



YELLOW SPRINGS
Community
Children's Center

Name of Child: _____ D.O.B _____

Name of Parents: _____

Application pick up date: _____ Application drop off date: _____

Start Date: _____

Enrollment paperwork Checklist:

- _____ Enrollment Contract
- _____ Payment Policy/ Liability release
- _____ Income Eligibility Application (Child and Adult Food Care Food Program) *Must be filled out
- _____ Enrollment Form (Child and Adult Care Food Program)
- _____ Medical Statement & Immunization records *Due within 30 days of Enrollment
- _____ State of Ohio Immunization Exemption (Optional)
- _____ Health Assessment
- _____ Special Diet Form *Must be signed by parent (Optional)
- _____ Family information for Step Up to Quality
- _____ Assessment Permission
- _____ Behavioral Policy Acknowledgement
- _____ Routine Trip Permission
- _____ Photo/Video/ Audio Release statement
- _____ Handbook Acknowledgement

Yellow Springs Community Children's Center

Center hours of operation 6:30 a - 6:00p

Before Care hours are 6:30 - 7:40/ After care hours of operation 2:45 - 6:00

Holidays, school closings, Snow days are an additional \$50.00 per day

5% discount for 3 months advance pay

10% Sibling discount

15% Military discount (Please bring ID)

Infant Program (6weeks-17months) **Toddler Program (18 months-3 years)**

Attendance	Monthly	Attendance	Monthly
5 full days	\$1095.50	5 full days	\$920.00
5 Mornings or Afternoon	\$916.00	5 Mornings or Afternoon	\$718.00
4 Full Days	\$1061.00	4 Full Days	\$883.00
4 Morning or Afternoon	\$819.50	4 Morning or Afternoon	\$620.50
3 Full Days	\$950.00	3 Full Days	\$815.00
3 Morning or afternoon	\$765.00	3 Morning or afternoon	\$525.50

Preschool Program (3 years - 5 years)

Attendance	Monthly
5 Full days	\$750.00
5 Mornings or Afternoons	\$546.00
4 Full Days	\$685.00
4 Mornings or Afternoons	\$478.00
3 Full Days	\$597.00
3 Mornings or Afternoons	\$420.00

Yellow Springs Community Children's Center

After School ONLY school Age Program

Before School ONLY School Age Program

*Includes snack and developmentally appropriate activities

5 Days per week	\$400.00	5 Days per week	\$300.00
4 Days per week	\$390.00	4 Days per week	\$280.00
3 Days per week	\$320.00	3 Days per week	\$215.00

***Before and After Care School Age Program**

*Includes snack in the afternoon, School Closings,
Snow Days and Holidays.

Summer Program

*Additional onetime \$130.00 activity fee
which covers field trips and classroom materials
* Includes Breakfast, Lunch, Snack

*Includes developmentally appropriate activities and lesson plans

5 Days per week	\$675.00	5 Days per week	\$680.00
4 Days per week	\$660.00	4 days per week	\$650.00
3 Days per week	\$600.00	3 days per week	620.00

YSCCC Enrollment contract

Enrollment Date: _____

Parent/Guardian name & email address: _____

Parent/Guardian name & email address: _____

Child Full name/Birthday/ Classroom _____

Child Full name/Birthday/Classroom _____

Child Full name/Birthday/Classroom _____

Contracted Days: (*Circle minimum of 3 days /Days cannot change on a weekly basis):

Monday, Tuesdays, Wednesday, Thursday, Friday ~ Full time or Part time ~

Private pay families: Monthly Tuition fee: _____

- * A \$25 registration fee is due upon initial enrollment date.
- * A late fee of \$35.00 will be applied to your account if payment is received after the 5th.
- * We do not offer adjustments due to illness, vacations or inclement weather closings.

Title XX families: Weekly co pay: _____

- * A registration fee of \$25. 00 is not required but if you owe a weekly co-pay, it must be paid consistently each month.
- * Fees are due on a weekly or monthly.
- * We do not offer adjustments due to illness, vacations or inclement weather closings.
- * A late fee of \$35.00 will be applied to your account if payment not received.

This is a legal binding contract between you and YSCCC. You are responsible for monthly payment of tuition/ Title XX co pays.

____ I understand that I am responsible for any and all charges associated with my account and that if I fail to pay any amount due in a timely manner, I will forfeit my child's enrollment spot at the end of the month.

Preferred method of payment: Cash _____ Check _____ Money order _____ Credit card _____

Credit card number: _____ Expiration date: _____

YSCCC payment policy and Liability Release

The following terms and conditions apply to the youth program accounts for our students enrolled in the center, aftercare program at Mills Lawn and Summer camp program.

(please read and initial each item)

____ A registration fee of \$25.00 is due at the time of enrollment including your first month's tuition.
(Excluding all families enrolled in the Title XX program)

____ An invoice will be provided via email or can be sent to your mailing address on file. Please update changes to your email and mailing address accordingly.

____ ~~Services are billed according to the youth program schedule for which you have contracted. Any~~
changes to your contracted schedule must be submitted in writing (two weeks) prior to the change.
Changes not submitted within the required time frame will not be adjusted on the current billing cycle.

____ Fees are not adjusted based on your child's absences on a day to day basis. Sick days and other short-term absences do not qualify for any type of credit. YSCCC will not credit accounts on days of inclement weather closings or delays.

____ The payment schedule is based on a month to month basis. All payments are due on the first of the month or no later than the 5th of the month. All late payments are subject to a late fee of \$35.00. *If payment is not received/payment plan is not discussed with Director or Business Manager by the end of the month, your child will not be admitted to attend the center until your full past due balance is received by the end of the following month.*

____ If your check/ credit card payment does not process (payment rejected), a \$25 returned item charge will be added to your account in addition to your required monthly tuition fee.

____ Late pick up policy will take into effect if your child is picked up past the closing time. Our center and aftercare program closes at 6:00. **The late fee charge is \$5.00 for each minute after our closing time and will increase to \$10 per 5 minutes after a half hour has passed.**

____ If your child will be absent from the program on a scheduled day for any reason, please call the center to notify the Director or administrator of their absence.

Liability: This is to certify that I give my child permission to attend YSCCC. I release the YSCCC from any liability. I understand that it is my responsibility to arrange transportation daily at the specified pick up time. I will be responsible for any late fees that accumulate due to late pick up, late payments and/or rejected payments.

***Our program cares for children ages 18 months – 12 years of age. Once your child turns 13, he/she will not be allowed to attend the center based on state rules and regulations. I understand that my student must abide by the code of conduct established by YSCCC and also the discipline code set up by the school and the school district.**

Print name of Parent/Guardian _____ Date: _____

Signature of Parent/Guardian _____ Date: _____

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name				Relationship to Child	
Home Address				Home Telephone Number	
City				State Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name				Relationship to Child	
Home Address				Home Telephone Number	
City				State Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name		Name			
City		State		City State	
Telephone Number		Relationship to Child		Telephone Number Relationship to Child	
Other numbers where emergency contact can be reached (if applicable)				Other numbers where emergency contact can be reached (if applicable)	
Name of Physician or Clinic/Hospital					
Street Address					
City		State		Telephone Number	

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (check all that apply)

- ☐ No
☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (check one)

- ☐ No
☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (check one)

- ☐ No
☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (check one)

- ☐ No
☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (check one)

- ☐ No
☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

- ☐ No
☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.
☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (check one)

- ☐ No
☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- ☐ No
☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."
☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport	OR	Do Not Give <u>Permission</u> to Transport
Program or Home Name		Program or Home Name
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.	Do not sign both	does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature		Parent's Signature
Date		Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No
(check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Please review in detail our Communicable Disease Policy from the Parent/Guardian Handbook. The State of Ohio mandates that a child be SYMPTOM-FREE for a full 24 hours before returning to the center.

COMMUNICABLE DISEASE POLICY

-When we send a Child home-

Each child, as required by law, has a physical exam upon entering the program. This exam is to be renewed each year (except for school-age children). It is vital that all parents/guardians communicate any and all information pertaining to their child's past and current medical history with the Center Staff.

Any child exhibiting any of the following symptoms will be considered to be carrying a communicable disease and should not be brought to the Center. Any staff member exhibiting any of the following symptoms will be sent home and a substitute staff member will replace them.

- Diarrhea (three or more abnormally loose stools within a twenty-four hour period)
- Severe coughing (child's face turns red or blue, or whooping or barking sound is heard)
- Difficult or rapid breathing
- Yellowing skin or eyes
- Redness of the eye, obvious discharge, matted eyelashes, burning, itching
- Temperature of 100 degrees Fahrenheit or more
- Untreated, infected skin patch(es)
- Unusually dark urine and/or gray or white stool
- Stiff neck with elevated temperature
- Vomiting more than one time or when accompanied by any other sign/symptom
- Evidence of lice, scabies or other parasitic infestation
- Sore throat or difficulty in swallowing

Teachers carefully observe children throughout the day. Any child who is suspected of having a communicable disease is isolated from the rest of the children and brought to the front office where they are made as comfortable as possible. The parent/guardian will be notified, and if they cannot be reached, "emergency contacts" will be called. An adult will be within sight and hearing of any child who is isolated due to illness.

Children are readmitted to the Center when symptom free for a period of 24 hours (or nit free in the case of lice). Because physicians and medications differ from case to case, written verification that the child is no longer contagious is required in order to return the child to the Center before the 24-hour symptom free time period.

Children who are not feeling well and are not exhibiting any of the above symptoms are considered "mildly ill" and will be cared for and observed for further signs of illness. The Center is not able to care for mildly ill children who cannot participate in the daily activities of the Center.

Please call the Center and let us know how your child is feeling and inform us of any diagnosis. Notifications of possible exposures are posted on the front door of the Center.

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)		Date of Birth
<input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. <input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).		
Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner		Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Telephone Number
Street Address		
City, State and Zip Code		

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent). <div style="height: 150px; border: 1px solid black;"></div>			
<input type="checkbox"/> I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.			
Signature of Parent			Date of Signature
Optional Recommended Assessments/Screenings			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Measurements		Notes	
Height			
Weight			
BMI			

STATE OF OHIO
LEGAL IMMUNIZATION EXEMPTION
Per OHIO STATUTE 3313.671 (Exemptions)

Religious, Good Cause, and Medical Exemption Form
Amended Substitute Senate Bill No. 282. Ohio Revised Code.
Sections 3313.671. Pat (3) and (4)

Section 3313.671, part (3): A pupil who presents a written statement of his parent or guardian in which the parent or guardian objects to the immunization for good cause, including religious convictions, is not required to be immunized.

Section 3313.671 part (4): A child whose physician certifies in writing that such immunization against my disease is medically contraindicated is not required to be immunized against that disease. This section does not limit or impair the right of a board of education of a city, exempted village, or local school district to make and enforce rules to secure immunization against poliomyelitis, rubeola, rubella, diphtheria, pertussis, and tetanus of the pupils under its jurisdiction.

I understand that the immunization Law permits me to sign a waiver on my child taking the immunization.

I hereby object and request the school to waive the immunization of my child against the following:

D.P.T.	Polio	Rubeola
Rubella	Mumps	Hepatitis B
Varicella	Hib	MMR

Child's Name: _____

Religious: _____ List name of denomination _____

Good Cause: Please Explain _____

Medical Reason: You must have a signed statement from your physician stating the condition and attach it to this form.

I further understand that during the course of an outbreak of any of the aforementioned vaccine preventable diseases, that the student named here is subject to exclusion from school for the duration of the outbreak.

~~This action is necessary not only to protect this student, but the remainder of the students and faculty of the school.~~

Parent/Guardian Signature: _____

Address: _____ Date: _____

Yellow Springs Community Children's Center Health Assessment

Parent/ guardian Health Assessment

Community Children's Center

Child's Name: _____

Parent/Guardian Name: _____

-
1. My child has a regular physician. (Yes/No)

Name of Physician: _____

2. My child's birth followed a full- term pregnancy with no complications prior to/immediately following the delivery. Yes/ No * If no, please describe.

3. My child takes medication on a regular basis. Yes/ No
- If Yes, please list medications, frequency and reason.

4. My child has been hospitalized and/ or undergone surgery. (Yes/ No)

5. My child has participated in therapy. (Yes/No)
-

Yellow Springs Community Children's Center Health Assessment

6. There is a history of learning disabilities, attention deficit disorder or language delays in the family. (If yes, describe)

-
7. I have concerns about my child's development, (Yes/ No)

8. If applicable, please describe health/ nutrition concerns, major childhood illnesses or diagnosed syndromes:

9. I would like to share the following additional health related information about my child:

Parent/Guardian signature: _____

Date: _____

ORIGINAL

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name (Last)	(First)	Nickname (If any)
<i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. (Check all that apply) How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

ORIGINAL

Please check all of the words that best describe your child's personality and behavior

- ☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

ORIGINAL

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date

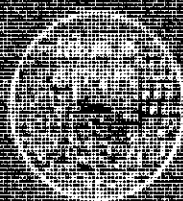
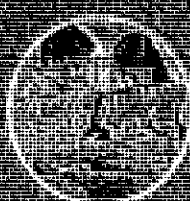
USDA

United States Department of Agriculture



WIC Since 1974
The Foundation of
Healthy Families

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program)



What is WIC? WIC was established as a permanent program in 1974 to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk. This mission is carried out by providing nutritious foods to supplement diets, nutrition education (including breastfeeding promotion and support), and referrals to health and other social services. Find out more: <http://www.fns.usda.gov/wic/about-wic-wic-glance>

Where is WIC available?

The program is available in all 50 States, 34 Indian Tribal Organizations, American Samoa, District of Columbia, Guam, Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands. While funded through grants from the Federal Government, WIC is administered by 90 State agencies, with services provided at a variety of clinic locations including, but not limited to, county health departments, hospitals, schools, and Indian Health Service facilities. To find the WIC offices serving your area go to:

<http://www.fns.usda.gov/wic/contacts>

What food benefits do WIC participants receive?

The foods provided through the WIC Program are designed to supplement participants' diets with specific nutrients. WIC authorized foods include infant cereal, baby foods, iron-fortified adult cereal, fruits and vegetables, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, yogurt, soy-based beverages, tofu, peanut butter, dried and canned beans/peas, canned fish, whole wheat bread and other whole-grain options. For infants of women who do not fully breastfeed, WIC provides iron-fortified infant formula. Spe-

cial infant formulas and medical foods may also be provided if medically indicated. Learn more about food benefits here: <http://www.fns.usda.gov/wic/wic-food-packages>

Program benefits include more than food.

WIC benefits are not limited only to food. Participants have access to a number of resources, including health screening, nutrition and breastfeeding counseling, immunization screening and referral, substance abuse referral, and more. Find out more:

<http://www.fns.usda.gov/wic/wic-benefits-and-services>

Am I eligible?

Pregnant postpartum and breastfeeding women, infants and children up to age 5 who meet certain requirements are eligible. These requirements include income eligibility and State residency. Additionally, the applicant must be individually determined to be at "nutrition risk" by a health professional or a trained health official. To find out if you might be income eligible for WIC benefits go to: <http://wic.fns.usda.gov/wps/pages/start.jsf>



How WIC Helps

WIC provides information about the foods and nutrients that are most important for the health of women, infants, and children. WIC also provides counseling and referrals to other health care services. WIC also provides food assistance to eligible women, infants, and children. WIC also provides information about the foods and nutrients that are most important for the health of women, infants, and children. WIC also provides counseling and referrals to other health care services. WIC also provides food assistance to eligible women, infants, and children.

What is "nutrition risk" and why is it important?

Two main factors of nutrition risk are recognized by WIC: children at medical risk (such as low birth weight, history of pregnancy complications, or poor pregnancy outcomes) and dietary risks, such as inappropriate nutrition/feeding practices or failure to meet the current Dietary Guidelines for Americans. Women, infants, and children at nutrition risk have much greater risk of experiencing health problems. Learn more about nutrition risk: <http://www.fns.usda.gov/wic/wic-eligibility-requirements>

I'm eligible, what do I do next?

Those who are interested in applying for benefits should contact their State agency to request information on where to schedule an appointment. Applicants will be advised on what to bring to the appointment in order to verify eligibility. Contact your State agency here:

<http://www.fns.usda.gov/wic/contacts/>

EBT makes it easier to use food benefits.

In most WIC State agencies, participants receive paper checks or vouchers to purchase food, while a few distribute food through centralized warehouses or deliver the foods to participants' homes. However, all WIC State agencies have been mandated to implement WIC electronic benefit transfer (EBT) statewide by October 1, 2020. EBT uses a magnetic stripe or smart card, similar to a credit card, that participants use in the check-out lane to redeem their food benefits. EBT provides a safer, easier, and more efficient grocery experience and provides greater flexibility in the way WIC participants can shop. Find out more and check if your State supports EBT:

<http://www.fns.usda.gov/wic/wic-electronic-benefits-transfer-ebt>

Focus on breastfeeding

Even though breastfeeding is the most nutritious source of food for infants, less than half of infants are breastfed at 1 year of age. A goal of the WIC Program is to improve the nutritional status of infants; therefore, WIC mothers are encouraged to breastfeed their infants, unless medically contraindicated. Pregnant women and new WIC mothers are provided breastfeeding educational materials and support through counseling and guidance. Explore the benefits of breastfeeding and find helpful resources here:

<http://www.fns.usda.gov/wic/breastfeeding-education-and-support>

WIC Facts

- If you participate in another assistance program you may be automatically income-eligible for WIC.
- Breastfeeding mothers are eligible to participate in WIC longer than non-breastfeeding mothers.
- More than half of the infants in the U.S. participate in WIC.
- WIC participants support the local economy through their purchases.
- WIC works with farmers markets to help increase participant access to provide fresh, locally grown fruits and vegetables. Find out more here:

<http://www.fns.usda.gov/fmnp/wic-farmers-market-nutrition-program-fmnp>

Where can I learn more?

Information on FNS programs is available at www.fns.usda.gov/fns/

SPECIAL DIET FORM

This center/facility participates in the Child and Adult Care Food Program (CACFP) and any meals, snacks, or milk claimed for reimbursement must meet program requirements. Food accommodations must be made when the food accommodation is due to a disability (a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment). Reasonable food accommodations may be made for children/participants without disabilities who may have special medical or dietary needs. Food accommodations are to be supported by a statement signed by a recognized state medical authority which is defined as a state licensed health care professional who is authorized to write medical prescriptions under state law.

To be completed by parent, guardian or authorized representative

Child/Participant Name:		Birth Date:
Parent/Guardian/Authorized Representative Name:		
Email:		
Home Phone:	Work Phone:	Cell Phone:
Address:		
City:	State:	Zip:

To be completed by recognized state medical authority

Check and complete appropriate information. For the safety of the child, please be as specific as possible.

☐ **Yes, this child/participant has a disability that requires food accommodation?**

Describe disability:

What major life activity is affected?

How does the disability restrict the diet?

☐ **Child/Participant has no disability but requires a special diet**

Describe the medical or other special dietary need that restricts diet:

List food/type of food to be omitted.

List food/type of food to be substituted for omitted food(s). Please be specific regarding any needed food texture changes or detailed menu to be followed.

Signature of Recognized State Medical Authority:	Date:
Printed Name:	Phone:

Yellow Springs Community Children's Center
Assessment Permission Form

Each year the teaching staff of the Community Children's Center performs developmental assessments and observations in the Fall, Winter and Spring. We utilize the Creative Curriculum, Developmental Screenings (ASQ & ASQ SE) and maintain individual portfolios to help teachers plan for each child's educational journey.

Parent teacher conferences are scheduled in the Fall and Spring to discuss observations, share work and create educational goals for your child.

Please sign permission for our teachers to conduct observations and do assessments on your child.

I give my permission for the Yellow Springs Community Children's Center to assess my child using a variety of assessment tools (as described above) to help set educational goals for my child while they are enrolled in the Yellow Springs Community Children's Center.

Parent signature: _____

Date: _____

Director's Signature: _____

Dear Yellow Springs Community Children's Center Parents/Guardians:

It is our top priority to keep your children safe while in our care. We want each child to feel safe and enjoy their time here at the Children's Center. To support this, Yellow Springs Community Children's Center will not tolerate excessive disrespect toward faculty or students, bullying or violence of any kind or disregard of the rules put into place to ensure the safety of children. If your child participates in any of these behaviors, he or she will be subject to suspension or expulsion from YSCCC.

The following protocol is in place to prevent these events:

Incident #1: The parent will be called and the child will receive a warning with the expectation that the behaviors will not continue.

Incident #2: The parent will be called and the child will be asked to go home immediately. An individualized behavior plan will be put into place, if necessary, noting specific strategies to help the child self-regulate.

Incident #3: The parent will be called and the child will be asked to go home immediately with a two day suspension.

Incident #4: The parent will be called and the child will be asked to go home immediately and the child will not be allowed to return to the center.

Child's Name: _____

By signing this form, I acknowledge this behavior policy and will follow it as needed.

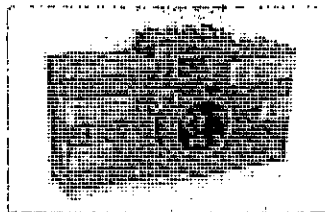
Parent signature: _____ Print Name: _____ Date: _____

Executive Director: _____

Ohio Department of Job and Family Services
ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s) Bike path, downtown YS, Antloch, Glen Helen, YS library, Toddler Park, Police & Fire Station, Mills Lawn,	
Date of Permission (valid for one year)	
Mode of Transportation (walking, school bus, public transportation, parent vehicles, provider vehicle and driver) Walking	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If yes, a swimming permission slip is required)	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

Photo and video/Audio recording release



For my child's participation in activities to be conducted by the Yellow Springs Community Children's Center, I hereby give me permission and consent, now and for all time, to YSCCC and collaborating third parties to make, produce, edit broadcast any video, film, footage, sound track recordings and photo reproductions of me/my child for marketing purposes via print, social media, television, radio and/or sound track recordings.

I Do give Permission:

Parent/Guardian Signature: _____

Date: _____

Participant Printed Name: _____

I DO NOT give Permission:

Parent/Guardian Signature: _____

Date: _____

Participant Printed Name: _____

Ohio Department of Education - Office of Integrated Student Supports
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME

(please print)

AGE

BIRTHDATE

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

☐ Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

**SIGNATURE OF
PARENT/GUARDIAN**

DATE

**DAY PHONE
NUMBER**

**MAILING ADDRESS:
STREET /APT.**

CITY

ZIP CODE

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

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Revised 10/2019

INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and Instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if *Part 3* is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME			CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)	PART 2 - LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.
PART 1 - PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER				
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE		Check type of benefit: <input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)
1.			<input type="checkbox"/>	CASE NO. _____
2.			<input type="checkbox"/>	CASE NO. _____
3.			<input type="checkbox"/>	CASE NO. _____
4.			<input type="checkbox"/>	CASE NO. _____

PART 3 - TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income; list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually.			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ amount / how often	\$ amount / how often	\$ amount / how often	\$ amount / how often
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 - SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* <u>SIGNATURE OF ADULT HOUSEHOLD MEMBER</u> Print Name: _____ Street / Apt: _____		* <u>DATE</u> Daytime Phone Number: _____ City / State / Zip: _____	* If Part 3 is completed, Insert last 4 digits of Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> (Check if applicable) I do not have a Social Security Number Work Phone Number: _____ County: _____
--	--	---	--

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

American Indian or Alaska Native	Asian	Black or African American
Native Hawaiian or Other Pacific Islander	White	Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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) case 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.

State Distribution: 7/1/2020

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.
Complete information below only if qualified child(ren) has/have:

<p>Complete information below only if qualifying child(ren) by household income from Part 3.</p> <p>Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion:</p> <p>Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12</p>		<p>Application-Certified/Categorized as:</p> <p><input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household size and income <input type="checkbox"/> Foster Child</p> <p><input type="checkbox"/> REDUCED, based on Household size and income</p>
<p>Total Household Size: _____</p>	<p>Total Household Income: \$ _____</p> <p>Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year</p>	<p><input type="checkbox"/> PAID, based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information</p>

Signature of Sponsor / Center Representative

Date Sponsor Certified/Categorized Form

Effective Date
(From the first of month of date signed)

Expiration Date
(Valid until last day of month in which
form was signed one year earlier)

Dear Parent/ Guardian,

Welcome to the Yellow Springs Community Children's Center! We are delighted to have your child/ren in our care and would like for him/her to be kept safe and comfortable here. Please read through the Parent Handbook and coming to us with any questions you might have.

I have read the Parent Handbook and agree to abide by the policies stated within. If I have any questions or do not understand something, I will ask. I understand that interpretation of policies ultimately falls with the director and I will seek his/her assistance as needed.

Signature of Parent/Guardian

Child's Name

Date

Child's Name : _____

Birthdate : _____

Mailbox # : _____ Enrollment Date : _____

Allergies : _____

Address : _____

Home phone : _____

Email : _____

Parent's/Guardian's name : _____

Cell phone : _____

Parent's/Guardian's workplace : _____

Work phone : _____

Parent's/Guardian's name : _____

Cell phone : _____

Parent's/Guardian's workplace : _____

Work phone : _____

Doctor : _____

Doctor's phone : _____

Emergency contacts : _____

phone : _____

phone : _____

Pick-up people : _____

phone : _____

phone : _____

Medical Information : _____

Special Needs : _____

Photographs of Child : Yes _____ No _____

Include in Parent Roster : Yes _____ No _____

Emergency transport : Yes _____ No _____

Hospital _____

Parent / Guardian signature(s) _____ Date _____

_____ Date _____