PHONE	Y	N

NAME (FIRST, LAST)	RELATIONSHIP	ADDRESS	PHONE	Y	N

**IF THERE IS ANYTHING SPECIAL ABOUT YOUR CHILD THAT YOU WOULD LIKE US TO KNOW SUCH AS ALLERGIES/SPECIAL NEEDS, PLEASE LIST:**

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**Kid's Castle LLC 2024-2025 School Year 2 Years Old**

CHILD'S NAME \_\_\_\_\_

**2 Days**

**3 Days**

**4 Days**

**5 Days**

	Full \$136.00	Full \$188.00	Full \$233.00	Full \$275.00
2 Years Old	Half (up to 5 hours) \$117.00	Half (up to 5 hours) \$169.00	Half (up to 5 hours) \$195.00	Half (up to 5 hours) \$227.00

TIME SCHEDULE	MON	TUES	WED	THURS	FRI
<b>HALF TIME</b>  (Under 5 hours)	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____
<b>FULL TIME</b>  (Over 5 hours)	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____

I receive or will be applying for WI SHARES childcare assistance: Yes \_\_\_\_\_ No \_\_\_\_\_

HOW DID YOU HEAR ABOUT US?	Internet _____	Friend _____	Facebook _____
Newspaper _____	Other (Please describe) _____		



# Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

## ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) \_\_\_\_\_ to initiate credit card charges to the below-referenced credit card account (**Section A**) OR, initiate debit entries to my (our) checking or savings account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

### COMPLETE ONE SECTION ONLY

#### SECTION A (Credit Card)

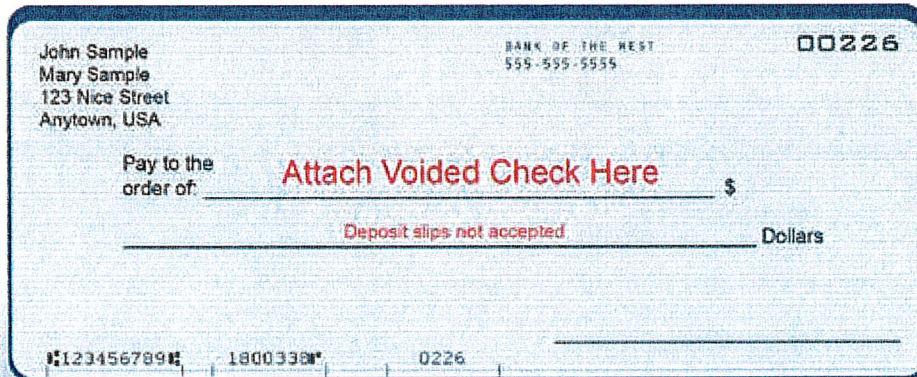
Cardholder Name	Phone #
Cardholder Address	City State Zip
Account Number	Expiration Date
Cardholder Signature	Date

#### SECTION B (Bank Account)

Your Name	Phone #			
Address	City State Zip			
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			

#### For Official Use Only

Date Received
Employee Signature



A service of



**Health History and Emergency Care Plan**

**Use of form:** This form is voluntary and meets the requirements in DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian may complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

**CHILD INFORMATION**

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)
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Home Address (Street, City, State, Zip Code)

**PARENT / GUARDIAN INFORMATION** Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

**PHYSICIAN / MEDICAL FACILITY INFORMATION**

Physician Name	Medical Facility Address	Telephone Number
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**SUNSCREEN / INSECT REPELLENT AUTHORIZATION** If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No   authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No   authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No   authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No   authorize the center to allow my child to self-apply repellent.		

**HEALTH HISTORY AND EMERGENCY CARE PLAN** If available, attach any health care plan information from the child's physician, therapist, etc.

- Check any special medical condition that your child may have.
  - No specific medical condition
  - Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
  - Asthma
  - Cerebral palsy / motor disorder
  - Diabetes
  - Epilepsy / seizure disorder
  - Gastrointestinal or feeding concerns, including special diet and supplements



Other condition(s) requiring special care – Specify.

Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

Food allergies – Specify food(s).

Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

a.

b.

c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

**SIGNATURE – Parent or Guardian**

Date Signed (mm/dd/yyyy)

Review dates:

## DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

**PERSONAL DATA**

PLEASE PRINT

<b>STEP 1</b>	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

**IMMUNIZATION HISTORY**

**STEP 2** List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- Yes year \_\_\_\_\_ (Vaccine is not required)  
 No or Unsure (Vaccine is required)

**REQUIREMENTS**

**STEP 3** The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib <sup>1</sup>	3 PCV <sup>2</sup>	2 Hep B	1 MMR <sup>3</sup>
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib <sup>1</sup>	3 PCV <sup>2</sup>	3 Hep B	1 MMR <sup>3</sup> 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT <sup>4</sup>	4 Polio			3 Hep B	2 MMR <sup>3</sup> 2 Varicella

<sup>1</sup>If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

<sup>2</sup>If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

<sup>3</sup>MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1<sup>st</sup> birthday is also acceptable).

<sup>4</sup>Children entering kindergarten must have received one dose after the 4<sup>th</sup> birthday (either the 3<sup>rd</sup>, 4<sup>th</sup> or 5<sup>th</sup>) to be compliant (Note: a dose 4 days or less before the 4<sup>th</sup> birthday is also acceptable).

**COMPLIANCE DATA AND WAIVERS**

**STEP 4** IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

- Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

**NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.**

- For health reasons this child should not receive the following immunizations \_\_\_\_\_ (List in STEP 2 any immunizations already received)

\_\_\_\_\_  
 Physician's Signature Required

- For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

- For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

**SIGNATURE**

**STEP 5** To the best of my knowledge this form is complete and accurate.

\_\_\_\_\_  
 SIGNATURE - Parent, Guardian or Legal Custodian

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

### Child Health Report – Child Care Centers

**Use of form:** Use of this form is required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. Completion of this form meets the requirements of DCF 202.08 (4), DCF 250.04 (6) (a) 4. and DCF 251.04 (6) (a) 8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

**PARENT OR GUARDIAN** – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)

Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

**HEALTH PROFESSIONAL** – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

Yes  No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

Yes  No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: \_\_\_\_\_ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

**AUTHORIZATION**

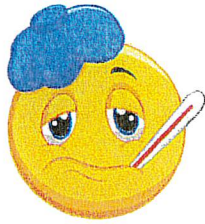
I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)

Address (Street, City, State, Zip Code)

**SIGNATURE** – MD, PA, or other EPSDT Provider

Date of Examination



## **Sick Day Guidelines:**

**Making the Right Call When Your Child is Sick**

### **Should I keep my child home or send him/her to preschool?**

School guidelines advise a child to stay home if he or she:

- Has a fever of 100 degrees or higher
- Has been vomiting or has diarrhea
- Has red, irritated eye/eyes
- Has a rash not evaluated by a medical provider
- Has a severe sore throat
- Has head lice
- Has symptoms that keep your child from participating in school, such as:
  - Very tired or lack of appetite
  - Deep or uncontrollable cough
  - Severe pain from earache, stomach ache, body ache or headache

### **24 Hour Rule:**

- **FEVER:** Keep your child home until they are *FEVER FREE* without medicine for 24 hours (48 hours with Covid-19 contact)
- **VOMITING OR DIARRHEA:** Keep your child home for 24 hours after the *LAST* time he or she has vomited or had diarrhea
- **ANTIBIOTICS:** Keep your child home at least 24 hours after the *FIRST DOSE* of the antibiotic

*\*Please help others from becoming sick by keeping your child home when ill\**



5. Here is a list of qualities that families view as qualities as desirable for their children to recognize and value. Which, if any, do you consider to be especially important? Mark N/A if not important to your family values.

Rank from most important to least important (1 being most important):

\_\_\_ Independence

\_\_\_ Hard work

\_\_\_ Feeling of responsibility

\_\_\_ Imagination

\_\_\_ Tolerance and respect for other people

\_\_\_ Determination, perseverance

\_\_\_ Religious faith

\_\_\_ Unselfishness

\_\_\_ Obedience

\_\_\_ Self-expression

6. Are there any other areas that your family values?

7. Is there anything you would like to tell us about your child's temperament? (what calms your child down when they are upset, excited, or frustrated?)

8. How would you describe how your child learns about the world around them (example: fearless (tries everything in sight or cautious, approaches their world slowly and cautiously)?

9. What is the most important thing that we should know about your child?



I give my permission to Kid's Castle LLC to photograph my child/children. These pictures will be displayed in the center and/or used for documentation of progress in their portfolios.

Agreed and accepted for:

Child/Children Names: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

Kid's Castle has a Facebook page and often uses it to share special activities or events. Sometimes we go on field trips or have special guests & post photos. Please sign below if you would like your child to be included.

\_\_\_\_\_ Yes, I will allow my child's picture/s to be on Kid's Castle's Facebook page.

\_\_\_\_\_ No, I do not want my child's picture to be on Kid's Castle's Facebook page.

Thank You!

Kid's Castle Staff

Dear Parent or Guardian:

**Kid's Castle** is enrolled in the CACFP, a USDA program which  
(Name of Agency)

provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. **In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year. Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files.** Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher ("Free" or "Reduced-price") meal reimbursement rates for your enrolled children, for 12 months from the *Effective Month of Determination* regardless of any change in your household size and/or income or termination from Benefits Programs.

• You are not required to complete this HSIS if no one in your household receives benefits from FoodShare WI (the Supplemental Nutrition Assistance Program (SNAP)), FDIPIR (Food Distribution Program on Indian Reservations), Wisconsin Works Cash Assistance Programs and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

### Determining Eligibility based on Participation in Benefits Programs → Complete Part 1 and Part 3 of HSIS form

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDIPIR, or WI Works Cash Assistance.

**Wisconsin Works Cash Assistance** is Wisconsin's Temporary Assistance for Needy Families (TANF) program. **It provides temporary cash assistance through work placement and training programs and IS NOT the WI Child Care Subsidy Program.** WI Works Cash Assistance Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), W-2 Transitions (W-2T), Custodial Parent of an Infant (CMC), Minor Parents Services, Noncustodial Parents, and Pregnant Women.

**You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDIPIR, WI Works Cash Assistance:**

- (a) The names of your enrolled children; • **DO NOT list case numbers for:**  
Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- (b) Checked box for the benefit your household receives and its case number; &
- (c) The signature of an adult member in the household & signature date • **DO NOT list a 16 digit Quest Card number (starts with 5077) for FoodShare WI**

### Determining Eligibility by Household Size and Income → Complete Part 2 and Part 3 of HSIS form

**Household-Size Income Scale** (Effective July 1, 2020 to June 30, 2021)

Household Size	Annual Income Level (at or below)
1	\$ 23,606
2	\$ 31,894
3	\$ 40,182
4	\$ 48,470
5	\$ 56,758
6	\$ 65,046
7	\$ 73,334
8	\$ 81,622
For each additional Household Member, add:	+\$ 8,288

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates ("Free" or "Reduced-price" meal rate) for your children.

**For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):**

- (a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
- (b) Income received by each household member identified by source of income and its pay frequency;
- (c) Total number of household members;
- (d) The signature of an adult member of the household and signature date; and
- (e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.

• Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

### Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children enrolled in Head Start:

Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below.

• Please note: These children's **eligibility for Free meals does not extend to other children in your household.**

**The respective documentation is required for these children to be eligible for Free Meals:**

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled in Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

**Use of Information Statement:** The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, WI Works Cash Assistance, or FDIPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

**Sharing Eligibility Information:** Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, **unless you tell us not to.** This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Please note that filling out this HSIS does not automatically enroll your children in these programs. **If you do not want your information to be shared with these programs, please notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement.** Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

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](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](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

*Lindsey Fox*

Signature of Agency Representative





**CACFP ENROLLMENT FORM**

**Parent/Guardian Instructions:**

This form can be used for up to three children per household. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. This form can be used for three years for the same child(ren), to meet the annual updating requirements.

Child Care Name:

HOURS AND MEALS WHILE IN CARE											
Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Meals Normally Received While in Care (Check ✓)					
						Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Date of Birth:	<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Monday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Tuesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Wednesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Thursday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Information (Year One):			Additional Information (Year Two):			Additional Information (Year Three):					

HOURS AND MEALS WHILE IN CARE											
Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Meals Normally Received While in Care (Check ✓)					
						Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Date of Birth:	<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Monday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Tuesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Wednesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Thursday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Information (Year One):			Additional Information (Year Two):			Additional Information (Year Three):					

HOURS AND MEALS WHILE IN CARE											
Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Meals Normally Received While in Care (Check ✓)					
						Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Date of Birth:	<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Monday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Tuesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Wednesday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Thursday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Information (Year One):			Additional Information (Year Two):			Additional Information (Year Three):					

PARENT/GUARDIAN SIGNATURE																	
Parent/Guardian Signature (Year One):			Date Mo./Day/Yr.			Parent/Guardian Initials (Year Two):			Date Mo./Day/Yr.			Parent/Guardian Initials (Year Three):			Date Mo./Day/Yr.		



HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household.

Refer to the accompanying Household Letter for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren): Center Kid's Castle

PART 1: BENEFITS

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPIR? If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

FoodShare Wisconsin (10-digit case number): DO NOT list a 16-digit Quest Card number: Wisconsin Works (W-2) Programs (10-digit case number): Wisconsin Shares Child Care Subsidy benefits is NOT a W-2 Program. It does not qualify a child as free in the CACFP. FDPIR (9-digit case number):

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete a, b, and c below; then go to PART 3.

a) Household Members Information: List full names of all members in first column, including yourself and all children. b) List all income on the same line as the person who receives it. Record each income source only once. Check the box for how often each income source is received.

Table with columns: Household Member Names, Age, Check if Foster Child, Check if No Income, Gross wages, Net income (self-employed), Tips, Commission, Cash bonuses, Military pay & allowances, Work comp, Unemployment, Weekly, Every 2 Weeks, Twice per Month, Monthly, Annually, Retirement, Social Security, SSI, Disability, VA benefits, Child Support, Alimony, Private pensions, Trusts, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income, Weekly, Every 2 Weeks, Twice per Month, Monthly, Annually.

c) Record total # of household members:

PART 3: SIGNATURE

An adult household member must sign and date this form. If PART 2 is completed, the adult signing the form must list the last four digits of their SS# OR check "None" if they do not have a SS#.

ETHNICITY AND RACE DATA COLLECTION - Completion is optional. This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. Please answer both questions. IS YOUR CHILD(REN) HISPANIC OR LATINO? SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN): I CERTIFY that all information on this form is true. Signature of Adult Household Member, Signature Date Mo./Day/Yr., Last 4 digits of SS# (or check "None" if you do not have a SS#)

FOR CENTER USE ONLY - Complete all 3 sections

Section 1: Basis of Determining Eligibility (A or B). Section 2: Eligibility Determination. Section 3: Determining Official's Initials/Approval Date Effective Month of Determination. A. Household Size & Income. B. Benefits/Foster. Total Household Size. \*Total Income \$. \*\*Effective Month of Determination.

\*Convert to yearly income only when multiple pay frequencies are reported, using only these multipliers: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12. \*\*This form expires one year from the Effective Month of Determination.