Kidz Korner

89 Long Branch Road
Dahlonega, GA 30533
(706) 864-8431

CHILD'S FULL NAME: _____

Birthdate : _____ Sex: Male _____ Female _____

Home Address: (Apartment #, Street # and Name, City, State & Zip Code)

_____

_____

Child's Social Security # ____ - ____ - ____ E-Mail Address: _____

Are the parents of the above listed child divorced? Yes _____ No _____

If you checked yes on the above question please list the child's visitation rights below.

_____

_____

Child's Living Arrangements: (Check one).

With both parents: _____ With Mother: _____ With Father: _____
With Grandparents: _____ With Foster Parents: _____ Other: _____

If you checked other please explain: _____

_____

Who has custody of the above listed child? (Check all that apply).

Mother & Father: _____ Full: _____
Mother: _____ Full: _____ Joint: _____
Father: _____ Full: _____ Joint: _____
Grandparents: _____ Full: _____ Joint: _____

*** IF A PARENT IS PROHIBITED FROM CONTACT WE MUST HAVE COURT PAPERS IN FILE TO ENFORCE THIS.*

MOTHER'S FULL NAME (Guardian): _____

Home Address: (Apartment #, Street # & Name, City, State & Zip code)

_____

_____

Driver's License # & State: _____

Home Phone # ( ) _____

Work Phone # ( ) _____

Cell Phone # ( ) _____

Work Place and Full Address: (Suite #, Street Name, City, State & Zip Code)

_____

Work Hours: _____

FATHER'S FULL NAME (Guardian): _____

Home Address: (Apartment #, Street # & Name, City, State & Zip Code)

_____

_____

Driver's License # & State: _____

Home Phone #: ( ) _____

Work Phone #: ( ) _____

Cell Phone #: ( ) _____

Work Place and Full Address: (Suite #, Street Name, City, State & Zip Code)

_____

Work Hours: _____

NAME OF 3 PEOPLE CHILD MAY BE RELEASED TO:

1. NAME: _____ DL# & State: _____
   Relationship to parent: _____ Relationship to child: _____

   Home Address: (Apartment #, Street Name, City, State & Zip Code)

   _____

   _____

   Home Phone ( ) _____ Cell Phone ( ) _____
   Work Phone ( ) _____ Ext. _____

2. NAME: _____ DL# & State: _____
   Relationship to parent: _____ Relationship to child: _____

   Home Address: (Apartment #, Street Name, City, State & Zip Code)

   _____

   _____

   Home Phone ( ) _____ Cell Phone ( ) _____
   Work Phone ( ) _____ Ext. _____

3. NAME: _____ DL# & State: _____
   Relationship to parent: _____ Relationship to child: _____

   Home Address: (Apartment #, Street Name, City, State & Zip Code)

   _____

   _____

   Home Phone ( ) _____ Cell Phone ( ) _____
   Work Phone ( ) _____ Ext. _____

In case of an EMERGENCY and we cannot contact you please list in order the people you want us to contact as an alternative.

1st Emergency Contact: _____ Relationship: _____ Phone: _____
2nd Emergency Contact: _____ Relationship: _____ Phone: _____
3rd Emergency Contact: _____ Relationship: _____ Phone: _____

CHILD'S MEDICAL INFORMATION

Child's Physician's Name: _____

Name of Practice: _____

Office Hours: _____ Phone # ( ) _____

Address: (Suite, Street Name, City, State & Zip Code)

_____

_____

List any allergies your child has: (food, medications, insects, etc.)

_____

List any Special Needs: _____

Name of Public School you child attends: _____

Grade: _____ Teacher: _____

PARENT'S SIGNATURE _____ DATE: _____

** *All blanks must be filled in. Please make sure that you have properly listed all parent information including working telephone numbers. We will not release any child to someone unless they are listed in each child's package. Photo ID is required for non-parental/guardian pick-ups.*

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if _____
Name of Facility

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

Sample
Transportation Agreement

This is to certify that I give _____
Name of Facility

Permission to transport my child _____
Name of Child

from _____ at _____ (am/pm)
Pickup Location

to _____ at _____(am/pm).
Delivery Location

My child will be transported from _____at _____(am/pm)

to _____ at _____(am/pm)
Delivery Location

on the following days:

_____ Monday
_____ Tuesday
_____ Wednesday
_____ Thursday
_____ Friday

_____ is authorized to receive my child. In the event the authorized
Name of Authorized Person

person is not present to receive my child, the following procedures are to be followed:

_____

_____

_____

The _____is approximately _____ miles from the center.
Location
In the event that my child is not to be transported as outlined above, I agree to notify the

_____.
Facility

Signature (Parent/Guardian) _____ Date _____

Parental Agreements with Child Care Facility

The _____ agrees to provide day care for
(Name of Facility)
_____ on _____ _____ a.m. to _____ p.m.
(Name of Child) (Days of Week)
from _____ to _____.
Month Month

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast
Morning Snack
Lunch
Afternoon Snack
Evening Snack
Dinner
Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The _____ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for
_____.
(Name of Facility)

I understand that the center will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Person-In-Charge)

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier 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 Program.

Non-discrimination Statement: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

WIC

A Special Food and Nutrition Education Program For Women, Infants and Children

WHO IS ELIGIBLE?

- A pregnant woman
- A breastfeeding woman
- A woman who has recently been pregnant
- An infant or a child less than 5 years old

SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

TO BE ELIGIBLE, YOU MUST ALSO:

- Have a low or moderate income
  AND
- Have a special need that can be helped by WIC foods and nutrition counseling

APPROVED WIC FOODS:

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.

Georgia WIC Program

Georgia WIC
Georgia Department of Public Health
2 Peachtree Street, NW
10th Floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
Website: http://dph.georgia.gov/WIC

INCOME ELIGIBILITY GUIDELINES
(Effective from July 1, 2014 to June 30, 2015)

Household size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A Month	Every Two Weeks	Weekly
1	21,590	1,800	900	831	416
2	29,101	2,426	1,213	1,120	560
3	36,612	3,051	1,526	1,409	705
4	44,123	3,677	1,839	1,698	849
5	51,634	4,303	2,152	1,986	993
6	59,145	4,929	2,465	2,275	1,138
7	66,656	5,555	2,778	2,564	1,282
8	74,167	6,181	3,091	2,853	1,427
For each additional family member add	+ 7,511	+ 626	+ 313	+ 289	+ 145

INFANT FEEDING PLAN

Child's full name_____ Date_____

Date of birth_____

Does child take bottle?	Yes [ ]	No [ ]
Is the bottle warmed?	Yes [ ]	No [ ]
Does the child hold own bottle?	Yes [ ]	No [ ]
Can the child feed self?	Yes [ ]	No [ ]

Does the child eat: (Check all that apply)

Strained foods	[ ]	Whole milk	[ ]
Baby foods	[ ]	Table foods	[ ]
Formula	[ ]	Other	[ ]
Breast Milk	[ ]		

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

Amount: _____ Date: _____

Does the child take a pacifier? Yes [ ] No [ ] If yes, when?_____

_____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula)_____

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods_____

_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

_____

PARENTS' SIGNATURE: _____ **Date:** _____

DECAL SAMPLE

Safe Sleep Practices Policy

Child's name:_____ Date of birth:_____

Parent/Guardian name:_____

Safe Sleep Practices/Policies:

1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.

2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.

3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.

4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.

5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.

6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:

_____

7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.

8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.

9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature_____ Date_____

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file

INSTRUCTIONS

Households that receive Food Stamps, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number. **Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children.**

Part II: Skip this part.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: Sign the form. A Social Security Number is not necessary.

Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home, child care center or adult day care, list participant's name.

Part II: To report total household income from last month, complete the following:

Column A-Name: List the first and last name of each person living in your household as an economic unit. You must indicate yourself and all children living with you (including foster and non-foster children). In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Attach another sheet if necessary.

Column B-Gross Income last month and how often it was received: Next to each person's name, list each type of income received last month, and how often it was received.

Box 1: 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. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

Box 2: List the amount each person got last month from welfare, child support, alimony.

Box 3: List Social Security, pensions, and retirement.

Box 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C-Check if no income: If the person does not have any income, check the box.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: An adult household member must sign the form, and list the last four digits of his/her social security number. Or, mark the box if he/she does not have one.

Part V: Answer this question if you choose to.

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

CENTER NAME

DATE OF BIRTH

Bright from the Start: Georgia Department of Early Care and Learning

Child Adult Care Food Program

Income Eligibility Statement

PART I: Child(ren) or Adult enrolled to receive day care-

Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant	Foster Child
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

PART II A:

A. Name (List everyone in household, including foster and non-foster children)	B. Gross income and how often it is received. Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly — 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	C. Check if [no] Income
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐

PART III: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of _______ [am/pm] to _____ [am/pm] on the following days:

Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:

(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign).

An adult household member must sign this form. If Part II is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving mea[ls] may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) listed on the form in Part I are enrolled for care.

Signature: X______________________ Print Name ______________________ Date______________

Address: ______________________ City ______________ State: GA Zip__________ Phone ______________

Last four Digits of Social Security Number XXX-XX__________ ☐ I do not have a Social Security Number

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ Asian ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: ______________ Per: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year Household Size: _______

Categorical Eligibility: ______ Date withdrawn ____________ Eligibility: Free _____ Reduced _____ Paid ______ Tier I _____ Tier II ______

Temporary: Free _____ Reduced _____ Time Period: ____________________ (expires after ______days)

[Deter]mining Official's Signature: ______________________ Date______________

Confirming Official's Signature: ______________________ Date______________

Follow Up Official's Signature: ______________________ Date______________

SHARING INFORMATION WITH MEDICAID/SCHIP

Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to.* Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced price meals.).

☐ No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Signature of Parent/Guardian: _____

Today's Date: _____

Print Your Name: _____

Address: _____

For more information, you may call _____ at _____