Sick Child Policy

If your child becomes ill, we will call you or a designated adult included on your Emergency Information form as soon as possible so that your child can be picked up from the Center. While your child waits for you or another trusted adult to arrive, he or she will rest quietly away from other children.

Specific Symptoms and/or Conditions

To maintain the healthiest environment for all children, we ask that parents please be respectful of the other attendees and staff members, and refrain from bringing children to the Center when a child exhibits any of the following:

- A contagious or communicable disease
- A temperature of 100 degrees or higher
- Heavy nasal discharge that is yellow or greenish in color
- A persistent cough
- Draining eyes, ears, nose or any open sore
- Diarrhea or vomiting
- Lack of proper immunizations
- Inability to participate in play, both indoors and outdoors
- Strep throat (child must be out of the Centerfor a minimum of 48 hours and must be taking prescription medication)
- Unknown questionable rashes and impetigo, measles, chicken pox, etc. Highly infectious conditions will require a physician's written approval before returning to the Center. The ROCK Early Learning Center reserves the right to require a physician's written approval to return to the Center due to any illness.

Form J-800-2935
Revised June 2017

ADMISSION INFORMATION

Purpose: Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

GENERAL INFORMATION

Operation's Name:	Director's Name:	
Child's Full Name:	Child's Date of Birth:	Child Lives With: ☐ Both parents ☐ Mom ☐ Dad ☐ Guardian
Child's Home Address:		
Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian (if different from the child's):	

List telephone numbers below where parents/guardian may be reached while child is in care.

Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File: ☐ Yes ☐ No

Give the name, address, and phone number of the responsible individual **to call** in case of an emergency if parents/guardian cannot be reached:	Relationship:

I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.

Name and Phone Number:	Name and Phone Number:	Name and Phone Number:

CONSENT INFORMATION

CHECK ALL THAT APPLY:

1.TRANSPORTATION

I give consent for my child to be transported and supervised by the operation's employees:

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2.FIELD TRIPS

☐ I give consent for my child to participate in field trips.

☐ I **do not** give consent for my child to participate in field trips.

Comments:

3.WATER ACTIVITIES

I give consent for my child to participate in the following water activities:

☐ water table play ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ aquatic playgrounds

CONSENT INFORMATION

CHECK ALL THAT APPLY:

4.RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operational policies, including those for:

☐ Discipline and guidance	☐ Procedures for release of children
☐ Suspension and expulsion	☐ Illness and exclusion criteria
☐ Emergency plans	☐ Procedures for dispensing medications
☐ Procedures for conducting health checks	☐ Immunization requirements for children
☐ Safe sleep	☐ Meals and food service practices
☐ Procedures for parents to discuss concerns with the director	☐ Procedures to visit the center without securing prior approval
☐ Procedures for parents to participate in operation activities	☐ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website

5. MEALS

I understand that the following meals will be served to my child while in care:

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. DAYS AND TIMES IN CARE

My child is normally in care on the following days and times:

Day of the Week	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address:	Phone Number:
Name of Emergency Care Facility:	Address:	Phone Number:

I give consent for the facility to secure any and all necessary emergency medical care for my child.	Signature - Parent or Legal Guardian

CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? Yes ☐ No ☐ Plan submitted on:

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature - Parent or Legal Guardian:	Date Signed:

SCHOOL AGE CHILDREN

My child attends the following school:

Name of School:	School Phone Number:

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address:

ADMISSION REQUIREMENT

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Health Care Professional's Signature:	Date Signed:

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name and Address of Health Care Professional:

Signature - Parent or Legal Guardian:	Date Signed:

REQUIREMENTS FOR EXCLUSION

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

VISION EXAM RESULTS

R 20/	L 20/	☐ Pass ☐ Fail
Signature:	Date Signed:	

HEARING EXAM RESULTS

Ear	**1000 Hz**	**2000 Hz**	**4000 Hz**	**Pass or Fail**
Right				☐ Pass ☐ Fail
Left				☐ Pass ☐ Fail
Signature:			Date Signed:	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	**Vaccine Schedule**	**Dates Child Received Vaccine**
Hepatitis B	Birth (first dose) 1–2 months (second dose) 6–18 months (third dose)	
Rotavirus	2 months (first dose) 4 months (second dose) 6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose) 4 months (second dose) 6 months (third dose) 15–18 months (fourth dose) 4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	

VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Pneumococcal	2 months (first dose) 4 months (second dose) 6 months (third dose) 12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose) 4 months (second dose) 6–18 months (third dose) 4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose) 4–6 years (second dose)	
Varicella	12–15 months (first dose) 4–6 years (second dose)	
Hepatitis A	12–23 months (first dose) The second dose should be given 6 to 18 months after the first dose.	

PHYSICIAN OR PUBLIC HEALTH PERSONNEL VERIFICATION

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature :	Date Signed:

VARICELLA (CHICKENPOX)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine.

Parent's Signature:	Date Signed:

ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/immunize/public.shtm.

TB TEST (IF REQUIRED)		
☐ Positive	☐ Negative	Date:

GANG FREE ZONE
Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

PRIVACY STATEMENT
DFPS values your privacy. For more information, read our Privacy and Security Policy online at http://www.dfps.state.tx.us/policies/privacy.asp.

SIGNATURES	
Child's Parent or Legal Guardian: X	Date Signed:
Center Designee: X	Date Signed:

BEHAVIOR MANAGEMENT POLICY

The ROCK Early Learning Center has developed a detailed set of policies regarding children's behavior management and discipline. Every member of our staff is required to follow each policy when handling behavior issues. The goal of our program is to emphasize respect for self, respect for others and their work, and respect for materials located in our Center.

Using appropriate methods of discipline that incorporate behavior management enables the young child to learn self-control and gain an understanding of the types of conduct that are acceptable. Children become more independent and self-sufficient when they take responsibility for their own behaviors. Self discipline, learned during the early childhood years, is necessary in order to become a productive member of our society.

Every the ROCK Early Learning Center operates under the following policies:

- Psychological abuse, coercion, and physical abuse, or injurious treatment of children is not permissible under any circumstances.
- No corporal punishment, including spanking, hitting, shaking, squeezing, jerking, biting, kicking, will ever be used.
- No child shall be subjected to cruel or severe punishment or verbal abuse, including those that are shaming, frightening or humiliating.
- No child shall be denied food, toileting or rest privileges as punishments.
- No harsh or profane language or implied threats promising physical punishment shall be used. ▪ No child shall be punished for soiling or wetting him/herself or not using the toilet. ▪ No coercion when disciplining a child, such as rough handling (shoving, pulling, pushing, grasping of any body part); forcing a child to sit down, lie down, or stay down, except when restraint is necessary to protect the child or others from harm; physically forcing a child to perform an action (such as eating or cleaning up).

We recognize and praise appropriate and positive behaviors. A teacher's response to inappropriate or negative behaviors may include redirecting the child's activity, reasonably discussing the problem or using planned ignoring. The child may be directed to an area of the classroom to participate in an activity that is calming. This approach gives the child an opportunity to reflect on his/her actions. In the event that inappropriate behavior continues despite utilizing the above-stated techniques, the director will observe the child in the classroom and collaborate with the teachers, to assess the function of the behavior. Then, the director will set up a meeting with the child's parents, and the classroom staff, to develop an individualized program that meets the child's needs and is agreeable to all parties. The specific program will include positive behavior support strategies and is to be implemented within the classroom's daily programming. As needed, additional resources, professionals, and/or local agencies may be included to support the behavior management plan.

In the event that all possible interventions and strategies have been exhausted, exclusionary measures, such as suspension or expulsion, will be considered. Our goal is to limit exclusionary measures and will only be considered when the health and safety of the child, other children, or staff is jeopardized. Examples include but are not limited to violent behavior (kicking, punching, throwing), extreme biting, or threatening harm to others. Before a decision is made to suspend or expel a child, teachers and management will work together with families to resolve the behavior using all other positive behavior methods as stated in the policy. Exclusionary measures are not taken unless there is an agreement from all parties that it is in the best interest of the child. If exclusionary measures are taken the program will offer assistance to the family in accessing services and an alternative placement.

Name: _____ Date: _____

Signature: _____ Enrollment/Start Date: _____

DIET RESTRICTION LETTER

Date:

To the The ROCK Early Learning Center

I,_____request that my child, _____
, not eat the following foods while at The ROCK Early Learning Center:

1._____ 2_____
3._____ 4._____

The reason for this diet restriction is (please check one):

☐ Personal Preference / Religious

☐ Allergy (a note from the Doctor is attached to this form)

☐ Other (Please explain) _____

The following substitutions may be provided to my child.

_____

_____

_____

Signature:

Printed Name:

Office Use Only

☐ Request added to Classroom and Kitchen Food Allergy Chart

☐ Photo taken and posted

☐ Request and documentation in child's file(s)

Parent Handbook Receipt

Parent Name:

Last	Middle	First

Student Name:

Last	Middle	First

Parent Signature :

Date

Status: **incomplete**

EMERGENCY INFORMATION

NOTE: THIS ENTIRE FORM MUST BE UPDATED SEMI-ANNUALLY

Child's Name:_____Birth Date: _____ Child's Home Address:

Enrollment Date: _____ Hours & Days of Expected Attendance: **M T W Th F**

PARENT/GUARDIAN 1:
Name:
Home Address:
Home Phone:
Employer/School:
Employer/School Address:
Work Phone:
Cell Phone:
Email:
Personal Security Pin:

Name of Person Authorized to Pick-Up Child (*daily*) _____Relationship to Child

Address_____Telephone

When parents cannot be reached, list at least two people who may be contacted to pick up in an emergency:

1. Name_____Relationship_____Telephone (H)
   (W) (Cell) Address

2. Name_____Relationship_____Telephone (H) _____(W) (Cell) Address

Child's Physician or Source of Health Care_____Telephone_____Address

Child's Dentist Telephone

Address

Health Insurance Provider and Policy Number:

I understand that every effort will be made to contact me in the event of an emergency requiring attention for my child. However, in the event such an emergency occurs and I cannot be reached, I hereby authorize the ROCK Early Learning Center to provide transportation of my child to Address: _____Phone: (or the nearest hospital) and to secure my child all necessary medical treatment. I understand that the teachers in the child care center are trained in the basics of first aid and I authorize them to provide my child with first aid when appropriate.

Emergency Information

Status: **Incomplete**

Signature (Parent/Guardian) Date

SEMI-ANNUAL UPDATE (Sign if information remains the same, otherwise complete a new form)

Signature (Parent/Guardian) Date Signature (Parent/Guardian) Date Signature (Parent/Guardian) Date

Signature (Parent/Guardian) Date Signature (Parent/Guardian) Date Signature (Parent/Guardian) Date

Signature (Parent/Guardian) Date

Marketing Sources:

PLEASE GET INITIALS in BLANKS at the END of the LINES BELOW where indicated. Thank You!

ENROLLMENT AGREEMENT

☐ **New Customer** ☐ **Revised Agreement (fill out NEW Agreement) (Date:_____)** ☐ **Withdrawal (Date:_____)** Child's Full Name:_____ Child's Age:_____ Child's Date of Birth:_____ Gender:_____

(1) Parent/Guardian:_____ Home Address:_____ E-mail:_____
Street City State/Zip

Employer:_____ Work Address: _____

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

(2) Parent/Guardian:_____ Home Address:_____ E-mail:_____
Street City State/Zip

Employer:_____ Work Address: _____

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

Child's Health Insurance: _____ Group Number: _____

Child will attend the Center on the following days (please check): M☐ T☐ W☐ Th ☐ F☐ START DATE: _____ • Center hours of operation: _____ a.m. to _____ p.m. Includes at a minimum 2 snacks and a lunch.

• The learning center's Enrichment Program hours are: _____ a.m. to _____ p.m. A snack, but NO LUNCH, is provided for the Enrichment Program. • The Center will be closed on the following holidays: New Year's Day; Memorial Day; Independence Day; Labor Day; Thanksgiving Day; and Christmas Day; and _____; and _____ . No discounts are provided; Full tuition is due and payable for each of these holidays. • The ROCK Early Learning Center offers a Reservation Discount Program providing for _____% off regular tuition for a limit of ____ weeks per calendar year if your child is absent for an entire week (Monday through Friday) from the Center. No discounts will be given for absences of less than a full week. _____ • The Center will be open whenever possible. However, all tuition payments will be due should the Center close due to severe weather conditions or other reasons beyond the ROCK Early Learning Center's control. _____

• A **non-refundable REGISTRATION FEE** of $_____ is payable upon the signing of this Enrollment Agreement, along with your child's first Tuition payment. **A non-refundable YEARLY RE-REGISTRATION FEE** is due every year on _____. In addition, a **SECURITY DEPOSIT** of $ _____ is required. _____

• Current **WEEKLY/MONTHLY TUITION** for your child is $_____ and is due IN ADVANCE on _____. Additional tuition payments will be due for any days your child attends the Center in addition to those days circled above and for any additional hours your child attends the Center if your child is enrolled in a non-full day program. _____

• A **LATE FEE** of $_____ will be added if your child's tuition is not paid by the close of business on _____. _____ • A **PAST TIME FEE** of $_____ will be added to your child's tuition charges for each _____ minute(s) after the Center closes that your child is NOT picked up. If your child is not picked up from the Center **within 1 hour of closing**, the ROCK Early Learning Center may contact the proper authorities. _____ • A **SERVICE CHARGE** of $_____ will be added to tuition charges for each returned check. Payments in CASH may be required thereafter. Should TUITION payments and other FEES NOT be paid as agreed upon herein, child care services may be terminated. _____ • You must provide WRITTEN NOTICE at least _____ week(s) prior to your child's last day of attendance. Failure to provide the required NOTICE **will result in additional tuition obligations for the notice period**. If after termination of your child's enrollment you re-enroll your child less than 30 days later, tuition will be due as if child care services had been provided on a continuous basis during the enrollment absence. _____

• No one, other than the owners/operators of the Center, may change, alter or modify this Agreement or the policies of the Center. All policy changes must be made in writing. Two weeks notice will be provided for all written modifications, by which the undersigned parents/guardians agree to abide. • **The owner/operator of this ROCK Early Learning Center location is an independent contractor and a franchisee of the ROCK Early Learning Center Domestic Franchising, LLC ("Franchisor"). The undersigned agree to indemnify and hold Franchisor harmless against any and all claims directly or indirectly arising from or related to the operation of the franchised business and/or the Center.** _____

• **The parties have read and understand this Enrollment Agreement, including all information on the second page. ALL INFORMATION CONTAINED ON THE SECOND PAGE OF THIS AGREEMENT CONSTITUTES A MATERIAL PART HEREOF; THE SIGNATURES BELOW CONSTITUTE AGREEMENT WITH ALL SUCH PROVISIONS. PLEASE READ SECOND PAGE!** _____

• The two pages of this Agreement constitute the entire Agreement (along with applicable provisions of the Parent Handbook) between the parties. PARENT/GUARDIAN:

_____
(1) Signature SS# Date

Driver's License #_____

_____ _____ Signature (the

The following items form a material part of this Agreement

The parents/guardians whose names appear on the first page of this Agreement hereby agree to permit the ROCK Early Learning Center to administer first aid and/or obtain medical treatment for the child whose name appears on the first page of this Agreement in the event of any injury to the child. The parents/guardians whose names appear on the first page of this Agreement also agree to pay all expenses incurred for such first aid and/or medical treatment and to indemnify the ROCK Early Learning Center and hold the ROCK Early Learning Center harmless against any liability arising from or related to such first aid and/or medical treatment.

The ROCK Early Learning Center may terminate this Agreement at any time upon written notice. the ROCK Early Learning Center reserves the right to terminate the enrollment of any child who is unable to adjust to the Center's program.

the ROCK Early Learning Center does not discriminate on the basis of race, color, national origin, cultural heritage, sex or marital status.

The parents/guardians whose names appear on the first page of this Agreement acknowledge and understand that the ROCK Early Learning Center MUST receive proper authorization IN WRITING to release a child to individuals NOT listed on the first page of this Agreement.

The parents/guardians whose names appear on the first page of this Agreement acknowledge and agree that they shall be liable for any and all costs incurred by the ROCK Early Learning Center arising from or relating to the collection of Tuition, Late Fees and/or Service Charges which are not paid as specified in this Agreement, including any and all attorneys fees and court costs. The ROCK Early Learning Center also has the right to collect interest, charged at the legal rate, for all outstanding balances.

Periodically, the ROCK Early Learning Center may institute increases in Tuition and/or other fees. Such increases shall not affect the other terms contained in this Agreement. All other terms shall remain in full force and effect.

All parents/guardians agree that should their child(ren) be the subject of an executed, court approved custody, separation or other form of legally enforceable agreement determining the custodial status of such child(ren), they shall provide copies of all such agreements to the ROCK Early Learning Center and shall provide to the ROCK Early Learning Center any and all changes, amendments and updates to such agreements in a timely manner.

From time to time, we may provide additional Optional Services from an outside vendor. (i.e. dance, gym, art classes, etc.) If you choose to have your child participate, you will be responsible for any additional cost, which will be paid directly to the vendor.

Care provided at the ROCK Early Learning Center meets or exceeds state and local child care requirements. You will periodically receive reports about your child's growth and development in relation to the services provided.

Please refer to the Center's *Parent* Handbook and Addendum for further information regarding the ROCK Early Learning Center's policies. Any failure to comply with the terms of the Parent Handbook or this Agreement could result in the termination of your child's enrollment.

Child and Adult Care Food Program (CACFP)

I have received the following CACFP Documents:

- ☐ CACFP Letter to Households
- ☐ Enrollment Form (Must be entirely filled out by parents)
- ☐ WIC Guidelines
- ☐ Building for the Future Flyer

_____

Child(ren) Name(s)

_____ _____

Parent Name **Parent Signature**

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **This Center** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. Do I need to fill out a Meal Benefit Form for each of my children in day care? You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [(Name of Center, address, phone number].**

2. Who can get free meals without providing income information? Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

3. Who can get reduced price meals? Your children can get low cost meals if your household income is within the reduced price limits on the Income Chart, sent with this application. Children in households participating in WIC may be eligible for reduced price meals.

4. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. What if I have foster children? Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form**.**

9. We are in the military, do we include our housing and supplemental allowances as income? If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. ***(Pricing program only)*** **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You can talk to **[enter name of staff person that handles complaints/disagreements]**, either in person or by telephone at **[enter phone number for the staff person above]**. You may ask for a hearing by calling or writing to: **[name, address, phone number].**

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **281-325-0365**

Income Eligibility Guidelines for Determining Free or Reduced-Price Benefits July 1, 2025 – June 30, 2026

Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.

Ingresos máximos para determiner la elegibilidad para beneficios gratuitos o a precio reducido 1 de julio de 2025 - 30 de junio de 2026

Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	$28,593	$2,413	$1,207	$1,114	$557
2	$39,128	$3,261	$1,631	$1,505	$753
3	$49,303	$4,109	$2,055	$1,897	$949
4	$59,478	$4,957	$2,479	$2,288	$1,144
5	$69,653	$5,805	$2,903	$2,679	$1,340
6	$79,828	$6,653	$3,327	$3,071	$1,536
7	$90,003	$7,501	$3,751	$3,462	$1,731
8	$100,178	$8,349	$4,175	$3,853	$1,927
For each additional family member add:	$10,175	+$848	+$424	+$392	+$196

NEW ☐ **UPDATE** ☐ **DROP IN** ☐

Institution Name: Healthy Plate Solutions Agreement Number: 05001

Facility/Provider Name: _____

Child and Adult Care Food Program (CACFP)

Participant Enrollment Form

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

(If the participant cannot be served the CACFP Meal Pattern, a statement from the participant's Health Care Provider must be provided.)

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm): **Arrive:** _____ ☐ am ☐ pm **Depart:** _____ ☐ am ☐ pm

RACE OF PARTICIPANT: You are NOT required to answer this question.

☐ White ☐ Black or African American ☐ America Indian/Alaska Native

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

ETHNIC IDENTITY: You are NOT required to answer this question.

☐ Hispanic or Latino ☐ Not Hispanic or Latino

If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

Please mark your preference (choose all that apply)	Today's Date Birth - 5 months	Today's Date 6 - 11 months
I will bring expressed breastmilk for my infant.		
I want the provider to provide the infant formula for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring.		

According to CACFP requirements, in order to claim meals for reimbursement, the provider must provide infant cereal and other foods when your infant is developmentally ready to accept them.

Please mark your preference	Today's Date 6 - 11 months
I want the provider to provide the infant cereal and other foods for my infant.	
I will bring the infant cereal and/or other foods for my infant.	
My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.	

Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.

I hereby certify the information given on this sheet is true and correct to the best of my knowledge. I also certify that I was given CACFP Meal Benefits Income Eligibility Form Letter to Household, the WIC information, Building for the Future Flyers, Civil Rights Appeals Procedures.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date Dropped:

Work Telephone Number: _____ Emergency Telephone Number: _____ _____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number:

NAME:_____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the 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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - __ __ __ __ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

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

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

❑ **I do elect to allow my household information to be disclosed.**

❑ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for 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____ Denied ___ Tier I____ Tier II ____

Reason:_____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

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 the participant for free or reduced price meals. You must include the last four digits of the Social Security Number 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 Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
This institution is an equal opportunity provider.

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

Join Texas WIC

We're here for you

"Thanks to WIC, I now have the tools I need to make sure my family stays on the path to a healthy lifestyle."

—Roxie, WIC Client

As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	$ 3,261	$ 39,128
3	$ 4,109	$ 49,303
4	$ 4,957	$ 59,478
5	$ 5,805	$ 69,653
6	$ 6,653	$ 79,828

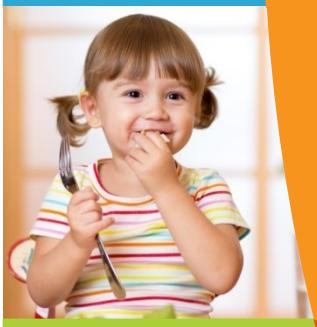
Effective May 1, 2025

* A pregnant woman's household can be increased by the number of infants she is expecting. For more than 6 household members, call your local WIC office.
** Income can also be determined on a weekly or biweekly basis.

Start now. Call 1-800-942-3678 or visit TexasWIC.org

TEXAS Health and Human Services | TEXAS WIC

This institution is an equal opportunity provider.



Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program

Questions? Concerns?

Call USDA at
1-866-873-2263

OR

Food and Nutrition at
1-800-TELL-TDA
(835-5832)

Your child care at

Contact Information:
Address
Phone Number
Email Address
Other Necessary Information

Fraud Hotline: 1-866-5-FRAUD or 1-866-537-2834
P.O. Box 12847 Austin TX 78711
www.SquareMeals.org
USDA is an equal opportunity provider and employer.

This product was funded by USDA. This institution is an equal opportunity provider.

Updated 12/2018

Child's Name:_____ Birth Date:_____
Last First Middle

Name of Parent/Guardian:_____ Relationship:_____

Home Address:_____
Street City State Zip

Home Telephone:_____

Dear Parent/Guardian:

All children should have regular health check ups, immunizations and physical exams from birth to 18 years of age.

State law requires you to submit proof of age-appropriate immunizations on the attached Immunization Certificate to The ROCK ELC prior to the child's first day. Any child who is under-immunized will be promptly excluded from the program if a vaccine-preventable disease to which the children are susceptible occurs.

This form is partially completed by you and the other portion will be completed by your physician. Please complete prior to your child's first day at the The ROCK Early Learning Center.

PLEASE RETURN THIS COMPLETED FORM TO:

Center Address:_____
Street

_____
City State Zip Code

Center Fax Number:_____

HEALTH HISTORY:

Section A: To be completed by parent/guardian	YES	NO
1. Are you concerned about your child's general health (eating, sleeping habits, posture, teeth, skin, weight, bowel/bladder, etc.)? If Yes, please explain:_____	☐	☐
2. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes)? If Yes, please explain:_____	☐	☐
Date of last eye examination: _____/_____/_____ Doctor's Name:_____		
Results:_____		
Does your child wear glasses or contact lenses? _____	☐	☐
3. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, etc.)? If Yes, please explain:_____	☐	☐
Date of last hearing evaluation: _____/_____/_____ Doctor's Name:_____		
Results:_____		
Does your child use a hearing aid?_____	☐	☐
4. Does your child have any speech problems (difficulty having speech understood, stammering, delayed speech development, etc.)? If Yes, please explain:_____	☐	☐
5. Does your child have any allergies (food or medical)? If Yes, please list:_____	☐	☐
6. Does your child have any other specific illness, disability or other limiting condition(s)?	☐	☐
(a) Does this condition require any special health care in the child care facility or school? If Yes, please explain:_____	☐	☐
(b) Has your child been evaluated in such a way that it could help the child care provider or teacher meet his/her health or education needs? If Yes, please explain:_____	☐	☐
7. Do you have any concerns about your child's behavior or emotional well-being which the child care provider or school should know about? If Yes, what are your concerns?_____	☐	☐
8. Has your child had any of the following? _____Chicken Pox _____Whooping Cough _____ Other:_____	☐	☐
9. Has he/she ever had any serious illnesses or hospitalization? If Yes, please explain:_____	☐	☐
10. Does your child have any physical disabilities? If Yes, please explain:_____	☐	☐

What arrangements can you make for care during illness?_____

How many colds has your child had this past year?_____

How does your child react to an elevated temperature?_____

Please give us any special instructions if the child becomes ill?_____

Is your child on any medications, regularly? If yes, please list medication and reason(s):_____

What was the date of the child's last physical exam?: _____

PARENT'S STATEMENT - PLEASE SIGN AND DATE BELOW

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE SECTION B OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS AT The ROCK Early Learning Center.

_____ _____
Parent's Signature Date

ONLY COMPLETE FOR SCHOOL AGE CHILD:

I give my permission to _____ School to release _____'s
Name of School Name of Child
health information to _____

_____ _____
Parent's Signature Date

Section B: To be completed by a HEALTH PRACTITIONER

Child's Name: _____ Child's Date of Birth: _____

1. Date of this child's most recent tuberculin test: ____/____/____. Result: ☐ Positive ☐ Negative.
2. Date of this child's last tetanus shot: ____/____/____
3. This child has the following which may significantly affect his/her child care or educational experience:

			COMMENTS
a. Vision problem	☐ YES	☐ NO	
b. Hearing problem	☐ YES	☐ NO	
c. Speech or language problem	☐ YES	☐ NO	
d. Other physical illness or impairment	☐ YES	☐ NO	
e. Mental, emotional or behavior problems	☐ YES	☐ NO	
f. Developmental delays	☐ YES	☐ NO	
g. Allergies	☐ YES	☐ NO	

Significant physical findings, comments and recommendations: _____

4. This child has a health condition which may require care or emergency action while at child care/school. ☐ YES ☐ NO
   Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____
   Recommendations: _____
5. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school. ☐ YES ☐ NO If YES, please specify: _____
6. This child requires a modified diet and/or special feeding procedures. ☐ YES ☐ NO
   If YES, please specify: _____
7. Does this child have any limitations that would effect full participation at the academy? ☐ YES ☐ NO
   If YES, please specify: _____
8. Does the child's physical activity need to be restricted? ☐ YES ☐ NO
   If YES, please specify: _____
9. Does this child require any specialized treatment? ☐ YES ☐ NO
   If YES, please specify: _____
10. Does this child require any adaptive equipment (e.g., braces, crutches, etc.)? ☐ YES ☐ NO
    If YES, please specify what type: _____
    Special instructions for use: _____
11. Additional comments: _____

HEALTH ADDENDUM

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name:_____

Medical Condition(s):_____

_____

Medications currently being taken by your child:_____

Allergies/Reactions:_____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/Symptoms to look for:_____

_____

(2) If signs/symptoms appear, do this:_____

_____

(3) To prevent incidents:_____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:_____

_____

COMMENTS:_____

_____

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I CONDUCTED A PHYSICAL EXAMINATION OF THE ABOVE-NAMED CHILD ON _____ (date) AND FIND THAT HE/SHE *IS / IS NOT* MEDICALLY CLEARED TO ATTEND
(Circle One)

_____ (_____)_____
Name of Health Practitioner (Signature) Telephone Number

IMMUNIZATION CERTIFICATE

CHILD NAME:
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ AGE: BIRTH DATE:_____ MONTH DAY YEAR

PARENT/ NAME: PHONE NO.
GUARDIAN ADDRESS: CITY: ZIP: COUNTY: _____

RECORD OF IMMUNIZATION

DOSE NUMBER	DTP MO/DAY/YR	DT (PED) MO/DAY/YR	HEB B MO/DAY/YR	POLIO MO/DAY/YR	MEASLES* MO/DAY/YR	RUBELLA* MO/DAY/YR	MUMPS* MO/DAY/YR	HIB vaccine MO/DAY/YR	VARICELLA MO/DAY/YR	PCV MO/DAY/YR	FLU MO/DAY/YR
1ST DOSE											
2ND DOSE											
3RD DOSE											
4TH DOSE											
5TH DOSE											

*Blood test verification of immunity and date may be entered in lieu of vaccination date.

PHYSICIAN,) TO THE BEST OF MY KNOWLEDGE, Signed:
HEALTH OFFICIAL) THE VACCINES LISTED ABOVE WERE (Physician or Health Official) ADMINISTERED AS INDICATED.

Title:

Date:

LOST OR DESTROYED RECORD: (Must Be Reviewed and Approved by Local Health Department)
I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable. To the best of my knowledge, the doses of DTP and TOPV listed above were administered on the dates indicated.

Signed: Date: _____ (Parent or Guardian)

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health.

This is a permanent condition □ This is a temporary condition □ until:_____ MO/DAY/YR
Check appropriate box; indicate vaccine(s) and reasons below.

Signed: Date:
(Physician or Health Official)

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunization being given to my child.

Signed Date

(Parent or Guardian)

TEXAS Health and Human Services

Form 2550
October 2019-E

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at _____ and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Safe Sleep Policy

All staff, substitute staff, and volunteers at _____ will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415(b) and §747.2315(b)]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415(b) and §747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing _____ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415(b) and §747.2315(b)].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised “tummy time” several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant’s health care professional [§746.2428 and §747.2328].

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

Signatures

This policy is effective on: _____ Child's name: _____

_____ Signature — Director/Owner

_____ Date Signed

_____ Signature — Staff member

_____ Date Signed

_____ Signature — Parent

_____ Date Signed

Parent Authorization and Consent Form

Child's Name:_____Date of Birth:_____

Please place a check (√) next to each item that you authorized. Staff may apply the following products to my child.

Diaper Ointment _____ Expiration Date: _____ Diaper Powder ☐ _____ Expiration Date: _____ Baby Lotion ☐ _____ Expiration Date: _____ Sunblock ☐ _____ Expiration Date: _____ Lip Balm ☐ _____ Expiration Date: _____ Mosquito Repellant☐ _____ Expiration Date: _____ Other: _____

_____

I understand that I must provide, clearly label with my child's name and date these products when I bring them to the center.

Parent Name: _____ Date: _____

Parent Signature: _____

THE R.O.C.K EARLY LEARNING CENTER

PARENTAL CUSTODY INFORMATION

Name of Child:_____ Date of Birth:_____

PARENTAL CUSTODY INFORMATION:

1. Are the child's parents separated,divorced, or together? **(circle the most appropriate answer)**
2. Is custody currently being disputed within the courts? ☐ Yes ☐ No
3. Has any court issued an order regarding custody of the child, or is custody of the child established in a written Separation Agreement? ☐ Yes ☐ No
4. Who currently has legal custody of the child? (names and relationships) (please provide as much information as possible regarding each person's custodial right).

_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE provide The ROCK Early Learning Center with a copy of any custody order or divorce decree issued by a court, and/or your legally binding separation agreement that establishes custody over the child (including all amendments). In order to maintain a safe and secure environment within the center, all custody disputes must be addressed outside of the academy. Thank you for your cooperation in this matter.

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE, AND AGREE TO NOTIFY THE CENTER OF ANY CHANGES IMMEDIATELY.

_____
Name of Parent

_____ _____
Signature of Parent **Date**

Doctor's Health Statement Admission Requirement

Must be signed by your child's physician upon

enrollment. Child's Name: _____

Health Care Professionals Statement: I have examined the above-named child within the past year and find that he/she is able to take part in the day care program.

_____ _____ Health Care

Professionals Signature Date

PUBLICITY RELEASE AGREEMENT

Date:_____

I hereby consent to the use of my name, photograph, video/audio or other likeness by The ROCK Early Learning Center and/or its corporate affiliates ("The ROCK Early Learning Center"), their respective members, shareholders, directors, employees, agents, licensees, franchisees, and assigns in all marketing and advertising materials, publications, word of mouth programs, social networking sites, websites and/or in media interviews without restriction as to form, manner, frequency or duration of usage.

I further agree that my name and/or photograph and/or video and/or other likeness may be used with whatever visuals, copy or other elements in The ROCK Early Learning Center's online newsletters, social networking sites, websites or visual, electronic or print media, and I agree that all such materials produced hereunder are and will remain the sole and exclusive property of The ROCK Early Learning Center and will not have to be reviewed with or by me prior to their use.

I further consent to the use of statements, comments, or opinions I have made, whether oral or written, referring or relating to The ROCK Early Learning Center, its business, the The ROCK Early Learning Center system and its programs, and my own franchised business.

I hereby warrant and represent that the statements attributable to me accurately reflect my true and honest belief and my actual experience with The ROCK Early Learning Center, which I testify to and recommend. I agree to execute whatever documents The ROCK Early Learning Center requires confirming this warranty and representation.

I represent that I am over the age required by law in this state to enter into binding agreements and that I have no conflicting contractual obligations that would interfere with my performing services hereunder or my granting the rights herein granted. If I am under age, the signature of my guardian below shall constitute the guardian's consent on my behalf to the terms and conditions of the Release Agreement. This consent is irrevocable and is given on the express understanding and condition that no reward or compensation is or shall be due to me or to the undersigned parent/guardian for the giving of this consent or for the grants and licenses provided herein.

I hereby certify and represent that I have read the foregoing and fully understand the meaning and effect thereof and that my signature below represents my consent and agreement.

Signature: _____

Printed Name:

_____

Address: _____

_____

Telephone: _____

For Minors under 18 yrs of age:

Signature of Parent/ Guardian: _____ Print Name: _____ Print

Child's Name: _____