Welcome to Kid's Castle

We are excited you have chosen Kid's Castle for your child's preschool! Our goal is to provide your child with quality care and an educational experience that will last a lifetime!

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

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. Please familiarize yourself with the important dates and events that occur here at Kid's Castle.

You will receive a monthly calendar and newsletter. Please pay close attention to these hand-outs, they will inform you of what is happening here at Kid's Castle!

Bills are due the first Friday of every month. You are billed for the days you sign up for. Please remember there is a two day a week minimum. Rotating schedules are a minimum of three days a week and are charged an additional fee.

Please remember to call Kid's Castle at 262-657-7413 child in within an hour after your child's scheduled start time if they will be absent for the day. We will make every reasonable attempt to contact you if you do not call.

Continued on back...

Our goals:

Your child will 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 life-long friendships with their peers and teachers.

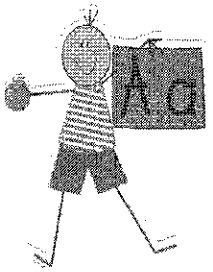
Your child will learn respect for others and other's belongings.

Your child will have opportunities to express their individualism and share ideas with their class.

What to bring:

- **Nap Bedding -** Parents should bring a crib sheet, blanket or sleeping bag. Nap items should be taken home at the end of every week to be washed. Bedding needs to be brought to school in a closeable bag.
- **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. All children will be provided with a hook in the hallway for their extra clothing and jackets.
- **Outdoor clothing -** In the winter months, the children go outside to play. Please provide the appropriate outdoor attire for your children. This includes coats, hats, boots, mittens/gloves and snow pants!
- **Diapering Materials -** Parents should bring diapers and wipes that will be kept in your child's classroom. If diaper cream is needed, please ask for a form to fill out so our teachers can administer the medication.

Kid's Castle Important Info:
Owner/Director: Kristine Cresco
Main Phone Number: 262-657-7413
Email: kckenosha@gmail.com



Kid's Castle Preschool Parent Participation Form 2018~2019

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 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 8:00am.
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 will be for allergies and/or special needs. Also, if my child arrives after lunch has been served it is my responsibility to have them eat before they arrive.
5. I understand that tuition is due the first Friday of every month for all families, unless prior arrangements have been approved by administration.
6. I understand if tuition is not paid in full by the last business day of that month the appropriate finance fee will be charged. Accounts with a remaining balance of $500.00 or below will receive a fee of $10.00. Accounts between $500.00-$1,500.00 will receive a fee of $20.00. Accounts above $1,500 will receive a fee of $50.00. Please see the Tuition Payment Policy and Agreement form for more information (included in registration packet).
7. I understand that after two months of insufficient payments Kid's Castle reserves the right to terminate enrollment.
8. I understand that if my payment is returned for any reason I will be charged a returned item fee of $30.00.
9. I understand if my account is sent to collections I will be charged a $50.00 collection fee.
10. I understand that if my account is delinquent for any reason Kid's Castle reserves the right to terminate enrollment and I'll be charged a reenrollment fee of $25.00 upon returning.
11. I understand that if I wish to dis-enroll my child from the program a two week written notice is required.
12. I understand that schedule changes must be submitted two weeks in advance, on a change/add form. There will be 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.
13. **I am aware that I must sign my child in and out of the program every day that they are in attendance and sign my name on the sheet weekly.**
14. I understand that Kid's Castle has a two day a week minimum and I am required to sign my child up for at least two days per week. If my child has a rotating schedule, the schedule must be submitted NO LATER than 4:00pm on the Friday of the prior week. If I fail to submit a schedule, I will be billed according to the previous week's schedule and any additional days will be billed accordingly. **Rotating children must schedule a minimum of 3 days per week and will be charged an additional fee.**
15. I understand that bills are based on a contracted schedule. I am required to pay for the days my child is scheduled for EVEN IF THEY DO NOT ATTEND.
16. I am aware that Kid's Castle has built in vacation throughout the year (childcare weeks). Parents will be notified about these childcare weeks in advance and must turn in the appropriate childcare week request off form on time. Parents may also choose up to two weeks of personal vacation to be used from June-May for children attending **yearly**. Children who only attend for the **school year** will only receive one week. A vacation request form must be filled out and given to the office two weeks prior to using a vacation day. If you withdraw early for any reason and have used over the allotted amount of days, your account will be charged accordingly.

Kid's Castle Preschool Parent Participation Form 2018~2019

17. I understand that I will be charged for the days Kid's Castle is closed for holidays and I will not be refunded for Kid's Castle closing due to severe weather. Kid's Castle will report closings to the local news stations and update their Facebook page.
18. I understand that if for any reason my child cannot have skim or whole milk, that I'm responsible for providing an alternative milk substitution.
19. 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.
20. 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.
21. I understand that I will be notified in writing of any pets (other than the fish) in the center.
22. 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 for the 4-K program is a Monday-Friday rate that includes a nutritious hot lunch and snacks.
23. I understand that my child may participate in field trips/outings (both walking and transported) sponsored and supervised by Kid's Castle LLC.
24. I understand that fieldtrips are a privilege and Kid's Castle reserves the right to not allow children to attend.
25. I understand Kid's Castle reserves the right to call 911 in case of an emergency.
26. I understand enrollment forms and fees are due two business days prior to your child's enrollment and are nonrefundable.
27. I understand that all Parent Share payments are due on the first business day of that month, prior to care being rendered, unless prior arrangements have been made.
28. I understand if I participate in WI Shares it is my responsibility to pay my child's tuition on the **first business day** of that month. A two day grace period will be given to make this payment and then a $5.00 per day late fee will be added to my account until my payment is received.
29. I understand that if my WI Shares payment is not made after two days **I will be responsible** for my child's tuition.
30. I understand that I need to review Kid's Castle's policy book 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.
31. I understand that no refunds will be provided for any monies paid from MY WI CHILDCARE EBT EDGE.
32. 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**_____

Kid's Castle LLC "Fall 2018-2019"

(12-24 Month Old)
4211 GREEN BAY ROAD Suite 102
KENOSHA, WI 53144
(262) 657 - 7413

REGISTRATION FEE $50.00 (New applicants only) ***DUE AT THE TIME OF REGISTRATION*** _____

STARTING DATE: _____

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

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

ADDRESS (STREET) (CITY) (WI) (ZIP) Child lives with? Circle one: Y N

EMAIL ADDRESS_____

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

ADDRESS (STREET) (CITY) (WI) (ZIP) Child lives with? Circle one: Y N

EMAIL_____

DOCTOR'S NAME ADDRESS PHONE

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

NAME	RELATIONSHIP	ADDRESS	WORK PHONE	CELL PHONE	Y	N
NAME	RELATIONSHIP	ADDRESS	WORK PHONE	CELL PHONE	Y	N
NAME	RELATIONSHIP	ADDRESS	WORK PHONE	CELL PHONE	Y	N
NAME	RELATIONSHIP	ADDRESS	WORK PHONE	CELL PHONE	Y	N

IS THERE IS ANYTHING SPECIAL ABOUT YOUR CHILD THAT YOU WOULD LIKE US TO KNOW?

ALLERGIES:

SPECIAL NEEDS:

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Kid's Castle LLC "Fall 2018-2019"

(12-24 Month Old)

CHILD'S NAME _____

REGISTRATION FEE $50.00 (New applicants only)

FEE	TIME SCHEDULE	MON	TUES	WED	THURS	FRI
$37.00	**PART TIME** **(Up to 5 hours)**	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____
$48.00	**FULL TIME** **(over 5 hours)**	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____	Drop off _____ Pick up _____

*Rotating schedules will be charged an additional fee.

I receive childcare assistance: Yes_____ No_____

HOW DID YOU HEAR ABOUT US?

Phone Book _____ Friend _____ Internet _____

Newspaper _____ Other (Please describe) _____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

dcf.wisconsin.gov/

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. 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. Except for a school-aged child, each child 2 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 HealthCheck provider to be completed, signed and dated. The licensee 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 were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

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

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

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

Date of 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 HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/2017)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child 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 (√) 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 child care entrance. Children who reach a new age/grade level while attending this child 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 child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child 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 child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child 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

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) 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 should 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)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

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

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	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 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically 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

☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns including special diet and supplements

☐ Cerebral palsy / motor disorder ☐ Epilepsy / seizure disorder ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

☐ 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* 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: _____ _____ _____ _____ _____

Dear Parents,

We are proud to announce that we have decided to give you the opportunity to virtually be with your children during the day.

You are the first and most important educators of your children. You will finally be able to share your children's day with them thanks to new mobile/web technology called LetsShare. We have high hopes that learning can now expand beyond the classroom walls and allow us to enter into an educational partnership.

LetsShare will mainstream all information to and from our childcare center into one mobile application keeping all parents "in the know". Teachers can now share daily and special activities through the classroom journal and photo gallery. They can also communicate easily with parents and receive important information from you through the messaging and parents share system.

You'll soon receive an email invitation to join us in this new experience.

In the meantime, we would like to make sure your email is up to date. Please return the form below as soon as possible.

Warmest Regards,

Kris Cresco

Child's name: _____ Bday_____

Child's name: _____ Bday_____

Child's name: _____ Bday_____

Mother's name: _____

Mother's email: _____

Father's name: _____

Father's email: _____

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 update special 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

INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

Use of form: This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12(a). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under age 2 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 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 on the department's form, Health History and Emergency Care Plan. 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

☐ 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 over age 1 year**

☐ Back ☐ Side or stomach

UPDATES

DIAPERING / TOILETING

Diaper – type

☐ Cloth ☐ Disposable

Diapers provided by parent

☐ Yes ☐ No

Plastic pants used

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

Highly sensitive skin

☐ Yes ☐ No

Frequent diaper rash

☐ 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 speaks what language – Specify.

☐ English ☐ 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 **indoor** favorite toys and activities – Specify.

Child's **outdoor** favorite 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

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
PARENT LETTER (Non-Pricing Programs)

For Group Child Care & Outside of School Hours Centers
FFY 2018, Rev. 6/17

Dear Parent or Guardian:

_____ 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. Refer to the requirements below for establishing eligibility of foster children, children enrolled in Head Start, and Runaway, Migrant, or Homeless children; *eligibility for these children does not extend to other children in your household.* Once we have properly approved your HSIS as eligible, our agency will receive the higher 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 and return this HSIS if no one in your household receives benefits from the Supplemental Nutrition Assistance Program (SNAP) (FoodShare Wisconsin), FDPIR (Food Distribution Program on Indian Reservations), or W-2 Cash Benefits (paid placement programs, and not child care subsidy) and your household income is higher than the amount indicated for your household size within the table below. In this case, however, we would appreciate you return the HSIS form 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 highest meal reimbursement rate for children in households receiving FoodShare Wisconsin, FDPIR benefits, or W-2 Cash Benefits (paid placement programs and not child care subsidy).

You must include the following information on the HSIS (a-c) for eligibility based on receiving FoodShare WI, FDPIR benefits, or W-2 Cash Benefits:

(a) The names of your enrolled children;

(b) The appropriate case number for FoodShare Wisconsin, FDPIR, or W-2 Cash Benefits *(paid placement programs, and not child care subsidy)*; and

(c) The signature of an adult member of the household and signature date

W-2 Cash Benefits are paid placement programs that do not include Wisconsin Shares Child Care (W-2 Child Care Assistance). W-2 paid placement programs include Community Service Job (CSJ), Custodial Parent of an Infant (CMC), W-2 Transition (W-2 T) and At Risk Pregnancy (ARP). **DO NOT list case numbers for Medicaid, SSI, or if you only receive W-2 Child Care Assistance; these benefits do not automatically qualify your children for the higher reimbursement rates.**

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

Household-Size Income Scale (Effective July 1, 2017 to June 30, 2018)

Household Size	Annual Income Level (at or below)
1	$22,311
2	$30,044
3	$37,777
4	$45,510
5	$53,243
6	$60,976
7	$68,709
8	$76,442
For each additional Household Member, add:	+$7,733

If your household earns a total income that is less than or equal to the income levels listed within this table, our agency will receive higher meal reimbursement rates for your enrolled children.

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

(a) Full names of all of your household members who share income and expenses, including children, parents, and non-related persons;

(b) Household income received by each household member identified by source of income and how often each source is received;

(c) The signature of an adult member of the household and signature date; and

(d) 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.

Our agency will receive the highest meal reimbursement rates for foster children, children enrolled in Head Start, and Runaway, Homeless, and Migrant children. In order to do so, please provide the following:

Foster children: Identify your foster children on the HSIS by checking the 'Foster Child' box next to their names when either completing a separate HSIS for your foster children or that includes them as household members on the same HSIS completed for your non-foster children. When including them on your HSIS completed for your non-foster children, report foster children's income only designated for their personal use.

Children Enrolled In Head Start: Submit written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.

Runaway, Homeless, and Migrant Children: Submit 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 for your foster child(ren); you list a case number for receiving FoodShare WI, W-2 Cash Benefits, or FDPIR; or when the household member signing the HSIS checks the 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.

Signature of Agency Representative

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.

First and Last Name(s) of Enrolled Child(ren)	Center

PART 1: BENEFITS

If any member of your household currently receives FoodShare Wisconsin, Wisconsin Works Cash Benefits, and/or FDPIR (Food Distribution Program on Indian Reservations), check the box for the benefit currently received and list the case number.
Then, complete PART 3 and return HSIS to the center. Do not complete PART 2.

If no one receives these benefits, go to PART 2.

☐ **FoodShare Wisconsin (10 or 16 digit #)** ☐ **Wisconsin Works Cash Benefits (10 digit #)** ☐ **FDPIR (9 digit #)**

Case Number/Quest Card Number: ____________________

If only receiving W-2 Child Care Assistance, do not list a case number; you must complete Part 2 of this form for eligibility determination.

PART 2: TOTAL HOUSEHOLD SIZE AND INCOME

1) List full names of all household members, including yourself and all children. *(Ages are optional.)*
2) List all gross income (before deductions or taxes, social security, etc) on the same line as the person who receives it. Self-employed household members should report net income. Check the box for how often it is received. Record each income only once.
If you listed a case number in Part 1, you do not need to list household and income information below.

1) List full names of all household members below	Age	Check if Foster Child	2) List gross income and how often it is received: Gross income from work	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Welfare Payments, Child Support, and/or Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Pensions, Retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	All Other Income Received Last Month (indicate frequency)	Check if no income
		☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	$ /___	☐
		☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	$ /___	☐
		☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	$ /___	☐
		☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	$ /___	☐
		☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	$ /___	☐
		☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	$ /___	☐

PART 3: ALL HOUSEHOLDS

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

ADULT HOUSEHOLD MEMBER SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SS#)

If Part 2 is completed, the adult signing the form must list the last four digits of his/her SS# OR check "None" if he/she does not have a SS#.

I CERTIFY that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on this form; and that deliberate misrepresentation of the information may subject me to prosecution 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 – All 3 sections and the *Effective Month of Determination* must be completed

Section 1: Basis of Determining Eligibility *(A or B)*		Section 2: Eligibility Determination	Section 3: Determining Official's Initials & Approval Date
A. Household Size & Income	***B. Benefits/Foster***		____________
Total Household Size ______	☐ **FoodShare WI**	☐ **Free**	****Effective Month of Determination**
	☐ **W-2 Cash Benefits**	☐ **Reduced**	
***Total Income $**______/______ ($ Amount) (Time Period)	☐ **FDPIR**		____________
	☐ **Foster Child(ren)**	☐ **Non-Needy**	*Month/Year*

***Convert to yearly income only when multiple pay frequencies are reported:** *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*.**

Wisconsin Department of Public Instruction
CACFP ENROLLMENT FORM
PI-6077 (Rev. 02-17)

Parent/Guardian Instructions:

Use a separate form for each enrolled child. 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, to meet the annual updating requirements.**

GENERAL INFORMATION

Child's Name	Child Care Facility	Child's Age

HOURS AND MEALS WHILE IN CARE

Days Normally in Care (Check ✓)	Hours Normally in Care				Meals Normally Received While in Care (Check ✓)					
	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
☐ Sunday					☐	☐	☐	☐	☐	☐
☐ Monday					☐	☐	☐	☐	☐	☐
☐ Tuesday					☐	☐	☐	☐	☐	☐
☐ Wednesday					☐	☐	☐	☐	☐	☐
☐ Thursday					☐	☐	☐	☐	☐	☐
☐ Friday					☐	☐	☐	☐	☐	☐
☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

ANNUAL UPDATE 1

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*

ANNUAL UPDATE 2

Please review the information above and write in any changes to your child's days and hours normally in care, and the meals normally received while in care. **Initial and date all changes.**

Additional Information

Signature of Parent/Guardian ➢	Date Signed *Mo./Day/Yr.*