Child and Adult Care Food Program Child Enrollment Form

Sponsor/Center Name: _	
Agreement #:	

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

			T18.00	TIMES CH								
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	AM	PM	TIME	AM	PM	TIME	SCH LEAVES	D ATTENDS IOOL RETURNS	MEALS RECEIVED		
IRST CHILD	MONDAY							CENTER	TO CENTER			
AME	TUESDAY ☐WEDNESDAY	Yes	No	I work multiple	shifts and	child(ren) may be in care	different days/h	ours	☐ EARLY MORNING SNACK ☐ BREAKFAST		
IRTH DATE	☐THURSDAY ☐FRIDAY	Other:		•		,		* *		A.M. SNACK LUNCH		
	SATURDAY									P.M. SNACK		
AGE	SUNDAY	Fnroll	ment D	ate:Withdrav	val Dat	e:				SUPPER EVENING SNACK		
				TIMES CH		ALLY AT	TENDS DURING					
FULL NAME OF ENROLLED CHILD	DAYS OF WEEK IN		TIMI	i-IN		TIME	OUT	_	D ATTENDS IOOL			
(Include Birth Date/Age	ATTENDANCE	☐Same	Times as	Above TIME	AM	PM	TIME	LEAVES	RETURNS	MEALS RECEIVED		
		AIVI	PIVI	TIIVIE	AIVI	PIVI	TIIVIE	CENTER	TO CENTER			
ECOND CHILD	☐ Same as Above ☐ MONDAY									☐ Same Meals as Above ☐ EARLY MORNING SNACK		
AME	TUESDAY	Yes	No	I work multiple	shifts and	child(ren) may be in care	different days/h	ours	☐ BREAKFAST		
IRTH DATE	☐ WEDNESDAY ☐ THURSDAY	Other:								A.M. SNACK LUNCH		
NGE	□FRIDAY □SATURDAY									P.M. SNACK SUPPER		
.GE	SUNDAY	Enroll	ment D	ate:			Withdrawa	Date:		EVENING SNACK		
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FULL NAME OF ENROLLED CHILD	DAYS OF WEEK IN		TIMI			TIME	001	_	D ATTENDS IOOL	MEALS RECEIVED		
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HIRD CHILD	☐ Same as Above ☐ MONDAY									☐ Same Meals as Above ☐ EARLY MORNING SNACK		
NAME	TUESDAY	☐Yes ☐	No	I work multiple	shifts and	child(ren) may be in care	different days/h	ours	BREAKFAST		
BIRTH DATE	THURSDAY	Other:								☐ A.M. SNACK ☐ LUNCH		
ACE.	☐ FRIDAY ☐ SATURDAY									P.M. SNACK SUPPER		
AGE	SUNDAY	Enroll	ment D	ate:Withdrav	val Dat	e:				EVENING SNACK		
					ILD NORN		TENDS DURING					
FULL NAME OF ENROLLED CHILD	DAYS OF WEEK IN		TIMI	:-IN		TIME	001		D ATTENDS IOOL	MEALS RECEIVED		
(Include Birth Date/Age	ATTENDANCE	☐Same	Times as	Above TIME	AM	PM	TIME	LEAVES	RETURNS	WEALS RECEIVED		
		7			7			CENTER	TO CENTER			
OURTH CHILD	☐ Same as Above ☐ MONDAY									☐ Same Meals as Above ☐ EARLY MORNING SNACK		
NAME	□TUESDAY □WEDNESDAY	Yes	No	I work multiple	shifts and	child(ren) may be in care	different days/h	ours	☐ BREAKFAST ☐ A.M. SNACK		
SIRTH DATE	THURSDAY	Other:								LUNCH		
AGE	□FRIDAY □SATURDAY									P.M. SNACK SUPPER		
	SUNDAY	Enroll	ment D	ate:Withdrav	val Dat	e:				EVENING SNACK		
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(Include Birth Date/Age	ATTENDANCE	AM Same	PM PM	Above TIME	AM	PM	TIME	LEAVES	RETURNS			
FIFTH CHILD	Same as Above							CENTER	TO CENTER	Same Meals as Above		
NAME	☐ MONDAY ☐ TUESDAY	Yes	No	I work multiple	shifts and	child(ren) may be in care	different days/h	ours	☐ EARLY MORNING SNACK ☐ BREAKFAST		
BIRTH DATE	☐ WEDNESDAY ☐ THURSDAY	Other:		Ť						A.M. SNACK LUNCH		
	FRIDAY									P.M. SNACK		
AGE	□SATURDAY □SUNDAY	Enroll	ment D	ate:Withdrav	val Dat	e:				SUPPER EVENING SNACK		
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gnature Signature	e of Parent or Guard	lian			ate			Telepho	ne Number o	f Parent or Guardian		
Signature	, or Guara			<i>D</i> .				. crepne		, sire or outsiding		
CHILD CARE REPRESENTATIVE USE ONLY:	Effective Date of This Enr	ollment Fo	rm:									
									-			

This portion of the form can be used to capture multi-yea		*****	******

Annual Time Period Covered by Signature:	to		
Signature Parent/Guardian		Date	
Signature Center Administrator/Home Provider			

Annual Time Period Covered by Signature:	to		
Signature Parent/Guardian		Date	
Signature Center Administrator/Home Provider			
************	******	*******	********

Annual Time Period Covered by Signature:			
Signature Parent/Guardian		Date	
Signature Center Administrator/Home Provider		_ Date	
***************	*******	********	*********

Annual Time Period Covered by Signature:			
Signature Parent/Guardian		Date	
Signature Center Administrator/Home Provider		Date	
*************	******	*******	*******

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

- 2. fax:
 - (833) 256-1665 or (202) 690-7442; or
- 3. email:

program.intake@usda.gov

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

	Child's First Name		MI	Child's	Last Nar	ne							En	eter Child	Migrant	Runaway	Homeless	+2 head s
efinition of Household ember: "Anyone who is													T	Ster Crittu	Migrant	Tunaway	Tometes	Tiedd 3tt
g with you and shares													>					
e and expenses, f not related."													all that apply					
n in Foster													l that					
d children who le definition of													유 교					
s, Migrant or are eligible for													Check	Ш	Ш			
ls.																		
								CNAD	TANE	EDDI								
Do any hous	sehold members (including you) currently particip	oate in one o	r more of	the follo	wing ass	istance	orogran	ns: SNAP,	IANF, OI	r FUPIF	₹?							
io to STEP 3 IF Y	ES > Write case number here and proceed to STEP 4	(do not comp	lete STEP	3)	CASE NUM	BER:												
															Write o	only one cas	se number i	n this space
Report Incor	me for ALL Household Members (Skip this step if	you answer	ed 'Yes' t	o STEP 2)													
	A. Child Income						Ch	ild Income			w often?							
sure what	Sometimes children in the household earn or						4	ita income	Weel	kly Bi-Wee	ekly Monthly	Bi-Monthly	ly					
include here?	include the TOTAL income received by all Chil	aren iistea in	SIEPIN	ere.			•											
page and review rts titled "Sources	B. All Household Members (Including yourself) List all Household Members not listed in STEP 1 (i																	
ne" for more ation.	for each source in whole dollars (no cents) only. If	they do not red	ceive incon	ne from an	y source, v	rite '0'. If	vou ente	or 'O' or los	ve any fiel	lde hlanl	k vou are	cortifyi	ina Incar	micina) t	that there	e is no inc	come to re	eport.
							you ente	o or tea	ve any net	ius biain	k, you are	certifyi	• .	-				
	Name of Household Members (First and last)	Earning	s from Work	Weekly F	How often	,	Wel	fare/Child		Hov	v often?		Pen Soci	sions/Ret ial Securit	irement/ ty/SSI/	ŀ	How often?	
	Name of Household Members (First and last)	Earning \$	s from Work	Weekly E	How often	,	Wel			Hov	•		Pen Soci	sions/Ret	irement/ ty/SSI/	ŀ		aly 2x Month
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Source of Income for Children							
Sources of Child Income	Examples						
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages						
Social Security - Disability Payments - Survivors Benefits	A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits						
Income from person outside of household	A friend or extended family member reguarly gives a child spending money						
Income from any other source	A child receives regular income from a private pension fund, annuity, or trust						

Source of Income for Adults									
Earnings from Work	Public Assistance/Alimony/ Child Support	Pensions/Retirement/ All other sources of income							
Salary, wages, cash bonuses Net income from self-employment (farm or business) If you are in the U.S. Military:	Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local	Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefit Income from trusts or estates							
Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing	government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	Annuities Investment income Earned interest Rental income Regular cash payments from outside household							

OPTIONAL Children's Ethnic and Racial Identities	(Optional)							
We are required to ask for information about your child and does not affect your children's eligibility for receiv	•	This information	n is important and helps to r	make sure we a	are fully serving	g our community. Respondi	ng to this section is optiona	al
Ethnicity (check one): Hispanic or Latino Not His	panic or Latino							
Race (check one or more): American Indian or Alaskan	Native Asian	Black or African	American Native Hawaiia	n or Other Pacifi	SIslander	White		
The Richard B. Russell National School Lunch Act requires the in application. You do not have to give the information, but if you do care center/provider receives may be impacted. You must include the social security number of the adult household member who slast four digits of the social security number is not required when a foster child or you list a Supplemental Nutrition Assistance Pro Assistance for Needy Families (TANF) Program or Food Distributi Reservations (FDPIR) case number or other FDPIR identifier for y	not, the funds your child e the last four digits of signs the application. The n you apply on behalf of Igram (SNAP), Temporary on Program on Indian Your child or when you	employees, an disability, age, require alterna Agency (State Federal Relay To file a progr	with Federal civil rights law and U.S d institutions participating in or add or reprisal or retaliation for prior cative means of communication for por local) where they applied for ber Service at (800) 877-8339. Addition am complaint of discrimination, cofiling_cust.html, and at any USDA	ministering USDA ivil rights activity is orgam information office. Individuals wally, program informatic the USDA Implete the	programs are prohil n any program or a on (e.g. Braille, large vho are deaf, hard o mation may be mac Program Discrimina	ibited from discriminating based of activity conducted or funded by USI e print, audiotape, American Sign I of hearing or have speech disabilit de available in languages other th ation Complaint Form, (AD-3027) fo	n race, color, national origin, sex, DA. Persons with disabilities who Language, etc.), should contact the ies may contact USDA through the an English.	e e e
indicate that the adult household member signing the application security number. We will use your information to determine the n your child care center/provider. We MAY share your eligibility info health, and nutrition programs to help them evaluate, fund, or deprograms, auditors for program reviews, and law enforcement of into violations of program rules.	neal reimbursement for ormation with education, termine benefits for their	form. To reque MAIL*: U 0	st a copy of the complaint form, cal S. Department of Agriculture ffice of the Assistant Secretary for 400 Independence Avenue, SW (ashington, D.C. 20250-9410	l (866) 632-9992.	FAX: (202) EMAIL: progra	•	*Only use this address if you are filing a complaint of discrimination.	=
For Official CACFP Sponsor Use Only NOT VALID V	WITHOUT DETERMINING	OFFICIAL'S SI	GNATURE AND DATE					
Annual Income Conversion: Weekly x 52, Every 2 Weeks	x 26, Twice a Month x 24,	Monthly x 12						
Total Income	y often? Household	size	Categorial Eligibility	Free Reduce	-			
Determining Official's Signature	Date Confirming (second ch	Official's Signatur	re	Date		Official's Signature Institutions - Verification Officia	Date	

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.



CACFP Infant Enrollment Form

Center/Provider Name:		
Dear Parent/Guardian, This childcare center/provider participates in the Child and Adult Care Food Prograreimbursement for serving nutritious meals to infants according to program require childcare centers/providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to follow specific meal patterns according to the serving providers to serving provid	ements. Participatio	
Childcare centers/providers participating in the CACFP <u>are required</u> to offer at least infants who are enrolled in care. You may decline the infant formula offered, and CACFP approved iron-fortified formula. (NOTE: A CACFP approved iron-fortified formula must have 1 mg of iron or more per 100 calories of formula and must be regulated by the FDA.)	supply breast milk an	d/or your own
Additionally, when you determine, in consultation with your physician, that your in childcare center/provider will also be required to offer iron fortified infant cereal a	•	•
Infant's NameInfant's	Date of Birth	
Iron Fortified Formula offered by the Center/Provider		
Breast milk and/or Formula preference		
Record date to indicate your preference (choose all that apply) *I understand that I may change my decision at any time with advance notice	Birth -5 months Date & Initial	6 – 11 months Date & Initial
I will provide expressed breast milk for my infant.		
I will breast feed my infant on site at the center/provider.		
I want the childcare center/provider to provide the infant formula it offers for		

1 PDE 7/30/2020

my infant.

I will provide the infant formula for my infant. (must be iron fortified)

the criteria for an approved iron fortified formula. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it

effects the infant, and the recommended substitution.

My infant has a special dietary need that requires a formula that does not meet

Name of infant formula I will provide:

Name of infant formula I will provide: __

Preference regarding infant cereal and other foods

Record date to indicate your preference *I understand that I may change my decision at any time with advance notice	6 – 11 months Date & Initial
I want the childcare center/provider to provide the iron fortified infant cereal and other foods for my infant.	
I want the childcare center/provider to provide all food items with one exception. (This option is only applicable if center/provider is providing the iron fortified infant formula)	
One food item that I will provide (must be a creditable CACFP food item):	
My infant has a special dietary need that requires modifications to the infant meal pattern requirements. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, the foods to avoid and the recommended substitutions	
I am aware and understand the all information provided on this form and my ability to have my infant participate in the CACFP; however, I decline the infant formula and food offered by the center/provider and elect to furnish ALL infant formula and food for my infant. (Center/Provider may not claim meals for this infant)	

This supplemental infant form must be completed for all infants in care and must be maintained by center/provider and if applicable, a copy must be maintained by the Sponsoring organization

Date

Center/Provider signature

Date

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: http://www.ascr.usda.gov/complaint_filing_cust.html, 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. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;

(2) Fax: (202) 690-7442; or

Parent/Guardian

(3) E-mail: program.intake@usda.gov. This institution is an equal opportunity provider.

2 PDE 7/30/2020

Parent/Provider fill in this part.

Parents may write immunization dates; health professional should verify and complete all data.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

CHILD'S NAME: (LAST)	(F)	IRST)		PARENT/GU	IARDIAN:	
DATE OF BIRTH:	НС	OME PHONE:		ADDRESS:		
CHILD CARE FACILITY NAME:						
FACILITY PHONE:						
☐ I authorize the child care staff and my child	's health profe	essional to co	mmunicate di	rectly if need	ed to clarify ir	formation on this form about my child.
PARENT'S SIGNATURE:						
This form may be updated b	y a health p		OT OMIT A Initial and d			hild care facility needs a copy of the form.
	TION PERTI	NENT TO RO	UTINE CHIL	D CARE ANI	D DIAGNOSI	S/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
NONE						
						EDICATION AND SPECIAL DIET. ALL MEDICATIONS A CAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
CHILD'S ALLERGIES (DESCRIBE, IF ANY)	•					
□ NONE	•					
	OULD BE FO					TACH ADDITIONAL SHEETS IF NECESSARY TO ATION OF SPECIAL TRAINING REQUIRED FOR STAFF,
IN YOUR ASSESSMENT, IS THE CHILD AE COMMUNICABLE DISEASES? PYES NO IF NO, PLEASE EXPLORED			CHILD CAR	E AND DOE	S THE CHIL	D APPEAR TO BE FREE FROM CONTAGIOUS OR
HAS THE CHILD RECEIVED ALL AGE APPROSCREENINGS LISTED IN THE ROUTINE PREHEALTH CARE SERVICES CURRENTLY RECOBY THE AMERICAN ACADEMY OF PEDIATRIC	VENTIVE MMENDED	THE SCREE	NING WAS	ABNORMA	L, PROVIDE	EARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE DATE THE SCREENING WAS COMPLETED AND TIONS OR ACTIONS RECOMMENDED FOR THE CHILD
SCHEDULE AT <u>WWW.AAP.ORG</u>)		VISION (s	ubjective u	ntil age 3))	
□ YES □ NO		HEARING	(subjective	e until age	4)	
		LEAD				
RECORD DATES OF IMMU	JNIZATION	S BELOW	OR ATTACH	і а рното	COPY OF T	HE CHILD'S IMMUNIZATION RECORD
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
НЕР-В						
ROTAVIRUS						
DTAP/DTP/TD						
НІВ						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						
MEDICAL CARE PROVIDER:	l				SIGNATURE	OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS]	
ADDRESS:					TITLE:	
		PHONE:			LICENSE NU	MBER: DATE FORM SIGNED:

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME		BIRTH DATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN	HOME T	ELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE	TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME	BUSINES	SS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN	HOME T	ELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE	TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME	BUSINES	SS TELEPHONE NUMBER
ADDRESS	I	
EMERGENCY CONTACT PERSON(S) NAME	TELEPHONE NU	JMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME	ADDRESS TELEPHONE NUMBER	ER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPH	ONE NUMBER
ADDRESS	l .	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATIO	N REACTIONS)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	l	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)	
PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PAR OBTAINING EMERGENCY MEDICAL CARE	RENTAL CONSENT ADMIN. OF MINOR FIRST - AID PROC	PEDLIRES
		, LDONEO
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	
ERIODIC REVIEW		
SIGNATURE OF PARENT OR GUARDIAN		DATE
		DATE
SIGNATURE OF PARENT OR GUARDIAN		DATE

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(C); 3280.123 & 181(c); 3290.123 & 181(c)

NAME OF CHILD					
FEE AMOUNT \$	PER-DAY-WEEK		DAY PAYMENT TO BE MADE		
Services to be provided as part of the	day care fee (example; tra	nsportation, care, meals	s, etc.)		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIM	E	PERSON(S) DESIGNATED BY PARE	NT TO WHOM CHILD	MAY BE RELEASED
LATE FEE \$	PER MIN-HR				
Extra services to be provided at an ad	dditional fee if applicable				
I, the parent/guardian;					
received complete wi	itten program inform	ation at the time o	f enrollments. (§ 3270. 121, 3	280.121, 3290.12	1)
agree to update the e months at a minimun			rm information whenever cha	anges occur or ev	ery 6
months at a minimum	1. (9 3270.124, 3200.12	24, 3230.124)			
SIGNATURE-OPERATOR	DA	TE	SIGNATURE-PARENT OR GUARDIA	AN	DATE
			PERIODIC REVIEW		
DATE OF CHILD'S ADMISSION			I LINODIO INEVIEW		
DATE OF WITHDRAWAL	SIGNA	TURE-PARENT OR GUA	ARDIAN	DATE	

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