Denton City County Day School

- est. 1952 -

Enrollment Packet

1603 Paisley, Denton, Texas 76209
940-382-6485
940-381-2418 fax
dccds@verizon.net

Checklist

- **Completed Enrollment Forms with Signatures-all pages must be completely filled out**
- **Immunization and Doctors Health Statement**
- **Income Verification (copy of two current paystubs or yearly tax forms for Food Program Eligibility)**
- **Non-refundable Enrollment Fee- $100.00**

Partners

Denton City County Day School (DCCDS) Enrollment Information

Child's Name: _____ (Male/Female) Nickname: _____

Date of Birth: ___/__/____ Date of Admission: _____ Date of Withdrawal:_____

Mother's Name: _____ **Father's Name**: _____

Address: _____ Address: _____Zip_____

City/State _____ Zip_____ City/State _____ Zip_____

Do you reside in the city limits of Denton? ☐Yes ☐NO	**How many years have you lived in Denton city or county?**

Mom's place of employment_____ Dad's place of employment_____

Mom's Main Phone _____ Dad's Main Phone _____

Mom's Work Phone_____ Dad's Work Phone _____

Mom's E-mail address _____ Dad's E-mail address _____

Or if child is with a legal guardian, complete: **Guardian Name**: _____

Address: _____ City/State:_____ Zip _____

Guardian place of employment_____ Guardian Main Phone _____

Guardian Work Phone_____ Guardian E-mail address _____

Child's Ethnicity: ☐Latino/Hispanic ☐Non-Hispanic/Latino	Child's Race: specify	Primary/Native Language:	Child Lives With: ☐Both Parents ☐ Mom ☐Dad ☐Guardian
Is this a single parent household? ☐ Mother ☐ Father		**Is anyone in the home disabled? ☐Yes ☐ No**	
Parent/Guardian Education: ☐ High School ☐ GED ☐ Some College ☐ Associates ☐ Bachelors ☐ Masters +			

My child ☐ will or ☐ will not be attending Ann Windle school from Aug-May.

My child will normally be in care the following days and times:

Circle the Days of attendance	From: (time)	To: (time)
Monday	am	pm
Tuesday	am	pm
Wednesday	am	pm
Thursday	am	pm
Friday	am	pm

I understand the following meals will be served to my child while in care: ☐ Breakfast (if arrive before 8:35am) ☐ Lunch ☐ Afternoon ☐ Snack

Parent Signature_____ Date:_____

Child's Name: _____

List siblings and ages _____

What is the primary language your child speaks at home? _____

What is the **primary language you speak at home**? _____

Is your child potty-trained? (**Children enrolling in three's and four's MUST BE potty-trained**) ☐Yes ☐No ☐In Process

What experiences has your child had away from parents? How does your child react away from parents?_____

_____

How does your child react away from parents? _____

_____

Does your child have any special fears? _____

How does your child communicate his/her needs? _____

_____

When your child gets upset, what helps him/her calm down? _____

_____

Has your child attended a preschool or daycare before? If so describe your child's behavior at school? _____

_____

Has your family or child been disenrolled from a previous childcare center or school? ☐Yes ☐No Describe the circumstances that led to this dismissal:

_____

How do you tell your child to stop a behavior that you don't approve of or that might be unsafe? _____

_____

What are your child's interests? _____

_____

List pets and family hobbies _____

_____

Are there special circumstances in your family we should be aware of? (Custody information, divorce, restraining orders, etc.) We must have a copy of all legal documents on file in order to enforce them. All information will be kept confidential.

_____

_____

_____

_____

Child's Name: _____

Authorized Pick Up List

I hereby authorize DCCDS to allow my child to leave the school **ONLY** with the following persons. Please list the name, phone number and driver's license number of all persons (**18 years of age and older**) who have my permission to pick up my child at school. **Only persons with names on this list will be allowed to pick-up my child from DCCDS.**

In the event a person not listed has to pick up my child, I understand that the school office must receive a phone call or email from one of the approved parents stating the person's name and driver's license number. Names may be added or removed from this list at any time. **Parent's names and driver's license number must be included.**

Name:_____ Phone:_____

DOB: _____State & Driver's License#_____ Relationship to child:_____

Name:_____ Phone:_____

DOB: _____State & Driver's License#_____ Relationship to child:_____

Name:_____ Phone:_____

DOB: _____State & Driver's License#_____ Relationship to child:_____

Name:_____ Phone:_____

DOB: _____State & Driver's License#_____ Relationship to child:_____

Name:_____ Phone:_____

DOB: _____State & Driver's License#_____ Relationship to child:_____

_____ _____

Signature of Parent or Legal Guardian Date

Emergency Contacts

In case you (the parent) cannot be reached, you must give three names, telephone numbers and address of people that can pick up your child:

Name	Telephone	Address
Name	Telephone	Address
Name	Telephone	Address

Child's Name: _____

Does your child have any food, medication or environmental allergies? □No □Yes (check all that apply)
□Food □Medication □Environmental List allergies: _____

_____

How should we respond if he/she has an allergic reaction? _____
Allergy Plans must be on file for all children with diagnosed allergies. A physician's note including listed allergy (ies), signs and symptoms and treatments must be included in the plan.

Does your child have a special health or medical condition, previous serious illness or injuries and hospitalizations within the past 12 months? □No □Yes - please explain _____

_____

Does your child have emotional, behavioral or physical needs? (Speech, hearing loss, learning disability, or other special diagnosis) □No □Yes – please explain _____

_____

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? □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 – **If your child has special dietary needs, as prescribed medically, and not able to have the food provided by the school, parents will be responsible to send prescribed nutritional food for their child.**

Is your child taking any medication? □No □Yes-if so, how is the medication administered, and will it need to be administered while in school? _____
Any medication must have the medication form filled out by the parent, be in original container containing prescription label with the child's name clearly marked. We ARE NOT able to give a child NON-Prescribed medication, Tylenol, Motrin or Advil.

Health Statement

ADMISSION REQUIREMENT: To attend DCCDS, one of the following must be presented BEFORE your child is admitted to the school:

1. ☐ **HEALTH-CARE'S PROFESSIONAL STATEMENT: I have examined the above-named child within the past year and has been found free of contagious disease and may participate in all school activities.**

_____ _____
Health Care Professional's Signature **Date**

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

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

Sight and hearing screenings: For children age 4 years old

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

A copy of the child's *current* shot record *must* be attached to this form. Up-to-date immunizations are required by state licensing to attend Denton City County Day School.

Child's Name: _____

Authorization for Emergency Medical Attention:

In the event of a medical emergency and a parent cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Doctor:	Address:	Phone#:
Name of Emergency Care Facility:	Address	Phone#

Insurance Company: _____ Policy #: _____

I give my consent for necessary emergency treatment when my child is in the care of this physician and/or hospital.

_____
Signature of Parent or Legal Guardian

CONSENT TO ADMINISTER EMERGENCY SERVICES

It is the responsibility of Denton City County Day School to issue the following statement as part of the school's policy:
In case of emergency, Denton City County Day School (DCCDS) will act as parent or guardian of each child while he/she is under the care of DCCDS. This means that DCCDS staff will, in good faith, act in the child's best interest by notifying emergency services of a serious or life-threatening condition. Notification of emergency services will result only if DCCDS staff, in their sole discretion, judge that the child's health or well-being is threatened for any reason.
Your signature below shall act to indemnify and hold DCCDS harmless from any claims that arise out of the use of this authorization and will act to authorize DCCDS to take such action as it deems necessary, in its sole discretion, to protect your child in the case of a serious or life-threatening condition. Further, DCCDS is not assuming liability for any fees or charges that result from such action, including emergency room bills, emergency transport bills, or hospital or doctors' fees. All such fees shall continue to be the responsibility of the parent and parent shall indemnify DCCDS for any such fees.

I, agree to the terms of the above school policy. In signing, I agree to allow Denton City County Day School to act as parent or guardian of my child in case of emergency.

_____ _____
Signature of Parent or Guardian Date

Child's Name: _____

Photography, Videos & Social Media:

I (we) hereby grant to Denton City County Day School permission to take and use photographs or videos of my child. I (we) also grant to Denton City Day School permission to use the finished photographs or videos for the purpose of education and/or membership promotion, including social media, i.e. Facebook and website, and grant the right to publish and/or publicly exhibit the photographs or videos in any lawful and legitimate manner.

_____ _____

Signature of parent or guardian Date

Water Play : (please initial on the line provided)

_____ I understand that during the summer months that DCCDS may have water/sprinkler play/ with adult supervision. My child will take part of this activity

OR

_____ During water play my child will sit outside and play. We do not have alterative staff to keep children inside during this time frame. All children will be outside. If you choose not to be part of water play, children will be given chalk or bubbles.

_____ _____

Signature of Parent or Legal Guardian Date

RECEIPT OF WRITTEN OPERATIONAL POLICIES: (parent handbook is online for review) **I acknowledge receipt of the Denton City County Day School (DCCDS) operational policies in the parent handbook, including those for:**	
☐ Discipline and Guidance	☐ Procedures for release of children
☐ Suspension and expulsion	☐ Illness and exclusion criteria
☐ Emergency plans	☐ Procedures for dispensing medication
☐ Procedures for conducting health checks	☐ Immunization requirements for children
☐ Meals and Food Service practice	☐ Food Allergy Plans
☐ Procedures for parents to discuss concerns with the director	☐ Procedures to visit the center without securing prior approval
☐ Procedure for parents to participate in operation activities	☐ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline and DFPS website

_____ _____

Signature of Parent or Legal Guardian Date

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

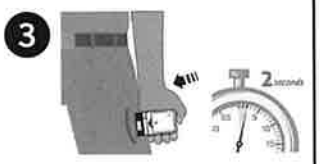
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

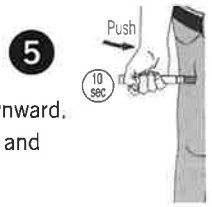


1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

TEXAS
Health and Human Services

Form 2987
October 2023

Parent's Rights

This form provides the required information per Chapter 42 of the Human Resource Code (HRC) Section 42.04271.

Directions: Parents will review these rights upon enrolling their child.

Rights of Parent or Guardian

A parent or guardian of a child at a child care facility has the right to:

(1) enter and examine the child care facility during the facility's hours of operation without advanced notice;

(2) review the child care facility's publicly accessible records;

(3) receive inspection reports for the child care facility and information about how to access the facility's online compliance history;

(4) obtain a copy of the child care facility's policies and procedures;

(5) review, at the request of the parent or guardian, the facility's:

(A) staff training records; and

(B) any in-house staff training curriculum used by the facility;

(6) review the child care facility's written records concerning the parent's or guardian's child;

(7) inspect any video recordings of an alleged incident of abuse or neglect involving the parent's or guardian's child, provided that:

(A) video recordings of the alleged incident are available;

(B) the parent or guardian of the child does not retain any part of the video recording depicting a child that is not their own; and

(C) the parent or guardian of any other child captured in the video recording receives written notice from the facility before allowing a parent to inspect a recording;

(8) have the child care facility comply with a court order preventing another parent or guardian from visiting or removing the parent's or guardian's child;

(9) be provided the contact information for the child care facility's local Child Care Regulation office;

(10) file a complaint against the child care facility by contacting the local Child Care Regulation office; and

(11) be free from any retaliatory action by the child care facility for exercising any of the parent's or guardian's rights.

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

_____ _____

Signed By: Parent or Guardian | Date

Resources

Facility Information and Online Compliance History:
http://txchildcaresearch.org
Child Care Regulation Contact Information:
https://www.hhs.texas.gov/services/safety/child-care/contact-child-care-regulation

TEXAS
Health and Human Services

Form 2935
April 2023

Admission Information

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

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

General Information

Operation's Name:	Director's Name:		
Child's Full Name:	Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian *(if different from the child's)*:		
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:	Relationship:	Area Code and Phone No.:	
Address:			
I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:	Area Code and Phone No.:		
Name:	Area Code and Phone No.:		
Name:	Area Code and Phone No.:		

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

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

2. Field Trips:

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

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

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

Is your child able to swim without assistance: ◯ Yes ◯ No

If no, what type of assistance is needed: _____

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

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

6. Days and Times in Care:

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

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯ Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian **Date Signed**

School Age Children

My child attends the following school:	School Area Code and Phone No.:

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

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

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

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

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

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

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

Admission Requirement

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

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

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

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

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

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

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

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

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

Signature **Date Signed**

Additional Information Regarding Immunizations

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

TB Test (If required)

◯Positive ◯Negative Date:

Gang Free Zone

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

Privacy Statement

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

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

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

Signature **Date Signed**

Denton City County Day School
1603 Paisley
Denton, Texas 76209
940-382-6485

Nondiscrimination statement and complaint Filing Procedures

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

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

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

Denton City County Day School operation meets the Americans with Disabilities Act (ADA), Title III. If you believe that DCCDS may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 voice or 800-514-0383 TTY.

Denton City County Day School
- est 1952 -

Denton City County Day School
1603 Paisley St., Denton, TX 76209 Office: 940-382-6485 Fax: 940-381-2418

Enrollment Agreement Form

Please review each point, initial and sign in the space provided.

_____ Denton City County Day School provides care to children Monday to Friday, 6:30 am-6:00pm. Children may not be dropped off before 6:30 am.

_____ Tuition is due weekly and are to be **paid every Monday**. Tuition must be paid via ACH payments. Tuition is considered **late if not paid on time and there will be a $25.00 late fee added** to your account. All accounts must be current and paid in full to attend DCCDS.

_____ Tuition refunds are not made due to illness, vacations, holiday, or school closing. Weekly tuition payments hold a place for a child for the week and are not refundable.

_____ **DCCDS must be notified in writing 14 days or two weeks prior to your child withdrawing from school**. If two weeks' notice is not given, you are still financially responsible for two weeks tuition following last day of attendance.

_____ Written medical plan of allergies, physical problems, or special limitations regarding the child must be provided by the parents to the school at the time of enrollment and as new conditions arise.

_____ Parents agree to inform DCCDS when there are changes in address, telephone number, or the name of persons designated to pick up a child.

_____ **Children must be picked up by 6:00 pm**. There is a $1.00 per minute late fee will be added to your account.

_____ DCCDS reserves the right to discontinue the enrollment of any child if:

a. Parents fail to cooperate reasonably with DCCDS in the provision of educational services to their child.
b. Payment of tuition fees is not kept current or picking up their child promptly.
c. The child is dangerous to him/herself or others (hits, bites, scratches, abusive language, throws things, etc.), is destructive of school property, or is so disruptive that the education of other students is significantly impaired.
d. The child requires another educational setting more appropriate to meet his/her needs.

According to our records, your child's weekly tuition will be_____.

I hereby certify that I have read and understand the conditions stated above. I will abide by these conditions and agreements as they are stated. I have also received a copy of DCCDS Parent Handbook and understand the policies and procedures of DCCDS. The Director &/or Staff have addressed any questions or concerns I may have had concerning my child's enrollment.

_____ _____

Parent/Guardian Signature Date Director/Assistant Signature Date

Communication with Parents outside Operational hours Policy

DCCDS staff will not communicate with parents on Brightwheel or any other communicating tool outside operational hours regarding operations and business. Operational hours are M-F 6:30-6:00. Parents have been asked not contact staff outside of operational hours pertaining to business that is conducted at our facility. If a parent is persistent in attempting to communicate with staff members, please notify the Director.

If it is an emergency situation please notify the Director.

Sign_____

Date_____

Discipline and Guidance Policy for Denton City County Day School

Name of Operation

- Discipline must be:
  (1) Individualized and consistent for each child;
  (2) Appropriate to the child's level of understanding; and
  (3) Directed toward teaching the child acceptable behavior and self-control.

- A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  (3) Redirecting behavior using positive statements; and
  (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

- There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  (1) Corporal punishment or threats of corporal punishment;
  (2) Punishment associated with food, naps, or toilet training;
  (3) Pinching, shaking, or biting a child;
  (4) Hitting a child with a hand or instrument;
  (5) Putting anything in or on a child's mouth;
  (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  (7) Subjecting a child to harsh, abusive, or profane language;
  (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed; and
  (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

_____ _____

Signature Date

Check one please:

☒ parent ☐ employee/caregiver ☐ household member of child-care home

2023-24 SELF-CERTIFICATION OF INCOME

INSTRUCTIONS: This is a statement from the beneficiary documenting the definition used to determine "Annual (Gross) Income", the household size (as applicable-based on the activity), and the household characteristics for the purpose of income determinaiton. Adult beneficiary members must then sign this form to certify that the information is complete and accurate.

Parent's Last Name & First Initial: _____ Child's Name Attending DCCDS: _____

Address (City/St/Zip): _____

Household Size[1]: _____ Annual Household Gross Income[2]: $ _____

[1]Household is defined as all the people in the housing unit that includes related and unrelated.

[2]Income is defined as total anticipated annual gross income of all household members expected in the next 12 months including wages, tips, commission, business income, alimony, child support; and Social Security, AFDC, TANF or other benefits)

SIGN HERE Signature and Date: _____

Signature above certifies that this information is accurate and agree to provide, upon request, documentation on all income sources to the Agency.

RACE

- ☐ 1. White
- ☐ 2. Black/African American
- ☐ 3. Asian
- ☐ 4. American Indian/Alaska Native
- ☐ 5. Native Hawaiian / Other Pacifici Islander
- ☐ 6. American Indian / Alaska Native & White
- ☐ 7. Asian & White
- ☐ 8. Black/African American & White
- ☐ 9. American Indian/Alaska Native & Black/African Am.
- ☐ 10. Other Multi Racial

ETHNICITY

- ☐ Hispanic
- ☐ Non-Hispanic

OTHER

- ☐ Female Head of Household
- ☐ Disabled

WARNING: The information provided on this form is subject to verification by HUD at any time, and Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony and assistance can be terminated for knowingly and willingly making a false or fraudulent statement to a department of the United States Government.

FOR OFFICE USE ONLY

Income Definition: Annual Income - HUD 24 CFR Part 5

Household Size: _____ Hispanic (Y/N): _____

Income Level: (See Table below) _____ Disabled Household (Y/N): _____

Race Category: (See above) _____ Female Head of Household (Y/N): _____

House-hold Size	Middle Income (NMI) +80%	Moderate Income (MI) 80%-50% AMI	Low Income (LI) 50%-30% AMI	Extremely Low Income (ELI) 30% AMI
1	above $57,750	$57,750-$36,101	$36,100-$21,701	$21,700 or below
2	above $66,000	$66,000-$41,251	$41,250-$24,801	$24,800 or below
3	above $74,250	$74,250-$46,401	$46,400-$27,901	$27,900 or below
4	above $82,500	$82,500-$51,551	$51,550-$30,951	$30,950 or below
5	above $89,100	$89,100-$55,701	$55,700-$35,141	$35,140 or below
6	above $95,700	$95,700-$59,801	$59,800-$40,281	$40,280 or below
7	above $102,300	$102,300-$63,951	$63,950-$45,421	$45,420 or below
8	above $108,900	$108,900-$68,051	$68,050-$50,561	$50,560 or below

SIGN HERE Signature and Date: _____

I certify that this information is complete and accurate. I also certify that source documentation (income backup) may need to be collected by the City of Denton.

Dear Parent/Guardian:

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

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

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

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

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

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

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

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

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

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

10. ***(Pricing program only)*** **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You can talk to the **Director** either in person or by telephone at **940-382-6485** You may ask for a hearing by calling or writing to:**1603 Paisley, Denton, Texas 76209**

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

If you have other questions or need help, call **940-382-6485.**

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the case number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have a case number, skip this part.
Part 3: **Applies only to parents/guardians of children in Tier II Day Care Homes.** Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.
Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**
Box 2: List the amount each person got from the month from welfare, child support, alimony.
Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

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

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

Non-discrimination Statement: This explains what to do if you believe you have been treated unfai

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

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

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

NAME:_____ CASE NUMBER: _____

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

Check here if no case number ☐

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

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

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

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: ___-___-____ ❑ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

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

Part 7. Sharing Information With Other Programs: OPTIONAL

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

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

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

Don't fill out this part. This is for official use only.

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

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

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

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) 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.

Non-discrimination Statement:

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.