SC Learning Center
Southwestern College
Enrollment Application

Date of Application: _____ Birth Date:_____

Child's Name: _____ Nickname: _____

Gender: Male / Female Age: _____

(Preschool Students) Type of Care Desired: Full Day ___ ½ AM ___½ PM___
Days of the week: _____

(School Age Students) Days Child Will Attend:_____
School Child Attends:_____

Parent/Guardian Information:

_____	_____
Mother/Guardian's Name	Father/Guardian's Name
_____	_____
Street Address	Street Address
_____	_____
City State/Zip	City State/Zip
_____	_____
Home Phone	Home Phone
_____	_____
Cell Phone	Cell Phone
_____	_____
Work Phone	Work Phone

Emergency Contact Information:

In case of an emergency, it is necessary that each child have the name of an authorized person who will be available to pick up your child when you may be unavailable.

Name	Home Phone
Cell Phone	Work Phone

Parent's Marital Status: ( ) Married ( ) Separated ( ) Divorced
( ) Widowed ( ) Living Together ( ) Other

If parents are separated who has custody of child? _____
(If center is to withhold child from parent, a court order must be on file.)

Other Children in the Family:

Name	Age	School

How did you hear about our school? _____

I affirm that to the best of my knowledge and belief, the statements in this application are true. I understand that it is my responsibility to notify the preschool of any changes.

Signature: _____
Relationship to Child: _____ Date: _____

A $15 non-refundable application fee is required. Please make application fee checks payable to the SC Learning Center.

For Center Use Only:

Date Application Received: _____
Date Child Enrolled: _____
Date Child Withdrawn: _____
Reason for Withdrawal: _____

CCL 010
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	**License #**
SC Learning Center	36168

I authorize Alexis Mees ; Staff (*caregiver/staff*) who is (are) representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (*child's first and last name)* while child or youth is in the facility's custody between _____ (MM/DD/YYYY) and end of care (MM/DD/YYYY).

Is child covered by health insurance? ☐ Yes ☐ No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____ (MM/DD/YYYY)

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

_____

_____

_____

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ (MM/DD/YYYY) by _____ (Name of Person).

(Seal, if any.)

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is transported by the facility.

CCL. 029
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas
Department of Health and Environment

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care_____ Name of Child Care Facility SC Learning Center

Child's Name_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____
Home Address_____
Street City Zip Code
Home Phone Number_____
Employer_____
Work Phone Number_____
Cell Phone Number_____
E-mail Address _____
Best way to contact_____

Parent/Guardian Information

Name_____
Home Address_____
Street City Zip Code
Home Phone Number_____
Employer_____
Work Phone Number_____
Cell Phone Number_____
E-mail Address_____
Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____
Address _____ Address _____
Phone Number _____ Phone Number _____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows: _____

_____

_____

Any known allergies or medical conditions of child:

_____

_____

Any major changes at home that might affect your child in care:

_____

_____

Please provide additional information or special instructions that will help the person caring for your child:

_____

_____

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

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:_____ **Date of Birth:** _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
**Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II.
Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

_____DTaP/DT _____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA _____HepB ____Hib
_____PCV ____Varicella ____Other

Physician's Signature (required): _____ **Date:**_____

☐ **(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.**

Section III.

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

Division of Public Health
Curtis State Office Building
1000 SW Jackson St., Suite 300
Topeka, KS 66612-1368

Kansas Department of Health and Environment

Phone: 785-296-1086
www.kdheks.gov

Janet Stanek, Secretary

Laura Kelly, Governor

LICENSED CHILD CARE FACILITIES AND EARLY CHILDHOOD PROGRAMS OPERATED BY SCHOOLS IMMUNIZATION REQUIREMENTS FOR 2024-2025 SCHOOL YEAR

Immunization requirements and recommendations for the 2024-2025 school year are based on the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) recommendations. The current recommended and minimum interval immunization schedules may be found on the CDC webpage. The best disease prevention is achieved by adhering to the recommended schedule. However, if a child falls behind, the catch-up schedule is implemented. To avoid missed opportunities, immunization providers may use a 4-day grace period, in most instances, per age and interval between doses. In such cases, these doses may be counted as valid.

K.A.R. 28-1-20, published July 18, 2019 in the Kansas Register, defines the immunizations required for children attending child care facilities and early childhood program licensed by the Kansas Department of Health and Environment (KDHE).

- **Diphtheria, Tetanus, Pertussis (DTaP):** Five doses required. Doses should be given at 2 months, 4 months, 6 months, 15-18 months, and 4-6 years (prior to kindergarten entry). The 4th dose may be given as early as 12 months of age, if at least 6 months have elapsed since dose 3. The 5th dose is not necessary if the 4th dose was administered at age 4 years or older.
- **Haemophilus influenzae type b (Hib):** Three to four doses required for children less than 5 years of age. Brands of vaccine approved for a three-dose series should be given at 2 months, 4 months, and 12-15 months. Brands of vaccine approved for a four-dose series should be given at 2 months, 4 months, 6 months, and 12-15 months. Total doses needed for series completion is dependent on the type of vaccine administered and the age of the child when doses were given.
- **Hepatitis A (Hep A):** Two doses required. Doses should be given at 12-23 months with a minimum interval of 6 months between the 1st and 2nd dose.
- **Hepatitis B (Hep B):** Three doses required. Doses should be given at birth, 1-2 months, and 6-18 months. Minimum age for the final dose is 24 weeks.
- **Measles, Mumps, and Rubella (MMR):** Two doses required. Doses should be given at 12-15 months and 4-6 years (prior to kindergarten entry). Minimum age is 12 months and interval between doses may be as short as 28 days.
- **Pneumococcal conjugate (PCV):** Four doses required for children less than 5 years of age. Doses should be given at 2 months, 4 months, 6 months, and 12-15 months. Total doses needed for series completion is dependent on the age of the child when doses were given.
- **Poliomyelitis (IPV/tOPV):** Four doses required. Doses should be given at 2 months, 4 months, 6-18 months, and 4-6 years (prior to kindergarten entry). Three doses are acceptable if 3rd dose was given after 4 years of age **and** at least 6 months have elapsed since dose 2.
- **Varicella (Chickenpox):** Two doses are required. Doses should be given at 12-15 months and 4-6 years (prior to kindergarten entry). The 2nd dose may be administered as early as 3 months after the 1st dose, however, a dose administered after a 4-week interval is considered valid. No doses are required when student has history of varicella disease documented by a licensed physician.

Legal alternatives to school vaccination requirements are found at K.S.A. 72-6262. In addition to the immunizations required for children attending child care facilities licensed by KDHE and early childhood programs operated by schools, other vaccine recommendations are:

- **Rotavirus:** Two or three doses are *recommended* for < 8 months of age. Total doses needed for series completion is dependent on the type of vaccine administered and the age of the child when doses were given.
- **Influenza** and **COVID-19**: Annual vaccination *recommended* for all ages ≥ 6 months of age. Number of doses is dependent on age and number of doses given in previous years.

Vaccination efforts by school and public health officials, immunization providers and parents are key to the success of protecting our children and communities from vaccine preventable disease. Thank you for your dedication.

Revision 1/2024

CCL. 029a
Rev. 05/2020

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: _____ **IN/CM %ILE**_____		**Weight:** _____ **LB/KG %ILE**_____
Physical Examination	**✓ If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) ☐ None	
Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

Your Child

Answers to the following questions will help us provide your child with a comfortable safe environment that will allow him or her to have a happy experience at our school.

Is this your child's first separation from home? _____

Has your child had any kind of group experience before? _____
Where: _____

Does your child make new friends easily? _____

Is he/she used to playing alone or with others? _____

What are his/her favorite toys or activities at home? _____

Are there other languages spoken in the home? _____
(Name Languages)

What is your child's race? _____
What is your religious preference?_____
Are there any cultural routines that we should be aware of?_____
_____

Does your child have to be reminded to go to the restroom? _____

Does your child take a mid-day nap or rest? _____
Time of Day _____ For How Long? _____
Special feeding instructions: (Food likes and dislikes, etc.) _____
_____

What fears does your child have (such as animals, storms, etc.)? _____
_____
How do you handle these fears? _____

To what behavior management practices or methods of discipline is your child accustomed? _____
_____
What other information could you provide to assist us in caring for your child? _____

PERMISSION TO PARTICIPATE IN THE SC LEARNING CENTER

1. I hereby grant permission for my child to use all play equipment and participate in all activities.
   _____Yes _____No

2. I hereby grant permission for my child to participate in supervised walks, outside play/activities and activities involving various college programs.
   _____Yes _____No

3. I hereby grant permission for my child to be included in photographs and video tapings for instructional, publicity, and portfolio use. I grant permission for my child's information to be shared with other relevant providers, agencies, or other programs.
   _____Yes _____No

4. I will pick up my child promptly. I agree to pay an extra $5.00 for each five (5) minute block (or any portion thereof) after the 6:00 PM closing, beginning at 6:05 PM (11:20 AM for half-day kids) as shown on the preschool clock.
   _____Yes _____No

5. I will provide the required birth, health, and immunization records for my child BEFORE he/she may begin school.
   _____Yes _____No

I hereby attest that I will pay all fees when due. I understand that this is a laboratory school and that university students and high school students will be observers and aids. Southwestern College students under the supervision of the Lead Teacher and the Director will be involved with my child on a daily basis.

_____ _____

Signature of Father/Guardian Date

_____ _____

Signature of Mother/Guardian Date

CCL. 034
Rev. 3/2020

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
SC Learning Center			361168
Street Address of the Facility	**City**	**Zip Code**	**County**
120 W. 12th Ave.	Winfield	67156	Cowley

_____ may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Public Lib.	605 College	Winfield	(By Vehicle)	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Southwestern College	100 College St.	Winfield	(By Vehicle)	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Rec. Center	624 College	Winfield	(By Vehicle)	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Arts & Humanities	700 Gray	Winfield	(By Vehicle)	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Island Park	N. End of Main	Winfield	(By Vehicle)	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Aqua Center	300 main St.	Winfield	(By Vehicle)	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Cherry St. Park	@ Cherry St.	Winfield	(By Vehicle)	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Cochran Park	11600 Manning	Winfield		
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Main St. Skate	515 main	Winfiad		
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

FOR SCHOOL AGE CHILDREN OR YOUTH ONLY

I hereby authorize my **school age child** _____
First and Last Name of Child or Youth **Birth Date MM/DD/YYYY**

To walk/bike to and from the following location(s) **without** adult supervision: This is Not Applicable

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

SC | LEARNING CENTER

Building Bright Futures Step By Step

Photographing, Videotaping, Audiotape, and Observation Release Form

I understand that the faculty, staff, and students of Southwestern College and SC learning Center will be taking digital images, photographs, and or/video tapes for decoration (e.g. posting pictures on bulletin boards, on cubbies, ect.) and/or security purposes.

I understand that parents are also allowed to come in the center and observe, photograph, video tape, and/or audiotape children.

I, hereby, consent that all digital images, photographs, videos, or other images taken of my child, _____, and/or recordings of his/her voice made by Southwestern College or SC Learning Center students and staff may be used by Southwestern College or SC Learning Center, and/or other with its consent, for education, decoration, illustration, advertising, publication, or security purposes in an manner.

I, also, understand that since my child _____ is enrolled at SC Learning Center, which is a campus based facility, he/she may be observed, video taped, recorded, digitally imaged, or photographed by the Southwestern College faculty, staff, and students to use in classroom assignments only. This will be supervised by the teachers and staff at SC learning Center. No child will be observed, video taped, or recorded, or photographed without supervision of a teacher and the authorization of the administration of the SC Learning Center.

Parent/Guardian Signature_____ Date_____

Parent Payment Contract

I _____ intend to pay the

SC Learning Center $_____ (circle one)

WEEKLY BI-WEEKLY MONTHLY OTHER

On (insert day of the month) _____

I understand my account must be maintained in order for my child to attend. If failure to make payment within 90 days, I understand my account will be charged 10% of my current balance monthly until payment is made. **Students will be discharged immediately until account is current.**

PLEASE CIRCLE ONE OF THE FOLLOWING TYPES OF PAYMENT:

DCF PRIVATE PAY FLEX PAY

The definitions are as follows: DCF means the family receives a supplement for childcare once a month. Private pay means the family pays from their own funds. Flex pay means the family participates in a program at work.

_____ _____

Parent's signature Date

_____ _____

Director's Signature Date

Behavior Management and Discipline Policy

The general goals of guidance and discipline at SC Learning Center are to help the individual child to become increasingly responsible for his or her own behavior.

We believe that children learn best within a safe and nurturing environment. The staff will provide positive support and reinforcement for appropriate behaviors, as well as any necessary guidance toward those appropriate behaviors. We encourage children to develop and use potentialities as fully as possible and to manage his or her own affairs with due consideration for others. We want children to solve problems intelligently and think for him or herself. We will help children manage feelings and emotions in an appropriate, constructive manner and will provide developmentally appropriate consequences when inappropriate, hurtful or harmful behaviors occur.

If determined by the director, teachers of the children, and parents/guardians an early childhood specialist from Winfield School District or other agency may be recommended. When a discipline plan has been developed for the child the center personnel will work with the agency. Ongoing communication will occur with parents/guardians, teaching staff, and the agency.

Discipline

The classroom rules at SC Learning Center are generated from student input along with teacher guidance. When children choose inappropriate behavior the following actions will be taken by the staff members: (All situations will be documented and notes will be sent home to inform parents of the behavior.)

- The problem will be discussed in a quiet voice.
- The child will be given an opportunity to come up with a solution to resolve the problem thus preventing a recurrence of behavior.
- A safe place is provided in each classroom for children to calm down. If needed the child will be sent there to think about their behavior and how it can be fixed.
- Parent will be called to discuss further disciplinary actions if needed.
- Termination of class membership – if problem behavior continues – as determined by Director.

I, the parent or guardian of _____ (child's full name), do herby state that I have read and received a copy of the Behavior Management and Discipline Policy and that the SC Learning Center (or other designated staff member) has discussed the Behavior Management and Discipline Policy with me.

Parent/Guardian Signature _____ Date_____

KANSAS WIC PROGRAM FACT SHEET

Kansas Department of Health and Environment

KANSAS WIC

For more information contact your local Health Department

www.kansaswic.org

What is WIC?

WIC is a nutrition program that provides nutrition and health education, healthy food, breastfeeding support and other services to Kansas families who qualify. WIC stands for Women, Infants and Children.

Who's Eligible?

WIC clients must meet WIC income guidelines and have a medical or nutritional need. WIC serves Kansas residents who are:

- Pregnant
- Breastfeeding mothers, up to baby's first birthday
- Non-breastfeeding mothers, up to six months after baby's birth
- Infants
- Children under five years old

Many working people are eligible for WIC and don't realize it. For example, in 2022:

- a household of 2 can have a gross income up to $33,874 a year
- a household of 4 can have a gross income up to $51,338 a year

WIC impacts Kansas families and counties

WIC serves approximately 44,000 Kansas residents in 102 counties across the state. The approximate cost of monthly food benefits provided to WIC clients is:

- Pregnant women: $83.00
- Breastfeeding mothers, up to baby's first birthday: $107.00
- Breastfed infants up to 6 months old: Priceless breastmilk
- Breastfed infants 6 to 9 months old: Priceless breastmilk + $90.00
- Breastfed infants 9 to 12 months old: Priceless breastmilk + $75.00
- Non-breastfeeding mothers, up to six months after baby's birth: $63.00
- Infants (fully formula fed): $160.00
- Children under five years old: $70.00

WIC Approved Foods

WIC benefits can be used to buy healthy food at over 340 authorized grocery stores statewide. Examples of WIC foods include:

- fresh fruits and vegetables
- milk or soymilk
- whole grains (bread, tortillas, rice, & pasta)
- eggs
- cereal
- fruit juice
- cheese
- baby food
- infant formula
- peanut butter
- canned or dried beans
- canned tuna or salmon

KANSAS WIC PROGRAM FACT SHEET

For more information contact your local Health Department

www.kanswic.org

Nutrition Education

Appointments with Registered Dietitians and Nurses ensure all WIC clients get the highest level of service. Nutrition services in the WIC program may include one or more of the following:

- Individual counseling
- Cooking classes
- On-line education modules
- Breastfeeding peer counselor support
- Interactive educational displays

Breastfeeding Support

Because a major goal of the WIC Program is to improve nutrition and health, WIC mothers are encouraged to breastfeed their infants. WIC provides a supportive environment for breastfeeding families and connects clients with available breastfeeding resources in the community.

Many Kansas WIC Clinics now have a Breastfeeding Peer Counselor. Breastfeeding Peer Counselors provide personalized support for WIC mothers. In most clinics, peer counselors are available to WIC clients both inside and outside usual clinic hours and the WIC clinic environment.

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: **mail:** U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** Program.Intake@usda.gov.

This institution is an equal opportunity provider.

I have read and understand the contents of the parent handbook. I understand that if I have any questions I may ask the director to explain. I also understand that after signing this form a copy will be put in my child's file.

Signature _____ Date _____

Child and Adult Care Food Program
ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.				
Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— **Any household member receiving benefits can establish eligibility for all children in the household.**	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.	

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
	Tell us how much and how often. If no income, write "0". Use net income if self-employed.														
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	Today's Date	Print Name of Adult Signing
X________________________________	______________	Social Security Number (SSN) (last four digits) XXX-XX- ☐ Check if no SSN
Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. 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.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. Toe request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW
Washington, D.C. 20250-9410

FAX: 202-690-7442

EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced Price ☐ Paid

Household Size: _____

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Determining Official **Today's Date**

X_____ _____
Signature of Confirming Official **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.

CACFP Enrollment and Income Eligibility Form (E/IEF) Instructions

This organization offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). We receive support from CACFP to serve those meals. The CACFP makes healthy food a regular part of your child's day care!

Please fill out the *CACFP Enrollment and Income Eligibility Form (E/IEF)*. This lets us know how much money CACFP will give to support your day care home or center. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2021 - June 30, 2022		
Household size	Yearly Income	Monthly Income
1	$23,828	$1,986
2	$32,227	$2,686
3	$40,626	$3,386
4	$49,025	$4,086
5	$57,424	$4,786
6	$65,823	$5,486
7	$74,222	$6,186

As you fill out the *CACFP Enrollment and Income Eligibility Form (E/IEF)*, please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, do not include overtime pay, if you do not normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children do not have to be U.S. citizens to qualify for meal benefits.
You are in the military	Do not include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

This institution is an equal opportunity provider.