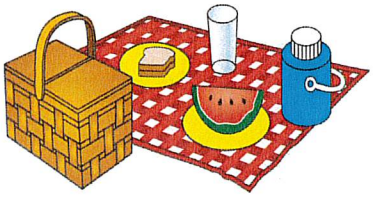
Welcome to Kid's Castle Summer Camp 2024!



Welcome to Summer Camp! Our preschool session will end on Friday, June 14th and camp begins Monday, June 17th. Summer camp is an exciting part of our program! Children will be placed in classrooms according to specific ages and grade levels. Kid's Castle accepts children ages 8 months through 13 years of age. There are many opportunities for your child to participate in activities that will enhance their personal growth, physical well-being, and build social skills!

Kid's Castle offers a variety of field trips over the summer for ages 5 and up. You will receive a monthly calendar explaining what activities are scheduled for the center as a whole. Each classroom will also plan individual fieldtrips and activities as well. You will be notified in advance of these activities as they are scheduled via the Procare app and the bus schedule posted in the entry way. Fieldtrips and other special activities are planned according to appropriate age groups.

In addition to making new friends and getting to know each other, children will have the opportunity to participate in creative arts & crafts, exciting science experiments, daily swimming and/or water activities, cooking projects, fun picnics, ice cream socials, sports events, concerts by the lake, scavenger hunts and much, much more! All activities will be supervised by well-trained staff members.

Parents may choose to send their children 2-5 days per week. Full and half-day options are available for ages 2 and up. Kid's Castle provides a 10% sibling discount (for the oldest child) for families with multiple children that are scheduled 3 or more days per week. Calendars will be handed out monthly in each child's cubby or folder. Vacation request forms are located outside of the main office. A vacation request form must be filled out and given to the office two weeks prior to using a vacation day. Please refer to the Parent Participation form for clarification on vacation time. Tuition is automatically withdrawn on Tuesday each week.

Summer Camp runs from Monday, June 17th through Wednesday, August 28th

We will be CLOSED on Thursday, July 4th in observance of Independence Day
We will be CLOSED on Thursday, August 29th, Friday, August 30th to prepare for the Preschool year!!

We are looking forward to a fun and exciting summer! Stop in the office or give us a call if you have any questions.

Thank you,
Kids Castle Administration

What to bring to Summer Camp:

Be sure to replenish these items as needed

ALL AGES:

- Extra change of clothes
- Swim-suit & Towel
- Reusable Water Bottle
- Bug Spray

AGES 5 & UNDER:

- Sunscreen
- Blanket & Sheet – children will be provided an XL Ziploc bag for storage (for children going into Kindergarten & below)

1st GRADE - 13 YEARS:

- Disposable bag lunch every day!

REMEMBER TO LABEL EVERYTHING WITH YOUR CHILD'S NAME!!

Paperwork must be submitted 2 business days prior to start date!

This Includes:

Registration Packet & Fee _____ (ALL AGES)
Provider/Parent Payment Agreement Form _____ (ALL AGES)
Health History Form _____ (ALL AGES)
Immunization Report _____ (ALL AGES)
Intake Form _____ (Under 2 Years)
YoungStar Intake _____ (ALL AGES)
Facebook _____ (ALL AGES)
HSIS/CACFP Form (All Households) _____ (ALL AGES)
Due NO LATER Than 60 Days After Enrollment:
Health Report (Signed By Doctor) _____ (8 Months-Kindergarten)

Kid's Castle Office Information

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

Kid's Castle Parent Participation Form Summer Camp 2024

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 my child 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 AGES 8 MONTHS THROUGH KINDERGARTEN ONLY. Parents of young children who are unable to eat solid foods must provide a substitution. Participation in the lunch program is mandatory. The only supplements allowed will be for allergies and/or special needs. I understand that Kid's Castle DOES NOT provide lunch for children 1ST GRADE THROUGH 13 YEARS-OLD. It is my responsibility to provide my child with a healthy disposable lunch each day. I will be charged a $6.00 lunch fee if my child does not have a lunch. Also, if my child arrives after lunch has been served (11:30-12:45p.m.), it is my responsibility to have them fed before they arrive. _____(Initials)
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 responsible for **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 session.
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 understand that parents with children going into 1st Grade through 13 years of age are granted 2 weeks of vacation over summer camp, effective immediately upon enrollment. Children ages 8 months through 5 years, who only attend summer camp will receive 1 week of vacation. Parents with children ages 8 months through 5 years of age, who attend yearly, may also choose up to 2 weeks of personal vacation per year. I am aware that this is an earned vacation that I will 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 days 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 Procare and their Facebook page.
15. I understand 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 contact information, such as: address, phone numbers, authorized pickups, 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.
18. I understand that my child (ages 5 and up) may participate in field trips/outings (both walking and transported) sponsored and supervised by Kid's Castle LLC. _____(Initials)
19. I understand that fieldtrips are a privilege and Kid's Castle reserves the right to **not** allow children to attend. _____(Initials)

20. I understand that my child will be participating in sports, physical activities and swimming/water play daily. Children ages 4 through 13 years will be swimming in our onsite pool daily – weather permitting. _____ (Initials)
21. **I understand that enrollment fees are due immediately upon my child's enrollment and are nonrefundable.**
22. I understand that my child's enrollment in Kid's Castle may be suspended or terminated effective immediately for failure to abide by this contract, failure to pay required fees by the due dates, failure to follow center policies and procedures as outlined in the Kid's Castle Policy Book or failure to comply with DCFS license requirements. I understand that if my childcare services are terminated, I may not be eligible to enroll in any Kid's Castle Child Care Program in the future. _____(Initials)
23. I understand that if I wish to dis-enroll my child from the program, a two week written notice is required, and I will be billed for those two weeks regardless of attendance. _____(Initials)
24. I understand Kid's Castle reserves the right to call 911 in case of an emergency. _____(Initials)
25. 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)
26. 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)
27. 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, diapering materials, and a disposable lunch (1st grade through 13 years of age). Children 8 months through Kindergarten will receive an XL Ziploc bag for nap items, and a gallon Ziploc bag for extra clothes. 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, $5.00 fee to replace a closeable storage bag, and a $6.00 fee for lunch. _____(Initials)
28. I understand if I participate in WI Shares it is my responsibility to pay my child's tuition on the first day of that 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.** _____(Initials)
29. I understand that if my WI Shares payment is not applied, **I will be responsible** to pay my child's tuition. _____(Initials)
30. I understand that no refunds will be provided for any monies paid from MY WI Childcare EBT EDGE.
31. 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 Printed Name: _____

Parent/Guardian or Responsible Party Signature: _____ **Date:** ____/____/_____

Parent/Guardian or Responsible Party: DOB: ____/____/_____ **Last Four SSN:** __ __ __ __

Kid's Castle LLC 2024 Summer Camp 8~24 Months Old

4211 GREEN BAY ROAD Suite 102, KENOSHA, WI 53144 (262) 657-7413

REGISTRATION FEE $70.00

DUE AT THE TIME OF REGISTRATION - ACH OR CARD PAYMENT ONLY

Office Use Only
Paperwork Given _____
Reg. Fee PMT _____
Procare Started _____
Procare Completed _____
Teachers Notified _____

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:

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 Summer Camp 8~24 Months Old

CHILD'S NAME: _____

	2 Days	3 Days	4 Days	5 Days
8 - 24 Months Old	Full $159.00	Full $223.00	Full $271.00	Full $313.00

TIME SCHEDULE	MON	TUES	WED	THURS	FRI
FULL TIME	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_____

Please indicate any vacation being taken off during the first two weeks of camp.
*Refer to the Summer Camp Vacation Policy with any questions.

	WEEK 1	WEEK 2
Please circle the day(s) of vacation being taken for the month of June.	6/17 6/18 6/19 6/20 6/21	6/24 6/25 6/26 6/27 6/28

HOW DID YOU HEAR ABOUT US? Internet _____ Friend _____ Facebook _____

Newspaper _____ Other (Please describe) _____

Tuition® Express

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 _____

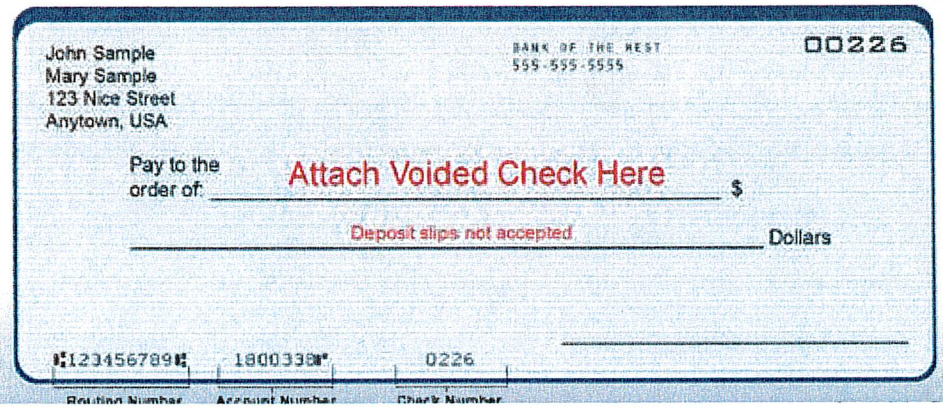
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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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)

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

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.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

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

1. 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: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 09/08)

STATE OF WISCONSIN
ss. 252.04,Wis. Stats.

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.

STEP 1 PERSONAL DATA — PLEASE PRINT

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)	

STEP 2 IMMUNIZATION HISTORY

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 *Influenzae* 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)

STEP 3 REQUIREMENTS

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[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]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).

[2]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.

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

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

STEP 4 COMPLIANCE DATA AND WAIVERS

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):

STEP 5 SIGNATURE

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

Intake for Child Under 2 Years – Child Care Centers

Use of form: This form is mandatory for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for licensed family and group child care centers; however, it meets the requirements of DCF 250.09(1)(c)1. and 251.09(1)(am). This form collects information about children under 2 years of age in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: This form is to be completed by a parent / guardian and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)	Nickname (If any)	Birthdate (mm/dd/yyyy)
Name – Parent(s) (Last, First, MI)		Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

HEALTH Note: Health conditions that may affect the care of the child must be recorded in the child's health history record. The form should be shared with any person who provides care for the child.

☐ Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

MEALS

Current feeding schedule

Length of time on current schedule

Food type

☐ Breast milk ☐ Formula ☐ Strained ☐ Junior ☐ Table ☐ Milk type – Specify:

New food timetable

When eating, child is

☐ Held in lap ☐ In highchair ☐ Other – Specify:

Feeds self

☐ Yes ☐ No If "Yes", uses: ☐ Spoon ☐ Fork ☐ Hands

Special feeding problems

☐ Yes ☐ No If "Yes" – Specify:

Food allergies

☐ Yes ☐ No If "Yes" – Specify:

Favorite foods – Specify

Refused foods – Specify.

UPDATES

SLEEP

Current sleep schedule

Length of time on current schedule

Falls asleep easily

☐ Yes ☐ No

Mood upon awakening – Describe

Takes favorite toy(s) to bed – **child over age 1 year**

☐ Yes ☐ No If "Yes" – list toy(s):

Sleep position – **child under age 1 year**

Note: Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached.

☐ Back for children under age 1 year ☐ Side or stomach (physician statement attached)

Sleep position – **child age 1 year and older**

☐ Back ☐ Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper type	Diapers provided by parent
☐ Cloth ☐ Disposable	☐ Yes ☐ No

Plastic pants used

☐ Always ☐ Never ☐ Sometimes If "Sometimes" – Specify:

Highly sensitive skin	Frequent diaper rash
☐ Yes ☐ No	☐ Yes ☐ No

Lotions, powders, or salves used

☐ Yes ☐ No If "Yes", product name(s) – Specify:

Toilet training attempted

☐ Yes ☐ No If "Yes", describe routine.

Type of toilet seat used at home

☐ Potty chair ☐ Special toilet seat ☐ Regular toilet seat

Regular bowel movements

☐ Yes ☐ No

How often

Time(s) of day

Toileting problems

☐ Yes ☐ No If "Yes" – Describe.

UPDATES

VERBAL COMMUNICATION

Family's spoken language.

☐ English ☐ Spanish ☐ Hmong ☐ Other If "Other" – Specify:

Age child began talking	Child speaks in ☐ Words ☐ Sentences

Words used to describe special needs – Specify

UPDATES

COMFORTING

Does child have a fussy time?

☐ Yes ☐ No If "Yes" – Specify time.

How is fussy time handled?

Child likes to be:

☐ Held ☐ Sung to ☐ Rocked ☐ Read to ☐ Other – Specify:

Special things you say or do to comfort child

UPDATES

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to – (Check all that apply)

☐ Sit up alone ☐ Pull up ☐ Crawl ☐ Walk holding on ☐ Walk without support

☐ Yes ☐ No Is your child used to playmates?

Comments

UPDATES

MISCELLANEOUS

Child's favorite **indoor** toys and activities – Specify

Child's favorite **outdoor** toys and activities – Specify

By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child.

UPDATES

SIGNATURE – Parent or Guardian

Date Signed

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

youngstar
Wisconsin's Child Care Quality Rating and Improvement System

Family Intake Questionnaire

This form is used to gather information about the children we serve. Families are encouraged to fill out this questionnaire as completely as possible within the family's comfort level. Any question may be left blank if the family does not wish to share the information.

Child's Name _____ **Date:** _____

1. Tell us about your family and your family's background. (State any information you are willing to share; such as: siblings, who lives in your home, where you may have lived previously, etc.):

2. Tell us about the holidays, traditions and/or customs that your family observes and explain how you observe it (what activities you do, what food you eat, music you listen to, clothing you wear, or artifacts that you use that represent your culture etc.):

3. Tell us about some of the different occupations and professions represented in your family:

4. What kind of things do you do as a family? How do you spend your free time? (Sports participation, TV watching, pets in the home, games, etc.)

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

CHILD AND ADULT CARE FOOD PROGRAM (CACFP) — For Group Child Care & Outside of School Hours Centers

HOUSEHOLD LETTER (Non-Pricing Programs) — **FFY 2021,** Rev. 6/20

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)), FDPIR (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, FDPIR, 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, FDPIR, WI Works Cash Assistance:

(a) The names of your enrolled children;

(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 case numbers for: Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- 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 FDPIR; 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.

Lindsey Fox

Signature of Agency Representative

CACFP ENROLLMENT FORM

Child Care Name:

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.**

HOURS AND MEALS WHILE IN CARE

Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Meals Normally Received While in Care (Check ✓)

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	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Meals Normally Received While in Care (Check ✓)

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	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Meals Normally Received While in Care (Check ✓)

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: ____________

☐ **FDPIR (9-digit case 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. ____________

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.

Household Member Names **Household Member:** anyone who is living with you and shares income and expenses, even if not related.	(Optional) 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	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	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? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):
☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

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#) ***-**-___ ___ ___ ___ ☐ None

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* Total Household Size ________ *Total Income $________/______ ($ Amount) (Time Period)	B. *Benefits/Foster* ☐ FoodShare WI ☐ W-2 Programs ☐ FDPIR ☐ Foster Child(ren)	☐ Free ☐ Reduced ☐ Non-Needy	Initials/Date: ____________ **Effective Month of Determination: ____________ Month/Year

*Convert to yearly income <u>only</u> 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.*

This institution is an equal opportunity provider.