Enrollment Application

Application Date: _____ Desired Enrollment Date:_____

***Priority is given to those children enrolling for full-time care (5 days a week) who meet the funding requirement.**

Full Name of Child:_____ Nickname_____

Date of Birth: _____

Address of Child: _____

Home Telephone:_____

The Child lives with:

____ Both Parents
____ Mother
____ Father
____ Other (if yes, please specify) _____

_____
Full name of enrolling Parent or Guardian:

_____
Signature of enrolling Parent or Guardian:

Family Information

Mother's/Guardian's Name: _____

Address if different from Childs:

_____

Email address: _____

Mother's cell phone number: _____

Mother's Employer: _____

Employer telephone number and address:

_____

_____

Fathers Name: _____

Address if different from Childs:

_____

Father's: cell phone number: _____

Email address: _____

Father's Employer: _____

Employer telephone number and address:

_____

_____

Name and ages of siblings:

Name	Age	lives with the child

Name of other people living in the home:

_____

_____

Name of Pediatrician: _____

Telephone number of Pediatrician: _____

Health insurance Provider: _____ ID: _____

General Information

In order for our staff to provide a comfortable setting for your child it is helpful if we know some background information. We would appreciate if you would share the following information.

Which language is your primary language at home?_____

Has your child previously received any other form of child care?
_____ Yes _____ NO

If yes please explain:

_____

Please note any difficulties your child had adjusting to his/her former child care:

_____

_____

What did your child enjoy most about this experience?

_____

_____

What did your child enjoy the least about this experience?

_____

_____

Is your child afraid of anything and if so, what?

_____

_____

How do you comfort your child?

_____

_____

How does your child react to stressful situations?

_____

_____

When your child misbehaves at home, what is your response?

_____

_____

General Information Continued

In order for our staff to provide a comfortable setting for your child it is helpful if we know some background information. We would appreciate if you would share the following information.

Does your child have any other children to play with?
_____ Yes _____ NO

If yes how does he/she relate to other children?

_____

_____

Is your child toilet trained?
_____ Yes _____ NO

If yes was it difficult, and or are you still working on it with your child?

_____

_____

If the child's Parent's are separated, divorced, or not living together at this time, how would you describe the present relationship between the parents?

_____

_____

Does your child have regular contact with the parent not currently living in the child's home? Please explain.

_____

_____

Do you have any custody/visitation agreements?

_____

_____

Sliding fee Scale

If your family income is less than 75% of State Median Income, you are eligible for a funded slot. At current time, these figures are:

Family Size	Gross Income Must be less than:
Family of 1-3	$65,656
Family of 4:	$78,161
Family of 5:	$90,666
Family of 6:	$103,172
Family of 7:	$105,517
Family of 8:	$107,861
Family of 9:	$110,206
Family of 10:	$112,551

Please mark one of the choices below:

_____ Yes, I believe I am eligible for a funded slot.
_____ No, I am not eligible for a funded slot.

Families on the sliding fee scale must document their income with 4 weeks worth of pay stubs or, if self-employed, Schedule C of your most recent Federal Income Tax return with a self employment form that has been notarized. If applicable, please also submit copies of unemployment or Worker Compensation award notification, as well as notification of TFA, etc. This documentation does not need to be submitted with this application. You will be asked to bring it with you when you come in to complete the enrollment process.

**for Infant Toddler and Preschool only*

Medical Information

Is your child in good health?
_____ Yes _____ NO

If no, please explain.

_____

_____

Please list any physical limitations:

_____

_____

Please list any allergies:

_____

_____

Please list any chronic conditions:

_____

_____

Has your child ever been hospitalized for a serious medical condition?

_____ Yes _____ NO

If yes, for what reason and at what age?

_____

_____

_____

Other Information

Please use the space below to share any other information that might help us care for your child.

_____

_____

_____

_____

_____

The Wallingford Community Day Care, Inc.

CHILD'S NAME_____ DATE OF BIRTH ____/____/____
HOME ADDRESS_____
HOME PHONE NUMBER_____ CELL PHONE_____
MOTHER'S NAME_____ WORK PHONE_____
BUSINESS NAME_____
BUSINESS ADDRESS_____
FATHER'S NAME_____ CELL PHONE_____
BUSINESS NAME_____ WORK PHONE_____
BUSINESS ADDRESS_____
EMERGENCY CONTACTS: (MUST BE DIFFERENT THAN PARENTS/GUARDIANS)
1. ADULT NAME_____ PHONE_____
2. ADULT NAME_____ PHONE_____
PHYSICAN NAME_____ PHONE_____
DENTIST NAME_____ PHONE_____

I hereby consent for my child to receive emergency medical care and/or transportation if necessary.
SIGN_____ DATE____/____/____

Checklist of what you will need to bring for enrollment completion:

_____ $25.00 application fee cash or check made payable to The Wallingford Community Day care Center (WCDCC)
_____ Emergency card filled out
_____ Child's Birth Certificate
_____ Child's Social Security card
_____-_____-_____ Child's Social Security number
_____-_____-_____ Parent's Social Security number

_____ Proof of Residency:
- -Utility Bill (phone, cable, electric, gas)
- - Property Tax Bill (car, home)
- -Driver's license/ State ID
- (If none of the above can be provided, must match address on enrollment forms and the parent's pay stubs.)

_____ 4 consecutive paystubs/ please see list of income eligibility on page 6
_____ CACFP form filled out
_____ Updated physical (if your child is school age, we will accept the physical you gave to his/her school):
_____ a flu shot is required if entering during the months of Sept-March
_____ Attached packet must be fully completed:
- - Authorization for child to be picked up
- - Non-medical emergency phone numbers
- - Absent Parent's Consent for Emergency Treatment
- - Other permissions
- - Parent/ Guardian agreement form
- - Confidential Financial Statement
- - Release of information/ RN and Social Worker
- - Consent for the release of information
- - Intake Interview documentation
- -

Required Documentation for Enrollment

$25.00 Application Fee

Child's Name_____

Parent/Guardian Name_____

Email Address_____

Child's Social Security #_____-_____-_____ Date received/documented_____

Child's Birth Certificate _____ Date received/documented_____

Proof of residency:

- Utility Bill: ( ) phone; ( ) cable; ( ) electric; ( ) gas
- Property Tax Bill: ( ) car; ( ) home
- Drivers License: ( ) only if none of the above can be provided [must match the address on the enrollment forms and the parent's pay stubs]
- State ID for non-driver: ( ) [may not be driving car to drop off or pick up children. address must match pay stubs and enrollment forms]

The information provided is true and correct to the best of my knowledge and belief. I understand that the child's enrollment may be terminated immediately if I fail to notify the office within 24 hours of ANY CHANGE in my or my child's residency, employment, custody of the child, or anything that may affect my child's eligibility for enrollment.

Signature _____Date_____

Wallingford Community Day Care Center

Confidential Financial Statement

Must be accompanied by 4 current pay stubs & IRS Form 1040. All information must be completed.

Child's Name: _____ SSN: _____-_____-_____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Family Information:

[ ] One Parent [ ] Two Parents [ ] Other _____

1st Parent/Guardian Name: _____ SSN: _____-_____-_____

Place of Employment: _____ Gross Income: _____/month

2nd Parent/Guardian Name: _____ SSN: _____-_____-_____

Place of Employment: _____ Gross Income: _____/month

Family Members not listed above:

Name: _____ Age: _____ Relationship: _____ Employed: [ ] Y [ ] N

Name: _____ Age: _____ Relationship: _____ Employed: [ ] Y [ ] N

Name: _____ Age: _____ Relationship: _____ Employed: [ ] Y [ ] N

Additional Financial Information:

Child Support: _____/month Unemployment: _____/month SSI: _____/ month

Other: _____/month Explain Other: _____

Receive Care 4 Kids Assistance with Day Care: [ ] Y [ ] N

OFFICE USE ONLY:

Date received: _____ Family Size: _____ Total Family Income: _____

Qualifies for: [ ] Funded Program [ ] Private Program Weekly Fee: _____

Parent/Guardian Agreement

Child's Name_____ Date of Birth_____

Is enrolled in the_____program.

I,_____(please print parent name) agree to the following terms.

1. To abide by all of the rules and regulations established by the Board of Directors for the operation of the program.
2. To pay the weekly fee of $_____ on Monday of the week of service regardless of attendance or center closing due to weather emergency.
3. To notify the center when my child will not be in attendance.
4. To provide the center with valid phone numbers, employment information, and up to date emergency contact numbers.
5. To notify the center immediately when there is any change in my employment status, work hours or earned income.
6. To notify the center of any potential custodial disputes or other concerns which may prove distressing or harmful for my child or others in the program.

The hours and days for which care is needed are:

Monday_____ AM to_____ PM

Tuesday _____ AM to_____ PM

Wednesday _____ AM to_____ PM

Thursday_____ AM to_____ PM

Friday _____ AM to_____ PM.

Please note: State rules allow for 1/2 hour travel time to and from your place of employment

I understand that service may be terminated immediately if any terms of this agreement are violated. This agreement is valid for one year from date of signature unless revised or terminated.

Signature _____Date_____

Authorization for Child to be Picked Up at Child Care

Date_____

Name of Child_____

I, *parent/guardian's name*_____

Authorize those individuals (over 15 years of age) listed below to pick up and remove my child/children from the center and to provide transportation for my child/children.

Signature_____ Date_____

PLEASE NOTE: Photo identification is required of all persons authorized to remove children from the center.

Name_____ Relationship to Child_____

Home Address_____

Home Phone/Cell Phone_____ Work Phone_____

Place of Employment_____

Name_____ Relationship to Child_____

Home Address_____

Home Phone/Cell Phone_____ Work Phone_____

Place of Employment_____

Name_____ Relationship to Child_____

Home Address_____

Home Phone/Cell Phone_____ Work Phone_____

Place of Employment_____

NON-MEDICAL EMERGENCY PHONE NUMBERS

In the event of a non-medical emergency, such as an early closing due to inclement weather, the individuals listed below may be called to pick up and remove my child from the center and provide transportation:

Signature_____ Date_____

Name_____ Relationship to Child _____

Home Address_____

Home/cell phone_____ Work phone_____

Signature_____ Date_____

Name_____ Relationship to Child _____

Home Address_____

Home/cell phone_____ Work phone_____

Signature_____ Date_____

Name_____ Relationship to Child _____

Home Address_____

Home/cell phone_____ Work phone_____

Signature_____ Date_____

Name_____ Relationship to Child _____

Home Address_____

Home/cell phone_____ Work phone_____

Absent Parent's Consent for Emergency Treatment of Minors

In the event of a medical emergency, center staff will call 911. Transportation will be provided by emergency services to an appropriate medical facility as is determined by the emergency response unit.

I give my permission for *Child's Name*_____ to receive emergency medical treatment and transportation to an appropriate medical facility for any additional treatment as may be indicated.

I authorize any licensed physician to provide treatment, order injections, hospitalize, give anesthesia or perform surgery for *Child's Name*_____ during my absence.

I understand that this authorization is given prior to any need for medical treatment, but is given to avoid unnecessary delay in emergency treatment, which the physician may deem advisable in the exercise of his/her best judgment. I presume a reasonable attempt will be made to contact me.

Signature_____ Date_____

Relationship to Child_____

In the event of such an emergency involving my child and I cannot be reached, The Wallingford Community Day Care Center, Inc. should contact the following:

Name_____ Phone: home_____ work_____

Relationship to Child_____

Name_____ Phone: home_____ work_____

Relationship to Child_____

Signature_____ Date_____

Name Printed_____

Known Medical Problems_____

Medications_____ Allergies_____

Date of Last Tetanus Shot_____ Child's Physician_____ Phone_____

Other Permissions

I give my permission for *Child's Name*_____ to be given first aid should the need arise.

Signature_____ Date_____

Relationship to child _____

I give my permission for *Child's Name*_____ to accompany the children of the Wallingford Community Day Care Center, Inc. on field trips made during the time of enrollment. I understand that transportation will be by vans or buses.

Signature_____ Date_____

Relationship to child _____

I give my permission for *Child's Name*_____ to accompany the children of the Wallingford Community Day Care Center, Inc. on supervised walks off the center premises.

Signature_____ Date_____

Relationship to child _____

I give my permission for *Child's Name*_____ to be photographed by center personnel, the newspaper and the media. I also allow them to use my child's name.

Signature_____ Date_____

Relationship to child _____

The Wallingford Community Day Care Center, Inc.
80 Wharton Brook Drive • Wallingford, CT. 06492 • (203) 294-4176

Consent for the Release of Information

Pursuant to Connecticut General Statutes section 10-10a(d) The Wallingford Community Day Care Center, Inc. must provide certain education-related information about all children receiving state and/or federal funding to the Connecticut State Department of Education. Information about children who do not receiving state or federal funding is not required by law, but may be provided with permission of the parent/guardian. Because your child's placement is not funded by state or federal grants, we are asking your permission to share your child's information with the State Department of Education.
The data are used for research purposes. The users of the personal data included the State Department of Education (Bureau of Early Childhood Education), local education agencies, state agencies (which may include the Department of Mental Retardation, the Department of Children and Families, the Department of Social Services, and the Department of Public Health). All of the aforementioned state agencies and the public at large use non-personalized statistical summary data gleaned from individual records.
The following information would be provided to the State Department of Education:

Name Date of Birth Race Gender Resident Town Health Insurance
Free/Reduced Lunch Status Exit Date Funding Source Information. Enrollment Days/ Hours

Under the Personal Data Act, Conn. Gen. Stat. sections 4-190 et seq., the State Department of

- take reasonable precautions to protect personal data;
- keep a complete record of every individual, agency or organization who has obtained access to or to whom disclosure has been made of personal data and the reason for each such disclosure or access; and maintain such record for not less than five years from the date of obtaining such access; and make available to the individual (in this case the parent or guardian,) upon written request, of this record;
- inform the parent or guardian, upon written request, whether the agency maintains personal data concerning his or her child;
- disclose to a parent or guardian , upon written request, all personal data concerning his or her child maintained by the agency;
- provide procedures which:
  - (1) allow the parent or guardian to contest the accuracy, completeness or relevancy of his or her child's personal data;
  - (2) allow personal data to be corrected upon the parent or guardian's request when the agency concurs with the proposed correction;
  - (3) allow a parent or guardian who believes the agency maintains inaccurate or incomplete personal data concerning his or her child to add a statement to the record setting forth what he or she believes to be an accurate or complete version of that personal data. Such statement shall become a permanent part of the agency's personal data system and shall be disclosed to any individual, agency or organization to which the disputed personal data is disclosed

If you agree to have information about your child and her/his enrollment in our program shared with the Department of Education, please complete the attached statement. If you do not wish to include your child, you do not need to take any action.

If you have any questions concerning this matter please contact Charles Martie: (860) 713 -6809..

Consent for Release of Information

I, _____ consent that
(Parent/guardian)

_____ may share information about my
(Preschool name)
child with the Connecticut State Department of Education. I understand that all

information provided will be used for providing grant information for the state and federal governments and for research. The users of the personal data are the State Department of Education (Bureau of Early Childhood Education), local education agencies, and other state agencies. State agencies and the public at large may use non-personalized statistical summary data gleaned from individual records. I further understand that the State Department of Education will comply with state and federal law concerning the protection and disclosure of such information.

_____
(Parent/guardian signature)

_____
(Date)

The Wallingford Community Day Care Center, Inc.
Discipline Policy Discussion with Parents/Guardians
Intake Interview

Time outs are not used in program. Redirection is used as a method for discipline...Remember to redirect to the positive, not away from the negative. We all have been trained positive guidance and we use similar techniques to those listed below. Corporal, frightening, humiliating,, neglectful, or abusive punishment is strictly prohibited. Children may not be tied or bound and the least restrictive means will be used to control any child who is in danger of hurting him/herself or others.

Behavior Management

Ground Rules

1. Be consistent
2. Decide what is important and what is not important for the child to do.
3. Be clear.
4. Be firm but supportive.
5. Set limits and follow through.
6. Make the consequence a direct, immediate response to the child's behavior.
7. Encourage positive behaviors.
8. Give the child choices whenever possible.

Examples of Positive Guidance

Do Say

Please sit on your bottom when you slide.
Please dig in the sand.
Use both hands when you climb.
Keep the puzzle at the table.
Use the books for reading.
Use your inside voices.
Sit on your bottom.
It is time to go inside.
Please drink your milk.
It's time to clean up now, please hand me the big block.

Don't Say

Don't stand when you slide.
Don't throw sand.
You'll fall if you don't watch.
Don't dump the puzzle pieces on the table.
Don't tear the books.
No shouting.
Do you want to go inside?

The Wallingford Community Day Care Center, Inc.

Intake Interview Documentation

I have received a copy of the parent handbook and had an opportunity to discuss my child's enrollment at the center. During this conversation, the discipline policy and other important policies were discussed. I understand that the center has an open door policy, and that I am always welcome in my child's classroom. I further understand that weekly fees must be paid by Monday of the week of service. If I have any questions, I know I may speak with my child's teacher or anyone in the office.

Signed: _____

Printed Name: _____

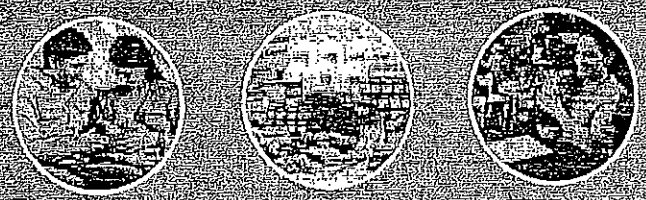
Relationship to Child: _____

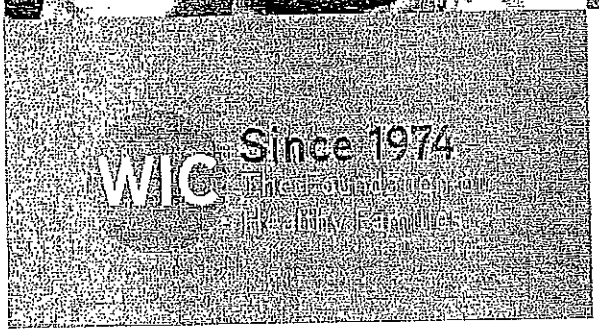
Child's Name: _____

Date: _____

USDA
United States Department of Agriculture

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. Special 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

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

Two major types of nutrition risk are recognized for WIC eligibility: medically-based risks such as anemia, underweight, 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 breast milk is the most nutritious and complete source of food for infants, nationally less than 30% of infants are breastfed at 1 year of age. A major 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-promotion-and-support-wic

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/

Income Eligibility Guidelines
(Effective from July 1, 2020 to June 30, 2021)
Household Size Larger Than 8

Household Size	Federal Poverty Guidelines- 100%					Reduced Price Meals - 185%				
	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
48 Contiguous States, D.C., Guam and Territories										
9	$48,600	$4,050	$2,025	$1,870	$935	$89,910	$7,493	$3,747	$3,459	$1,730
10	53,080	4,424	2,212	2,042	1,021	98,198	8,184	4,092	3,777	1,889
11	57,560	4,797	2,399	2,214	1,107	106,486	8,874	4,437	4,096	2,048
12	62,040	5,170	2,585	2,387	1,194	114,774	9,565	4,783	4,415	2,208
13	66,520	5,544	2,772	2,559	1,280	123,062	10,256	5,128	4,734	2,367
14	71,000	5,917	2,959	2,731	1,366	131,350	10,946	5,473	5,052	2,526
15	75,480	6,290	3,145	2,904	1,452	139,638	11,637	5,819	5,371	2,686
16	79,960	6,664	3,332	3,076	1,538	147,926	12,328	6,164	5,690	2,845
Each add'l family member add	+ $4,480	+ $374	+ $187	+ $173	+ $87	+ $8,288	+ $691	+ $346	+ $319	+ $160
Alaska										
9	$60,750	$5,063	$2,532	$2,337	$1,169	$112,388	$9,366	$4,683	$4,323	$2,162
10	66,350	5,530	2,765	2,552	1,276	122,748	10,229	5,115	4,722	2,361
11	71,950	5,996	2,998	2,768	1,384	133,108	11,093	5,547	5,120	2,560
12	77,550	6,463	3,232	2,983	1,492	143,468	11,956	5,978	5,518	2,759
13	83,150	6,930	3,465	3,199	1,600	153,828	12,819	6,410	5,917	2,959
14	88,750	7,396	3,698	3,414	1,707	164,188	13,683	6,842	6,315	3,158
15	94,350	7,863	3,932	3,629	1,815	174,548	14,546	7,273	6,714	3,357
16	99,950	8,330	4,165	3,845	1,923	184,908	15,409	7,705	7,112	3,556
Each add'l family member add	+ $5,600	+ $467	+ $234	+ $216	+ $108	+ $10,360	+ $864	+ $432	+ $399	+ $200
Hawaii										
9	$55,880	$4,657	$2,329	$2,150	$1,075	$103,378	$8,615	$4,308	$3,977	$1,989
10	61,030	5,086	2,543	2,348	1,174	112,906	9,409	4,705	4,343	2,172
11	66,180	5,515	2,758	2,546	1,273	122,433	10,203	5,102	4,709	2,355
12	71,330	5,945	2,973	2,744	1,372	131,961	10,997	5,499	5,076	2,538
13	76,480	6,374	3,187	2,942	1,471	141,488	11,791	5,896	5,442	2,721
14	81,630	6,803	3,402	3,140	1,570	151,016	12,585	6,293	5,809	2,905
15	86,780	7,232	3,616	3,338	1,669	160,543	13,379	6,690	6,175	3,088
16	91,930	7,661	3,831	3,536	1,768	170,071	14,173	7,087	6,542	3,271
Each add'l family member add	+ $5,150	+ $430	+ $215	+ $199	+ $100	+ $9,528	+ $794	+ $397	+ $367	+ $184

INCOME ELIBILITY GUIDELINES
(Effective from July 1, 2020 to June 30, 2021)

Household Size	Federal Poverty Guidelines- 100%					Reduced Price Meals - 185%				
	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
48 Contiguous States, D.C., Guam and Territories										
1	$12,760	$1,064	$532	$491	$246	$23,606	$1,968	$984	$908	$454
2	17,240	1,437	719	664	332	31,894	2,658	1,329	1,227	614
3	21,720	1,810	905	836	418	40,182	3,349	1,675	1,546	773
4	26,200	2,184	1,092	1,008	504	48,470	4,040	2,020	1,865	933
5	30,680	2,557	1,279	1,180	590	56,758	4,730	2,365	2,183	1,092
6	35,160	2,930	1,465	1,353	677	65,046	5,421	2,711	2,502	1,251
7	39,640	3,304	1,652	1,525	763	73,334	6,112	3,056	2,821	1,411
8	44,120	3,677	1,839	1,697	849	81,622	6,802	3,401	3,140	1,570
Each add'l family member add	+ $4,480	+ $374	+ $187	+ $173	+ $87	+ $8,288	+ $691	+ $346	+ $319	+ $160
Alaska										
1	$15,950	$1,330	$665	$614	$307	$29,508	$2,459	$1,230	$1,135	$568
2	21,550	1,796	898	829	415	39,868	3,323	1,662	1,534	767
3	27,150	2,263	1,132	1,045	523	50,228	4,186	2,093	1,932	966
4	32,750	2,730	1,365	1,260	630	60,588	5,049	2,525	2,331	1,166
5	38,350	3,196	1,598	1,475	738	70,948	5,913	2,957	2,729	1,365
6	43,950	3,663	1,832	1,691	846	81,308	6,776	3,388	3,128	1,564
7	49,550	4,130	2,065	1,906	953	91,668	7,639	3,820	3,526	1,763
8	55,150	4,596	2,298	2,122	1,061	102,028	8,503	4,252	3,925	1,963
Each add'l family member add	+ $5,600	+ $467	+ $234	+ $216	+ $108	+ $10,360	+ $864	+ $432	+ $399	+ $200
Hawaii										
1	$14,680	$1,224	$612	$565	$283	$27,158	$2,264	$1,132	$1,045	$523
2	19,830	1,653	827	763	382	36,686	3,058	1,529	1,411	706
3	24,980	2,082	1,041	961	481	46,213	3,852	1,926	1,778	889
4	30,130	2,511	1,256	1,159	580	55,741	4,646	2,323	2,144	1,072
5	35,280	2,940	1,470	1,357	679	65,268	5,439	2,720	2,511	1,256
6	40,430	3,370	1,685	1,555	778	74,796	6,233	3,117	2,877	1,439
7	45,580	3,799	1,900	1,754	877	84,323	7,027	3,514	3,244	1,622
8	50,730	4,228	2,114	1,952	976	93,851	7,821	3,911	3,610	1,805
Each add'l family member add	+ $5,150	+ $430	+ $215	+ $199	+ $100	+ $9,528	+ $794	+ $397	+ $367	+ $184

Dear Parent or Guardian:

The Wallingford Community Day Care Center, Inc. is planning to seek assistance for nutritious meals served under the Child and Adult Care Food Program (CACFP). The CACFP is funded by the U.S. Department of Agriculture (USDA) and administered by the Connecticut State Department of Education.

Our program may receive reimbursement for meals served to children meeting the eligibility criteria for free or reduced-price meals. We must document the eligibility of these children by obtaining family size and income data. Households with incomes at or below the level in "Gross Income Guidelines for Reduced-price Meals" (see page 2) are eligible for free meals. Please complete, sign, date, and return the attached application. **The information you provide will be treated confidentially and will be used only for eligibility determination.**

Please provide the information requested on the enclosed Income Eligibility Application and return as soon as possible. We will use this information to decide the level of CACFP benefit your provider will receive. We may also inform officials of other child nutrition, health, and education programs of the information on your form to determine benefits for those programs.

Participants categorically eligible as free for CACFP benefits: Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children are eligible for free CACFP meals.

- **SNAP or TFA:** If you currently receive SNAP or TFA benefits for your child, you only need to list your child's name, SNAP or TFA case number, and **sign and date** the application.
- **Foster children:** If your household includes a foster child, you only need to list your child's name, check the foster child box, and **sign and date** the application. In accordance with the Healthy, Hunger-Free Kids Act of 2010, foster children who are the responsibility of the state or are formally placed by a state child welfare agency or court are categorically eligible for free CACFP benefits. *This provision does not apply to informal arrangements or placements that may exist outside of state or court-based systems.* Eligibility for formally placed foster children is no longer determined based on their personal use income and a family size of one. The child care institution must obtain documentation from an appropriate state or local agency documenting the child's foster status. Households with both foster and non-foster children may choose to include all children on the same application. However, the presence of a foster child in the household does not convey eligibility for free meals to all children in the household.

All other households: If your household income is at or below the level shown in the chart on page 2, "Gross Income Guidelines for Reduced-price Meals," you must provide the following information for your application to be processed.

- **Household members:** List the names of everyone who lives in your household. Include parents, grandparents, **all** children, other relatives, and unrelated people who live in your household.
- **Social Security number:** List the last four digits of the social security number of the adult household member who signs the application. If the adult does not have a social security number, check (☑) the box next to the statement, "I do not have a SSN."
- **Current income:** List the amount of income each person earned **last** month (*before* deductions for taxes, social security, etc.), and where it is from, such as wages, retirement, or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.

Signature and date: An adult household member must **sign and date** the application.

Reporting changes: In accordance with the Child Nutrition and WIC Reauthorization Act of 2004, households are no longer required to report changes in circumstances, e.g., increase in income, decrease in household size, or when the household is no longer certified eligible for SNAP or TFA benefits. Once properly approved for free or reduced-price benefits, a household will remain eligible for those benefits for a period not to exceed 12 months.

Reapplication: If you are not eligible now but have a decrease in household income, an increase in household size, or become unemployed, fill out an application at that time. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family income during the period of unemployment to be within the eligibility standards for those meals.

Gross Income Guidelines for Reduced-Price Meals
Effective from July 1, 2020, through June 30, 2021

Number in family	Annual (Yearly)	Monthly	Twice per month	Every two weeks (biweekly)	Weekly
1	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
Each additional family member.	+ 8,288	+ 691	+ 346	+ 319	+ 160

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: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. 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.

For information on the CACFP, visit the Connecticut State Department of Education (CSDE) CACFP website or contact the CACFP staff in the CSDE's Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841. This document is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/IncElig/Letter_Household_CACFP_Centers.pdf.

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Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

Wallingford Community Day Care Center, Inc
80 Wharton Brook Drive
Wallingford CT 06492
203-294-4176

John Frassinelli, Chief
State Department of Education
Bureau of Health/Nutrition, Family Services and Adult Education
450 Columbus Boulevard, Suite 50
Hartford, CT 06103

Learn more about CACFP at USDA's website:

https://www.fns.usda.gov/

USDA is an equal opportunity provider, employer and lender.

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

Child and Adult Care Food Program (CACFP) Child Enrollment Form for Child Care Centers

Our child care center participates in the U.S. Department of Agriculture (USDA) CACFP. This program helps us provide nutritious meals and snacks to children enrolled in our center. For information on the CACFP meal pattern requirements, review the CACFP Meal Patterns for Children and the CACFP Infant Meal Patterns at https://portal.ct.gov/SDE/Nutrition/Meal-Patterns-CACFP-Child-Care-Programs.

Section 1 – Waiver of CACFP participation

Check here **only** if you are choosing **not** to enroll your child in the CACFP. *Complete section 3 on page 2, and return to the child care center.*

☐ I do not want my child to participate in the CACFP.

Section 2 – CACFP enrollment

To verify your child's enrollment in this child care center, complete this section and section 3 on page 2, and return to the child care center. You may be contacted by the center, the Connecticut State Department of Education, or the USDA to verify this information. ***Please print all information.***

Child care center's name: ______________________________

Child's name: ______________________________ Birth date: ______________

Last name *First name* *Month, day, year*

☐ Male ☐ Female First day of attendance: ______________

Complete the chart below. My child will normally be in child care during the following days and times, and will receive the meals indicated below.

Days and hours of care and meals served							
Normal days of care *Check all that apply*	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**	☐ **~~Saturday~~**	☐ **~~Sunday~~**
Normal hours in care *Circle AM or PM*	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	____ AM/PM to ____ AM/PM and ____ AM/PM to ____ AM/PM	~~____ AM/PM to~~ ~~____ AM/PM~~ ~~and~~ ~~____ AM/PM to~~ ~~____ AM/PM~~	~~____ AM/PM to~~ ~~____ AM/PM~~ ~~and~~ ~~____ AM/PM to~~ ~~____ AM/PM~~
Meals normally served to my child *Check all that apply*	☐ Breakfast ☐ ~~AM snack~~ ☐ Lunch ☐ PM snack ☐ ~~Supper~~ ☐ ~~Evening snack~~	☐ Breakfast ☐ ~~AM snack~~ ☐ Lunch ☐ PM snack ☐ ~~Supper~~ ☐ ~~Evening snack~~	☐ Breakfast ☐ ~~AM snack~~ ☐ Lunch ☐ PM snack ☐ ~~Supper~~ ☐ ~~Evening snack~~	☐ Breakfast ☐ ~~AM snack~~ ☐ Lunch ☐ PM snack ☐ ~~Supper~~ ☐ ~~Evening snack~~	☐ Breakfast ☐ ~~AM snack~~ ☐ Lunch ☐ PM snack ☐ ~~Supper~~ ☐ ~~Evening snack~~	☐ ~~Breakfast~~ ☐ ~~AM snack~~ ☐ ~~Lunch~~ ☐ ~~PM snack~~ ☐ ~~Supper~~ ☐ ~~Evening snack~~	☐ ~~Breakfast~~ ☐ ~~AM snack~~ ☐ ~~Lunch~~ ☐ ~~PM snack~~ ☐ ~~Supper~~ ☐ ~~Evening snack~~

CACFP Child Enrollment Form for Child Care Centers

For infants only

Infant formula: The center offered to serve: _____

*Name of approved iron-fortified infant formula **

Check all that apply:

☐ I would like my child to receive the above named iron-fortified infant formula supplied by the center.

☐ I will provide my own infant formula: _____

*Name of approved iron-fortified infant formula **

☐ I will provide expressed breast milk for my child.

☐ I will breastfeed my child on site in the center.

* **Note:** Infant formula provided by the parent/guardian must be **iron-fortified** and comply with the USDA's infant formula regulations indicated in USDA Memo CACFP 02-2018: *Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers.* Infant formulas that do not meet these requirements cannot be substituted unless an infant has a disability that restricts his/her diet, and the parent/guardian provides a medical statement signed by a recognized medical authority. Recognized medical authorities include physicians, physician assistants, doctors of osteopathy, and advanced practice registered nurses (APRNs). Medical statements are available on the Connecticut State Department of Education's (CSDE) Special Diets in CACFP Child Care Programs webpage.

Section 3 – Contact information and signatures

Parent/guardian name: _____

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

Work phone: (_____) _____ Home phone: (_____) _____

Parent signature: _____ Date: _____

Sponsor representative's signature: _____ Date: _____

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

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Child and Adult Care Food Program (CACFP)

Income Eligibility Application for CACFP Child Care Centers and Head Start

For instructions, refer to *Instructions for Income Eligibility Application for CACFP Child Care Centers and Head Start.*

Part 1 — Child's information

Child's name: _____ Age: _____ Birth date (*month, day, year*): _____

Child's normal child care schedule (*Check all days that apply):*

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ ~~Saturday~~ ☐ ~~Sunday~~

Child's normal hours of care ***(include time and circle AM or PM):***

_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM

Normal meal services provided to child *(Check all meals/snacks that apply):*

☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ ~~P.M. Snack~~ ☐ ~~Supper~~

Part 2A — Participants categorically eligible as free for CACFP benefits

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children. Complete this part and part 3. Do **not** complete part 2B.

SNAP case number: _____ TFA case number: _____ Check if foster child: ☐

Part 2B — All other households

If you did not complete part 2A, complete this part and part 3.

Names of all household members *List everyone in the household, including the child listed in part 1 above*	**Gross income and how often it was received:** Indicate if income was received monthly, two times a month, every two weeks, or weekly by placing the **amount of income** in the appropriate frequency box. *You **must** place the income in the appropriate frequency box.*											
	Earnings from work (before deductions) – job 1				**Public assistance/ alimony/child support**				**Pensions/retirement/social security/all other income**			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	$200					$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

Part 3 — Contact information, signature, and social security number

*An adult household member must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed name of adult: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX- _____ ☐ I do not have a SSN

Home telephone: _____ Work telephone: _____

Home address: _____ City: _____ State: _____ Zip code: _____

Income Eligibility Application for CACFP Child Care Centers and Head Start

Part 4 — Racial and ethnic identity (optional) *You are not required to complete this part.*

Ethnicity *(Check one):*

- ☐ Hispanic/ Latino
- ☐ Not Hispanic/Latino

Race *(Check one or more):*

- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander

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 your child 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 last four digits of 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 or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
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For sponsor use only – Do not write below this line

Annual income conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a month X 24 • Monthly X 12

Total family income: $ _____ Family size: _____ **OR** ☐ SNAP/TFA household ☐ Foster child

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Sponsor eligibility official: _____ Date: _____

Signature

Accepting/Rejecting Infant Formula in the Child and Adult Care Food Program (CACFP)

Section 1: To be completed by the center or day care provider

Name of center/provider: _____

Infant formula served by center/provider: _____
*Name of approved iron-fortified infant formula **

* **Note:** Infant formula offered by the center/provider must be **iron-fortified** and comply with the USDA infant formula regulations in USDA Memo CACFP 02-2018: *Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers.*

Section 2: To be completed by the parent/guardian

Name of infant: _____ Birth date: _____

Name of parent/guardian: _____

Check all that apply:

☐ I would like my child to receive the above named iron-fortified infant formula supplied by the center/provider.

☐ I will provide my own infant formula: _____
*Name of approved iron-fortified infant formula ***

** **Note:** Infant formula provided by the parent/guardian must be **iron-fortified** and comply with the USDA infant formula regulations indicated in USDA Memo CACFP 02-2018: *Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program; Questions and Answers.* Infant formulas that do not meet these requirements cannot be substituted unless an infant has a disability that restricts his/her diet, and the parent/guardian provides a medical statement signed by a recognized medical authority. Recognized medical authorities include physicians, physician assistants, doctors of osteopathy, and advanced practice registered nurses (APRNs). Medical statements are available on the Connecticut State Department of Education's (CSDE) Special Diets in CACFP Child Care Programs webpage.

☐ I will provide expressed breast milk for my child.

☐ I will breastfeed my child on site in the day care center or family day care home.

Parent/guardian signature: _____ Date: _____

Accepting/Rejecting Infant Formula in the CACFP

For more information, visit the CSDE's Feeding Infants in CACFP Child Care Programs webpage or contact the CACFP staff in the CSDE, Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841.

This form is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Infants/Accepting_Rejecting_Infant_Formula_CACFP.pdf.

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

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State of Connecticut Department of Education
Early Childhood Health Assessment Record
(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	☐Male ☐Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity	
	☐American Indian/Alaska Native	☐Native Hawaiian/Pacific Islander
Primary Health Care Provider:	☐Asian	☐White
	☐Black or African American	☐Other
Name of Dentist:	☐Hispanic/Latino of any race	
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months?	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	Y	N	7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization** Form signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian _____ Date _____

C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168.

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name_____ Birth Date_____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

☐I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT____in/cm____% *Weight____lbs.____oz /____% BMI____/____% *HC____in/cm____% (Birth–24 months) *Blood Pressure____/____ (Annually at 3–5 years)

Screenings

***Vision Screening**
☐ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
☐ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐Unable to assess
☐Referral made to: _____

***Hearing Screening**
☐ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
☐ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	☐ Pass	☐Pass
	☐ Fail	☐Fail

☐Unable to assess
☐Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | ***Date**

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level
≥ 5µg/dL ☐nNo ☐nYes

***TB:** High-risk group? ☐No ☐Yes
Test done: ☐No ☐Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ☐No ☐Yes
☐Referral made to: _____
Has this child received dental care in the last 6 months? ☐No ☐Yes

***Result/Level:** ***Date**

Other:

***Developmental Assessment:** (Birth–5 years) ☐No ☐Yes **Type:**

Results:

*IMMUNIZATIONS ☐Up to Date or ☐Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

***Chronic Disease Assessment:**

Asthma ☐No ☐Yes: ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent ☐Exercise induced
If yes, please provide a copy of an Asthma Action Plan
☐Rescue medication required in childcare setting: ☐No ☐Yes

Allergies ☐No ☐Yes: _____
Epi Pen required: ☐No ☐Yes
History/risk of Anaphylaxis: ☐No ☐Yes: ☐Food ☐Insects ☐Latex ☐Medication ☐Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes ☐No ☐Yes: ☐Type I ☐Type II **Other Chronic Disease:** _____

Seizures ☐No ☐Yes: Type: _____

☐ This child has the following problems which may adversely affect his or her educational experience:
☐Vision ☐Auditory ☐Speech/Language ☐Physical ☐Emotional/Social ☐Behavior

☐ This child has a developmental delay/disability that may require intervention at the program.

☐ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

☐No ☐Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

☐No ☐Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

☐No ☐Yes This child may fully participate in the program.

☐No ☐Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐No ☐Yes Is this the child's medical home? ☐ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):
State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	☐Male ☐Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	Normal	**Referral Made:**
Completed by: ☐Dentist	Completed by: ☐MD/DO ☐APRN ☐PA ☐Dental Hygienist	☐Yes ☐Abnormal (Describe) _____ _____ _____ _____ _____	☐Yes ☐No

Risk Assessment	**Describe Risk Factors**	
☐Low	☐Dental or orthodontic appliance	☐Carious lesions
☐Moderate	☐Saliva	☐Restorations
☐High	☐Gingival condition	☐Pain
	☐Visible plaque	☐Swelling
	☐Tooth demineralization	☐Trauma
	☐Other_____	☐Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____
Signature of Parent/Guardian Date

_____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA/ RDH	Date Signed	Printed/Stamped *Provider* Name and Phone Number

Child's Name:_____ Birth Date:_____ REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6; https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN /PA Date Signed Printed/Stamped *Provider* Name and Phone Number