Guiding. Growing.
KidsPoint
SCHOOL AGE PROGRAM

2021-2022 CHILD CARE INFORMATION AND RATE SHEET

SCHOOL AGE PROGRAM LOCATIONS AND HOURS

	SCHOOL	LICENSED CAPACITY
LOCATIONS	Cleveland	40
	Erskine	60
	Garfield	50
	Hiawatha	50
	Hoover	30
	Jackson	50
	Kenwood	50
	Madison	30
	Pierce	40
	KidsPoint Downtown	54
	KidsPoint C Street	45
HOURS	Monday – Friday 6:30 a.m. to start of school and end of school to 6 p.m.	KidsPoint maintains a 1 to 15 teacher/child ratio

TO ENROLL

Complete the registration packet and submit to the Director with the following:

- Recent immunization card
- Annual registration fee of $50.00 per family in school age will be deducted from account on file.

FEES

Payment is required through automatic withdraw from a banking account, debit or credit card. Payments are submitted to the banking account, debit or credit card the Friday <u>preceding</u> care and will be withdrawn on the following Monday.

Full-time AM/PM	$98.00 per week	Rate includes all scheduled early dismissals and all day outs. It also includes care for all weather-related late starts, early dismissals, and all day outs.
Part-time AM	$80.00 per week	Rate includes regular before school programming and all scheduled early dismissals and all day outs. It also includes care for all weather-related late starts, early dismissals, and all day outs.
Part-time PM	$80.00 per week	Rate includes regular after school programming and all scheduled early dismissals and all day outs. It also includes care for all weather-related late starts, early dismissals, and all day outs.

AVAILABLE DISCOUNTS

<u>Multiple Child Discount:</u> When there is more than one full-time child enrolled in any KidsPoint Child Care Program, a $5 weekly discount is given for the oldest child in School Age/Summer Camp Programs and $20 weekly discount is given for oldest child in an Early Child Care Program ($15 weekly for additional older child in EC).

<u>Department of Human Services Assistance / KidsPoint Sliding Fee</u>**:** Financial assistance is available to families who qualify and if funds are available. This assistance is available from funding received through United Way of East Central Iowa, Early Childhood Iowa and other grant revenue. For more information, call KidsPoint at 319.731.6179.

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Guiding. Growing.
KidsPoint
SCHOOL AGE PROGRAM

SCHOOL AGE CONTRACT FOR SERVICE

Date: _____ Requested Start Date: _____ Confirmed Start Date:_____

Type of Care: □Full-time AM & PM □Part-time AM □Part-time PM

Weekly Fee: $_____

Site Choice for School Year: □ Cleveland □ Erskine □ Garfield □ Hiawatha □ Hoover □ Jackson □ Kenwood □ Madison □ Pierce □ KidsPoint C Street □ KidsPoint Downtown (Grant Wood, Johnson, Arthur)

CHILD'S INFORMATION

Child's Full Name: _____ Child's Birthdate: _____

Child's Nickname: _____ Sex: □ Male □ Female

Race *(for statistical purposes)* □ Caucasian □ African American □Multicultural □ Hispanic □ Asian/Pacific Islander □ Indian/Alaskan Native □Other: _____

FAMILY INFORMATION

Parent/Guardian #1: _____ **Preferred Contact #: _____**

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

Employer: _____ E-mail:_____ _____

Parent/Guardian #2: _____ **Preferred Contact #: _____**

Home Phone: _____ Work Phone: _____ _____ Cell Phone: _____

Address: _____

Employer: _____ E-mail: _____

Marital Status of Parents: □ Married □ Divorced □ Separated □ Single □ Widowed

Name of Others in the Home	**Birthdate/Age**	**Relationship to Child**
_____	_____	_____
_____	_____	_____

KidsPoint agrees to provide child care for the child listed above for the time periods specified in this contract as long as terms of this agreement are met.

FEES AND FINANCIAL ASSISTANCE

1. Initial payment is due and payable with registration fees prior to, or on the first day of care. Payment is required through automatic WEEKLY withdrawal from a bank account, debit or credit card. **If payment is made by any type of credit card, an additional fee of $5.00 will be added to the weekly tuition.
2. Payments are submitted to the bank account, debit or credit card on the Friday preceding care and will be withdrawn from the account on the following Monday.
3. A late fee of $5.00 for the first five minutes and $10.00 for every fifteen minutes, or portion thereof, will be applied to each child not picked up by 6 p.m. This fee will be added to the next automatic withdrawal.
4. Child care will be terminated for non-payment as well as excessive late pickups.
5. The signer of this contract is responsible for any damage done to KidsPoint's property by the child.
6. Child care charges are due and payable in the absence of the child for whatever reason: vacation, illness, holidays, snow days, or behavioral suspension. For medical absences exceeding two weeks, a reduced fee is available with a doctor's authorization for up to six weeks.
7. Other fees may occur for field trips or other additional activities.
8. In the event that financial support (DHS, sliding fee, etc.) is cancelled or denied, the parent is responsible for all fees as applicable in the regular fee structure.
9. For those receiving financial support (DHS, sliding fee, etc.), an absence of over four days per month may result in termination from the program.

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

I am interested in financial assistance. □ No □ Yes

Have you completed an application for child care assistance through DHS? □ No □ Yes

If yes, please provide the most recent copy with your enrollment paperwork.

Have you received a notice of decision from DHS? □ No □ Yes

If yes, please provide the most recent copy with your enrollment paperwork.

How did you hear about KidsPoint? □ KidsPoint Website □ Advertisement □ Social Media
□ Child Care Resource & Referral □ Current Enrolled Family □ Other _____

Name of parent who referred you? _____

Multiple Child Discount _____

Child 1 Name: _____ Enrolled Program: _____

Child 2 Name: _____ Enrolled Program: _____

Child 3 Name: _____ Enrolled Program: _____

I am a Waypoint employee □ No □ Yes, at this program: _____

_____ **I understand that a one-time, non-refundable registration fee of $50 is required.**
Initial Here

_____ **I understand that child care fees will be deducted WEEKLY from the account I have provided.**
Initial Here

_____ **I understand that a two-week written notice is required for termination of care. If I do not provide a two-week written notice, I will be automatically charged.**
Initial Here

_____ **I understand that school year registration does not include registration for winter, and spring breaks.**
Initial Here

_____ **I understand that availability is limited and children will be enrolled on a first come first serve basis in all programs.**
Initial Here

PROVISION OF CARE

1. KidsPoint School Age Program is open for child care from 6:30 a.m. to start of school and the end of the school day to 6 p.m. during the school year.
2. Early Childhood Programs: KidsPoint South and KidsPoint North are open for child care from 6:30 a.m. – 6:00 p.m. KidsPoint Downtown is open for child care from 6 a.m. to 6 p.m.
3. KidsPoint will be closed on the following holidays or the Monday following for any holiday falling on the weekend: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving*, Christmas Eve*, and Christmas Day. *communications regarding business hours on these days will be posted if the center is not closed.
4. All child care programs will be closed for KidsPoint Teacher Professional Development Days – **2 per year**. Notification on the specific day(s) will be communicated in advance to all parents.
5. Severe weather conditions or emergencies may merit sudden or early closing for the safety of children, parents and staff. KidsPoint reserves the right to close under severe circumstances, and will give parents adequate notice of closing times.
6. Other days of closing may be scheduled without benefit of refund with 30 day written notice.
7. Waypoint cannot care for ill children. The signer of this contract must follow the illness policies listed in the Family Handbook.
8. Waypoint is not responsible for damaged or lost clothing, personal possessions or personal injuries.
9. Waypoint reserves the right to combine child care rooms if deemed necessary.
10. Parents must provide a current physical form, immunization card, enrollment forms and emergency consent forms for their child's file.

Parent/Guardian Signature: _____ Date:

CANCELLATION OF CONTRACT

1. This agreement is renewable annually in conjunction with the school district's academic school year.
2. Immediate termination may result for any violation of Waypoint policies.
3. Termination of this agreement does not allow the certainty of a place for your child at a future date.
4. Registration fees are non-refundable.
5. A two-week written notice is required for termination of care. If you do not provide a two-week written notice, you **will be automatically charged for two weeks of care.**
6. Waypoint reserves the right to terminate care for violation of the discipline policy in the Family Handbook.

Parent/Guardian Signature: _____ Date: _____

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AGREEMENT FOR PRE-AUTHORIZED PAYMENTS

I have chosen and completed one of the pre-authorized payment options below for my child care.

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

I hereby authorize Waypoint Services for Women, Children and Families also known as KidsPoint, hereinafter called the ORGANIZATION, to initiate (please select one)

□ **I am a Waypoint employee and authorize payroll deduction OR**

□ **Debit entries to my checking account OR**

□ **Charges to my credit card account**

The account indicated below, hereinafter called DEPOSITORY. Debit/charge will occur on every Monday (or on the next banking day after any Monday that is a banking holiday)

Name of child(ren): _____

Program: □ KidsPoint Downtown □ KidsPoint C Street □ KidsPoint School Age

Date of first payment: _____ **Weekly Amount:** _____

I authorize the ORGANIZATION to automatically add to my weekly amount any late fees I may incur on the next weekly payment.

This authorization is to remain in full force and effect until ORGANIZATION and DEPOSITORY have received written notification from me of its termination in such time and in such manner as to afford ORGANIZATION and DEPOSITORY a reasonable opportunity to act on it.

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

□ DEBIT PAYMENTS

Depository Name: _____ **City:** _____ **St:** _____ **Zip:**

Account Number: _____ **Transit/ABA Number:** _____

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

□ CREDIT PAYMENTS

Credit Card Type: □ MasterCard □ Visa **Security Code:** ____ ____ ____ (3 digits on back of card)

Credit Card Number: _____ **Expiration Date:** _____

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Iowa CACFP Child Care Center Parent/Guardian Letter - Pricing (front) 7/2021

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Enrolled participants may buy lunch and supper for $_____, breakfasts for $_____, and snacks for $ _____. Enrolled participants from families whose income is at or below the level shown on the chart below are eligible for either free meals, or reduced price meals that no more than cost $ .40 for lunch/supper, $.30 for breakfast, and $ .15 for snacks.

To apply for free or reduced price meals, please fill out this application as soon as possible, sign it and return it to the center. An application, which does not contain all required information, cannot be used by the center. If required information is missing, meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child, who is the legal responsibility of a welfare agency or court, may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for SNAP or FIP, you may fill out an application at that time.

You will be notified of the approval or denial of this application. If you do not agree with the center's decision about your application, you may wish to discuss it with them. You also have a right to a fair hearing. This can be done by calling or writing the following official:

_____

(Name, Address, and Telephone of Hearing Official)

Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2021 to 6-30-2022

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$23,828	$1,986	$993	$917	$459
2	$32,227	$2,666	$1,343	$1,240	$620
3	$40,626	$3,386	$1,693	$1,563	$782
4	$49,025	$4,086	$2,043	$1,886	$ 943
5	$57,424	$4,786	$2,393	$2,209	$1,105
6	$65,823	$5,486	$2,743	$2,532	$1,266
7	$74,222	$6,186	$3,093	$2,855	$1,428
8	$82,621	$6,886	$3,443	$3,178	$1,589
For each additional family member add:	+ $8,399	+ $700	+ $350	+ $324	+ $162

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a SNAP number, or Family Investment Program number, or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

This institution is an equal opportunity provider.

Instructions for Completing Iowa Eligibility Application

Complete both sides of an application for each household.

All applicants should complete Part 1. This application may be used to apply for benefits in school meals or milk programs, child care centers and home based care for children. Check all boxes that apply to your family. You may make copies of a completed application for each program in which your child participates.

FIP OR SNAP HOUSEHOLD MEMBER, including child(ren) in Head Start or Even Start, follow these instructions.

Part 3. List one FIP or SNAP **Case Number** per household in the area provided. **Use the Case Number listed in the DHS Notice of Decision**. Eligibility based on Head Start or Even Start is available only if your child is enrolled in Head Start and documentation from the Head Start agency is provided. **NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable.**

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

HOMELESS, MIGRANT OR RUNAWAY, follow these instructions.

Part 2. For children attending school, check if any child is Homeless, Migrant, or a Runaway and call your child's school.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your child's ethnic and racial status if you do not complete this section.

Part 5. Skip this section.

Part 6. Read the certification and complete this section.

FOSTER CHILD IN HOUSEHOLD, follow these instructions. A foster child is a child who is living with a household but who remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.

Part 4. List the child's name, date of birth, grade (if applicable), name of school/Head Start/child care center attended. Check the box for foster child. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of your foster child's ethnic and racial status if you do not fill this section.

Part 5. Complete this section only if the foster child receives money for personal use or has other regular personal income. If the foster child has no income, check the box indicating no income. DO NOT include the stipend received by the foster family to provide care to the foster child.

Part 6. Read the certification and complete this section.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions for reporting income.

Part 4. List the name, date of birth, grade (if applicable), name of school/Head Start/child care center/home attended for each child in your household. Provide ethnic and racial information if you choose, but the school/Head Start/child care will make the determination of each child's ethnic and racial status if you do not complete this section.

Part 5. Follow these instructions to report total household income from last month.

- **Name:** List the last and first names of **each** person living in your household, related or not (such as grandparents, other relatives, or friends); include yourself and all children living with you. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- **Age:** List the age of each household member.
- **Check if No Income:** Put a mark in the box if the household member **does not** have an income.
- **Gross Income last month and how it was received:** Report the amount of income received in the appropriate Gross Income column (weekly, every 2 weeks, twice monthly, **or** monthly). List the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. If you have a household member for whom last month's income was higher or lower than usual, list that person's expected average income. If the household includes the foster child, they must report any personal income received by the foster child on the foster parent's household application.
- **Other Monthly Payments or Income:** Money is reported in this section if it is regularly received. List the amount each person received last month from welfare, child support, alimony, adoption subsidies, pensions, retirement, Social Security, Supplemental Security Income (SSI), and Veteran's benefits (VA benefits). In the **All Other Income** column, include Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, cash withdrawn from savings, investments or trusts, interest and **ANY OTHER INCOME**. Use the Self-Employment Income Worksheet on the back of the application to calculate net income for self-owned businesses, farm, or rental income and report in the **All Other Income** column. **Do not report**: Scholarships, educational benefits, lump sum payments, combat pay, Deployment Extension Incentive Pay (DEIP) or children's incidental income from occasional activities such as babysitting, shoveling snow, or cutting grass. If you are in the Military Housing Privatization Initiative or get combat pay do not include these allowances.
- **Social Security Number:** If the application is being made on the basis of income, the adult signing the form must provide the last 4 digits of his or her Social Security number or mark the "I do not have a Social Security number" box. If you do not provide your Social Security information or mark the box, your application cannot be processed.

Part 6. Read the certification and complete this section.

Iowa Eligibility Application

FFY 21-22

Complete one application per household. Fiscal Year 2021-2022

Part 1. Check all applicable boxes:

- ☐ school meals
- ☐ special milk (restrictions apply)
- ☐ children in child care center
- ☐ Tier I home provider (HP)
- ☐ Head Start/Even Start
- ☐ children in child care home (HP) Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or SNAP Eligible: Enter the FIP or SNAP Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.

Name of household member with Case Number _____ **List Case Number** ___-___-___-___-___-___-___-___-___-___-___

Part 4. Children enrolled: REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino

Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White

If ethnicity & race are not completed, the form will be completed based on visual observation

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income: DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR SNAP NUMBER IN PART 3.

Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	Gross Income: Report income by how often the household member is paid. Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: **X XX** - **X X** - ___ ___ ___ ___ ☐ I do **not** have a Social Security Number.

If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.

I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form_____

Signature of Adult Completing Form | Printed Name of Adult Completing Form | Date Signed

Address of Adult Completing Form | Town | ZIP Code | Work Phone | Home Phone | Cell Phone

Part 7. TO BE COMPLTED BY CENTER STAFF.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12

Household Income: $ _____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _____

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/SNAP ☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

CACFP HP ONLY: ☐ Tier 1 Area (Provider's own children)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk

Application Denied: ☐ Incomplete ☐ Over income limits

☐ Tier 1 Income (All children) ☐ Tier 1 Child (Tier 2 mixed)

_____ _____

Determining Official Signature | **Effective Date**

Self-Employment Income Worksheet: This worksheet will help you calculate the amount to report if you farm, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for meal benefits. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this Application, it is not possible to have a negative income. The **least self-employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for Tier 1 meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced-price eligibility. Wages paid to a spouse or other family or household member in the operation of a farm or private business must be shown as household income in Part 5 of this Application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return – Form 1040 or 1040-SR including Schedule 1 (Additional Income and Adjustments to Income). Complete the identified lines from Form 1040 or Form 1040-SR and Schedule 1.

Capital gain or (loss): Form 1040 or 1040-SR, Line 7 $ _____

Business income or (loss): Schedule 1 Part 1, Line 3 $ _____

Other gains or (losses): Schedule 1 Part 1, Line 4 $ _____

Rental real estate, royalties, partnerships, S corporations, trusts, etc.:
Schedule 1 Part 1, Line 5 $ _____

Farm income or (loss): Schedule 1 Part 1, Line 6 $ _____

*Total = $ _____

*The least income possible is zero (a negative number cannot be reported).

***Enter amount in the "**All other Income**" column in Part 5 on the front of this Application.

CHILD & ADULT CARE FOOD PROGRAM

Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

June 2020

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Birthdate	Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, the center's Program representative is required to note race/ethnicity on the basis of visual observation.

Infants only (0 to 12 months): ❑ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

❑ I will provide breastmilk for my infant. ❑ Yes ❑ No ***If infant is still hungry and no breastmilk is available, list what to feed*** _____

❑ I would like to breastfeed on site, if this option is available[1]. ❑ Yes ❑ No If yes, time(s) _____

❑ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____

❑ I accept the center's formula for my infant. Name of iron-fortified formula: _____

❑ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____

❑ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

❑ I will provide solid foods for my infant[2]. The center may supplement with additional solid foods when my infant needs them: ❑ Yes ❑ No

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

[1]Ask your center if you can breastfeed on-site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

This institution is an equal opportunity provider.

Guiding. Growing.
KidsPoint
SCHOOL AGE PROGRAM

REGISTRATION FOR SCHOOL AGE CARE PROGRAMS

Date: _____ **Requested Start Date:** _____ **Confirmed Start Date:** _____

Type of Care: □ **Full-time AM & PM** □ **Part-time AM** □ **Part-time PM**

Site Choice for School Year: □ Cleveland □ Erskine □ Garfield □ Hiawatha □ Hoover □ Jackson □ Kenwood □ Madison □ Pierce □ KidsPoint C Street □ KidsPoint Downtown (serving Grant Wood, Johnson, Arthur)

CHILD'S INFORMATION

Child's Full Name: _____ **Child's Birthdate:** _____

Child's Nickname: _____ Sex**:** □ Male □ Female

Race *(for statistical purposes)* □ Caucasian □ African American □ Multicultural □ Hispanic
□ Asian/Pacific Islander □ Indian/Alaskan Native □ Other: _____

FAMILY INFORMATION

Parent/Guardian #1: _____**Preferred Contact #:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Address: _____

Employer: _____ **E-mail:** _____

Parent/Guardian #2: _____**Preferred Contact #:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Address: _____

Employer: _____ **E-mail:** _____

Marital Status of Parents: □ Married □ Divorced □ Separated □ Single □ Widowed

Name of Others in the Home	**Birthdate/Age**	**Relationship to Child**
_____	_____	_____
_____	_____	_____
_____	_____	_____

CUSTODY OR RESTRAINING ORDERS

Waypoint requires a copy of a court order mandating custody of the child or restricting parental rights of the noncustodial parent. A copy of any restraining order must be provided to the Site Director.

Do you have a court order mandating custody of the child or restricting parental rights of the non-custodial parent? □ No, please continue to the next section □ Yes, please provide a picture and complete the following:

Please explain the separation, divorce or custody order:

_____

_____

Social Worker (if applicable): _____ Agency**:** _____

Please list the name(s) of person(s) who MAY NOT pick up your child or has any restrictions with child pick up.

Name: _____ Relationship to Child: _____

Restrictions: _____

Name: _____ Relationship to Child: _____

Restrictions: _____

PLAY AND SOCIALIZATION

How does your child get along with other children and what are your child's special interests?

_____

_____

Are you a new family to KidsPoint Child Care Services? □ No □ Yes, Describe your child's previous child care/play group setting and experience:

_____

PERSONALITY AND EMOTIONAL DEVELOPMENT

Please provide information which will be helpful in understanding your child (likes, dislikes, etc.):

_____

_____

PHYSICAL REGIME

Does your child have any unusual eating problems or food dislikes? □ No □ Yes, please explain:

_____

_____

Child's usual bedtime: _____ **Child's usual wake-up time:** _____

GENERAL HEALTH INFORMATION

I have included a signed copy of my child's immunizations. Initial / Date Here: _____

Or

My child's immunizations are on file at my child's elementary school. Initial/Date: _____

*****Please note: if your child is registered for care at KidsPoint Downtown or KidsPoint C Street, then immunizations are required to be on site.***

Is your child on any medication? □ No □ Yes, _____ Purpose: _____
Note: A medication authorization must be completed if medication is to be given at the child care center.

Has your child been hospitalized or had any surgeries? □ No □ Yes, explain with dates: _____

_____

_____

_____

_____

Please check if your child has experienced any of the following:

□ Allergies	□ Developmental/Learning Delay	□ Chicken Pox	□ Convulsive Disorder
□ Pneumonia	□ Repeat Ear Infections	□ Ear Tubes	□ Frequent Sore Throat
□ Asthma	□ Pregnancy/Delivery Complications		□ Premature Delivery

Other: _____

If you checked any of the above illnesses or diseases, please provide details:

_____

_____

_____

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PARENT/ GUARDIAN INVOLVEMENT

There are a variety of ways you can stay involved with KidsPoint and your child's development center.

Sign up for KidsPoint School Age e-newsletters to receive updates about our programs and services, ways to get involved, upcoming events, and agency news articles.

Sign up for Waypoint's newsletters to receive updates about our programs and services, ways to get involved, upcoming events, and agency news articles.

Join us on Facebook for regular updates about our programs and services, shared photo albums, ways to get involved, and upcoming events.

Visit our website at www.kidspointchildcare.org for details about our programs and services, lists of upcoming events, and agency news articles.

Yes, I would like to (please check all that apply):

□ Receive Waypoint agency communications via mail at the address below

□ Receive Waypoint e-communications at the address below

Name: _____ **Preferred Contact #:** _____

Address: _____

E-mail: _____

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PARENT AUTHORIZATIONS

Child's Name: _____ **Child's Birthdate:** _____

PHOTO / MEDIA AUTHORIZATION

I give KidsPoint consent that photos of my child while participating in child care activities may be used on behalf of KidsPoint in brochures, displays, newsletters, newspapers, television, childcare web site, childcare Facebook page, or other media.

□ **I consent** □ **I do not consent** □ **I consent only for classroom and program projects**

FIELD TRIP AUTHORIZATION

I give my consent for my child to participate in field trips offered by KidsPoint. I believe that the necessary precautions will be taken for the care and supervision of my child during times that are away from the program site. Beyond this, I will not hold KidsPoint, or those supervising the trips, responsible for lost items or injuries sustained by my child. I understand an authorization for each field trip will be provided separately and I am required to return the consents at least **48** hours in advance of the scheduled field trip. I additionally understand alternate care is the parents' responsibility to locate and is **NOT** provided if I choose not to participate in the field trip.

□ **I consent** □ **I do not consent**

FIRST AID AUTHORIZATION

Parents must provide over the counter medications and sign an authorization to dispense any and all over the counter medications including sunscreen. KidsPoint will not provide any over the counter medications including but not limited to cough and cold medications, pain reliever, diaper rash ointment, or non-prescription allergy medications. I give KidsPoint staff permission to provide simple first aid including (please check):

□ **I consent**

□ including, tweezers for splinter removal □ including, finger and toe nail clipper

□ **I do not consent**

PERMISSION TO APPLY SUNSCREEN TO CHILD

As the parent or guardian of the child listed above, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at Waypoint to apply a sunscreen product of SPF-15 or higher to my child, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. I understand a separate consent authorizing the application of sunscreen will be provided at the start of the applicable season.

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

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EMERGENCY CONSENT AND AUTHORIZATION

Child's Full Name: _____ **Birthdate:** _____

This consent will be in effect for up to seven years beginning first date of attendance **(date):** _____

Every effort will be made to notify parents/guardians immediately in case of an emergency. This form will be presented upon admission of treatment.

MEDICAL AND/OR SURGICAL TREATEMNT

In the event, that my child (listed above) may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent for medical and/or surgical treatment to

_____ **(hospital and doctor)** or designee to provide this care.

Child's Doctor: _____ **Doctor Phone:** _____

Doctor Address: _____

Date of Last Tetanus: _____ **Known Allergies:** _____

Current Medications: _____ **Religious Preference (optional):** _____

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

DENTAL AND/OR DENTAL SURGICAL CARE

In the event that my child (listed above) may require dental and/or dental surgical care while I am out of the city or unable to be reached, I hereby give my consent for dental and/or dental surgical care to

_____ **(hospital and doctor)** or designee to provide this care.

Child's Dentist: _____ **Dentist Phone:** _____

Dentist Address: _____

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

PAYMENT OF CARE

I agree to pay all costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

Insurance Company: _____ **Policy Holder's ID:** _____

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

EMERGENCY CONSENT AND AUTHORIZATION (continued)

I give permission for my child to leave the program with the persons listed below. In the case of an emergency, if I cannot be reached, I would like the persons listed below contacted in the order I have them listed. At least two local contact persons have been provided and the contacts listed are able to pick up the child within one hour of contact.

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

THIS FORM WILL ACCOMPANY YOUR CHILD TO AN EMERGENCY CARE CENTER, THEREFORE IT MUST BE FILLED OUT COMPLELTELY.

Child's Full Name: _____ **Birthdate:** _____

PARENT / GUARDIAN #1

Name: _____ **Relationship to Child:** _____

Home Phone: _____**Work Phone:** _____ **Cell Phone:** _____

Address: _____

Employer: _____ **Department:** _____ **Work Hours:** _____

PARENT / GUARDIAN #2

Name: _____ **Relationship to Child:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Address: _____

Employer: _____ **Department:** _____ **Work Hours:** _____

PRIMARY LOCAL CONTACT (other than parent / guardian) *identification required

Name: _____ **Relationship to Child:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Address: _____

Employer: _____ **Department:** _____ **Work Hours:** _____

OTHER AUTHORIZED CONTACT (other than parent / guardian) *identification required

Name: _____ **Relationship to Child:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Address: _____

Employer: _____ **Department:** _____ **Work Hours:** _____

FOOD ALLERGY ACTION PLAN

Child's Full Name: _____ **Birthdate:** _____

Program: ❑ KidsPoint Downtown ❑ KidsPoint C Street ❑ KidsPoint School Age

Classroom: _____ ❑ **NO known food allergies; Initial here:** _____ **Date:** _____
***If no known food allergies, then please sign and date below and then skip to next page

Asthmatic? ❑ No ❑ Yes **Food allergies to**: _____

Child's Doctor: _____ **Doctor Phone:** _____

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

STEP 1: TREATMENT – only complete if your child has food allergies

GIVE CHECKED MEDICATION

❑ Epinephrine ❑ Antihistamine ❑ None
❑ Epinephrine ❑ Antihistamine ❑ None
❑ Epinephrine ❑ Antihistamine
❑ Epinephrine ❑ Antihistamine
❑ Epinephrine ❑ Antihistamine
❑ Epinephrine ❑ Antihistamine
❑ Epinephrine ❑ Antihistamine
❑ Epinephrine ❑ Antihistamine _____
❑ Epinephrine ❑ Antihistamine ❑ Call 911

SYMPTOMS

- If a food allergen has been ingested, but no symptoms
- Mouth: Itching, tingling, or swelling of lips, tongue, mouth
- Skin: Hives, itchy rash, swelling of the face or extremities
- Gut: Nausea, abdominal cramps, vomiting, diarrhea
- †Throat: Tightening of throat, hoarseness, hacking cough
- †Lung : Shortness of breath, repetitive coughing, wheezing
- †Heart: Thready pulse, low blood pressure, fainting, pale, blueness
- †Other: _____
- If reaction is progressing (several of the above areas affected)

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one): EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: _____ _____
Medication / Dose/ Route

Other: _____ _____
Medication / Dose/ Route

STEP 2: EMERGENCY CALLS – only complete if your child has food allergies

1. **Call 9-1-1**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. **Call doctor at:** _____
3. **Call Emergency Contacts** –

Name / Relationship Primary Phone Number Secondary Phone Number

1. _____

2. _____

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ENROLLMENT PACKET STATEMENTS

For first year: I understand this enrollment form will be updated annually and it is my responsibility to notify and provide any changes to the Director.

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

For continuing care: I have received the enrollment packet and have been given the opportunity to make necessary changes on this form or a new enrollment form. I agree the information is accurate and correct.

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

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