The Gathering Place

Enrollment Application/Intake

Enrollment Date:_____

Child's Name:_____ Sex:_____ Age:_____

DOB:_____

Home Address

(Street):_____

City:_____ State:_____

Zip:_____

Home Phone Number:_____

Parent One Name:_____

Home Phone Number:_____

Home Address (if different from the child's) Street:_____

City:_____ State:_____

Zip:_____

Parent One Place of Employment:_____

Work Phone:_____

Employer's Street Address:_____

City:_____State:_____

Zip:_____

Parent Two Name:_____

Home Phone Number:_____

Home Address (if different from the child's) Street:_____

City:_____ State:_____

Zip:_____

Parent Two Place of Employment:_____

Work Phone:_____

Employer's Street Address:_____

City:_____State:_____

Zip:_____

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

The child may be released to the person(s) signing this agreement or to the following:

Name:_____

Address:_____

Telephone:_____

Relationship to Child:_____

Relationship to Parent/Guardian:_____

Other identifying information (if any):_____

Name:_____

Address:_____

Telephone:_____

Relationship to Child:_____

Relationship to Parent/Guardian:_____

Other identifying information (if any):_____

Name:_____

Address:_____

Telephone:_____

Relationship to Child:_____

Relationship to Parent/Guardian:_____

Other identifying information (if any):_____

Eating:

Is your child on any special diet?_____

Does your child have any food allergies? If yes, please describe:

_____

Sleeping:

Does your child nap? If so, what time of the day and how long:

_____

Does your child sleep with a special blanket or item for comfort? If so, describe:

_____

Are there specific bedtime routines at home?_____

Where does your child sleep at home?_____

Toileting:

Does your child use diapers? If so, which type:_____

If cloth, we are unable to launder diapers and they will be bagged and sent home un-rinsed and un-emptied.

*Any diaper creams your family uses for your child will be brought from home, labeled with their name, and not used on others. This helps reduce the risk of allergic reactions.

Does your child use a potty or toilet? If so explain:

_____Ho

w does your child let you know when it is time "to go":

_____Do

es your child need regular reminders to use the bathroom?: Yes:_____ No:_____

Development:

What is your child's primary spoken language? At home?:_____

Do you have any concerns regarding your child's development: If so, explain:

_____

_____

My child has the following special needs:

_____

_____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:

_____

_____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre- existing illness, allergies, or health concerns:

_____

_____

Social/Emotional Development:

Has your child been in child care before? Yes:____ No:____

Is your child comfortable in group settings? Yes:____ No:____

What is your child's regular routine at home?

_____

_____

Is there anything we should know about your child's play with other children, by themselves, any concerns?

_____

_____

What kind of activities does your child enjoy? Are there activities that your child avoids?

_____

_____

How would you describe your child's temperament/personality?

_____

_____

Does your child have any siblings?_____

Does your family have any pets?_____

What soothes your child?_____

What frightens your child?_____

What are your expectations or goals for your child at our child learning center?

_____

What are your expectations for the child learning center and your child's caregivers ?

_____

Is there anything regarding your family, extended family or child that you would like to share with us?

_____

Emergency Medical Contact and Authorization

Should (child's name)_____

Date of Birth:_____ suffer an injury or illness while in the care of The Gathering Place: A Child Learning Center and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (we) shall assume responsibility for payment for services.

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name:_____

Telephone Number:_____

Name:_____

Telephone Number:_____

Name:_____

Telephone Number:_____

Child's Doctor or Clinic

Name:_____

Telephone Number:_____

Last Visited:_____

Parent/Guardian:

Signature:_____ Date:_____

Signature:_____ Date:_____

Facility Administrator/Director:

Signature:_____ Date:_____

Signature:_____ Date:_____

Parental Agreement

The Gathering Place: A Child Learning Center agrees to provide child care for (name of child)_____.

I (we) understand that The Gathering Place will make every effort to provide full-time child care for my child and that hours may be subject to change based on unexpected circumstances.

I (we) understand that there is a late fee of $10 every 5 minutes that I (we) are late picking up.

I (we) understand that my (our) child will participate in the following meal plan based off of the Montana Child and Adult Care Food Program. They will receive breakfast, lunch, and an afternoon snack. https://dphhs.mt.gov/hcsd/childcare/cacfp

I (we) understand that my (our) child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent(s), or facility personnel.

I (we) acknowledge it is my (our) responsibility to keep the child's records current to reflect any significant changes as they occur; telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans, immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which includes my child as an immediate response.

The Gathering Place: A Child Learning Center agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for The Gathering Place: A Child Learning Center at Bozeman United Methodist Church.

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Director)

The Gathering Place: A Child Learning Center Tuition Agreement

Child's Name:_____
DOB:_____

Current Tuition Rate: _____

I (we) agree that tuition is due on the 1st of every month and will be paid in full by cash, check, SmartCare (may be subject to added fee) or pay online (added fee) at https://bozemanumc.breezechms.com/give/online
There will be a $25 late fee after the 5 day grace period. This ensures that tuition is due on time and can fund this program at Bozeman United Methodist Church.

I (we) agree that if we are using the Best Beginning's scholarship that I (we) will be responsible for paying the monthly copay by the 1st of every month and any uncovered tuition balances by the end of the given month. I (we) understand that Best Beginning's scholarship amounts are subject to change. I (we) agree to keep all information current with Best Beginning's and to notify The Gathering Place of any scholarship changes that may impact the tuition balance.

I (we) understand that there is no discount, refund, or other allowance for absence, illness, vacation, holidays, school closures, or any other reason.

I (we) understand it will be required to give one month's notice to terminate enrollment, submitted to the preschool director via email or written statement. I (we) will pay tuition for the one month notice period, even if the child does not attend the school during that month.

I (we) understand that school operational hours may be subject to change based on holiday's, school breaks, unexpected circumstances, etc.

I (we) understand that there is an annual registration fee (Fall) and an annual 10% tuition increase (January). These support annual licensing fees, the increased cost of childcare, and more.

Tuition, waitlist fees, registration fees, late payment fees, late pick-up fees and all other fees are payable directly to The Gathering Place.

By signing below, each signatory declares to have read, understood, and come into agreement with the terms of this Preschool Tuition Contract.

Signature:_____ Date:_____

Signature:_____ Date:_____

DPHHS-QAD/CCL-113
(Revision 7-2006)

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: _____ **Birth Date:** _____

Address: _____

Mother / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Father / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Physician / Medical Care Source: _____ **Contact Number:** _____

Health Insurance Carrier & Policy Number: _____

Persons authorized to pick up child:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

– SEE REVERSE SIDE –

WRITTEN CONSENT IS GIVEN FOR:

☐ **Yes** ☐ **No** EMERGENCY MEDICAL CARE

☐ ADMINISTRATION OF PRESCRIPTION MEDICATIONS	**Medication Authorization form and Medication Administration Log Must be completed**
☐ ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS	**OTC Medication Authorization Form and Medication Administration Log must be completed**

☐ ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:
Please Specify:

☐ TRIPS: ☐ **Yes** ☐ **No** TRANSPORTATION BY THE FACILITY FOR TRIPS

☐ **Yes** ☐ **No** DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

HEALTH HISTORY

	YES	NO		YES	NO
Hay fever, asthma, or wheezing	☐	☐	Chickenpox	☐	☐
Eczema or frequent skin rashes	☐	☐	Diabetes	☐	☐
Convulsions/Seizures	☐	☐	Trouble with passing urine / bowel movement	☐	☐
Heart condition	☐	☐	Frequent colds, sore throats, earaches, tonsillitis, pneumonia	☐	☐

	YES	NO
Allergies or reaction: (food or other)	☐	☐

Please Explain:

	YES	NO
Other Health Concerns (special disabilities):	☐	☐

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN **DATE**

STATE OF MONTANA— CHILD CARE FACILITY/SCHOOL CERTIFICATE OF IMMUNIZATION

Complete immunization requirements and penalties for those who fail to meet the requirements are referenced in Section V. This form is required for ALL persons attending school or child care. See the reverse side for information about EXEMPTIONS and INSTRUCTIONS.

SECTION I *PLEASE PRINT CLEARLY*

Child/Student's Name	Birth Date	Sex	Primary Provider	
Name of Parent/Guardian	Address		City	Telephone Home Work

SECTION II IMMUNIZATION HISTORY

Valid only when filled out by School, Child Care or Medical Personnel (NOT to be filled out by the parent).

Required Vaccines (CC= Child Care Requirement; SR=School Requirement)	Month, Day & Year of Each Dose 1	2	3	4	5
Diphtheria/Tetanus/Pertussis (DTaP)					
Booster Dose Tdap required prior to 7th grade entry					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					
Measles/Mumps/Rubella (MMR) or					
Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has documentation of disease					
Hepatitis B					
Pneumococcal Conjugate vaccine (PCV13)					

ACIP* Recommended Vaccines *Advisory Committee on Immunization Practices, U.S. Centers for Disease Control and Prevention	Month, Day & Year of Each Dose 1	2	3	4	5
Hepatitis A					
Human Papillomavirus (HPV) - for adolescents					
Influenza- recommended annually for all over 6 mos.					
Meningococcal Conjugate Vaccine (MCV4) (Ages 11-12 & later)					
Rotavirus					

NOT A COMPLETE IMMUNIZATION RECORD- CONTACT YOUR PROVIDER OR PUBLIC HEALTH AGENCY FOR MORE INFORMATION

If filled out by health department or health care provider:

To the best of my knowledge, this child has received the above immunizations.

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

If filled out by school or child care personnel:

I CERTIFY this information has been transferred from supporting documentation as stated in the Administrative Rules of Montana:

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

SECTION III INSTRUCTIONS

Health Department or Physician

1. For medical exemption purposes, a physician is a person licensed to practice medicine in any jurisdiction of the U.S. or Canada. This does not include chiropractic or naturopathic doctors, nurse practitioners or physician assistants.
2. In Section II, please include vaccine doses with month, day and year for each administered dose. Immunization dates, as specified in the administrative rules, are necessary. Please sign and date the form.
3. **If the child is completing a vaccine series,** a Conditional Attendance form can be used. The physician or health department will determine the date of each dose to be administered and put the schedule on the Conditional Attendance form. Please sign the Conditional Attendance form, and return to the school or child care facility.
4. Immunization forms can be obtained directly from the local health department or the Montana Immunization Program at www.immmunization.mt.gov.

School and Child Care Official

1. **Prior to attending**, all students and child care facility attendees must have either **a)** the required immunizations **and documentation** or **b)** have completed the appropriate exemption or conditional attendance documentation. This includes transfer students.
2. **Documentation** must meet the criteria of the Administrative Rules of Montana. This is **limited** to other school health records and certain documents from health departments and physicians.
3. **Transferring information from supporting documentation to this form** must be done by a school or child care official. The school or child care official must then sign and date the form (Section II) and attach the supporting documentation.
4. **Conditional Attendance** form, once completed and attached to this document, allows attendance so long as immunization continues as scheduled.
5. **School Transfer Students**.

There is no transfer period allowed. Transfer students must provide adequate documentation of immunization **PRIOR** to attending school.

a) **Transferring In:** Students who transfer into Montana from out of state must have their immunization information recorded on this form (*See number 2 above regarding acceptable documentation.)* Students must meet Montana immunization requirements.

b) **Transferring Out:** If students transfer out of your school, a **copy** of this record should be maintained for one year following the transfer. The Montana law requires schools to forward the original Certificate of Immunization to the school to which students transfer.

c) **Homeless Students:** All homeless students must be immediately enrolled in a Montana school to ensure compliance with the McKinney-Vento Act. Students should be assigned a liaison who can assist them in obtaining either appropriate documentation of immunization or in obtaining the required immunizations.

Parent

1. Montana law requires immunization information be recorded on this document for persons to attend Montana schools, preschools and child care facilities.
2. **ONLY school, child care and health officials can complete this form.** School and child care officials need documentation from physicians or health departments as described by the Administrative Rules of Montana (*examples: A completed Montana Certificate of Immunization; A signed Immunization record card).* **It is the parent's responsibility to provide these documents to the school or child care facility.**
3. **Religious exemption and conditional attendance** may be used in accordance with the Immunization Law and Administrative rules. The Religious Exemption may be used in school settings and must be renewed annually. Religious exemption for child care only applies to Haemophilus influenzae type b (Hib), and must be renewed annually.
4. Montana law prohibits children from attending any Montana school or child care facility **prior** to meeting immunization requirements.
5. If your child transfers to another Montana school, a copy of this completed form will allow your child to enter that school. However, the original Certificate of Immunization must be provided to the new school within 30 days of transfer in order for the child to attend.

SECTION IV EXEMPTIONS

Please refer to the form HES101A at
https://dphhs.mt.gov/assets/publichealth/Immunization/HES101A.pdf

SECTION V LEGAL REFERENCES

Montana Codes Annotated
20-5-101 - 410: Montana Immunization Law
52-2-735: Day Care Certification

Administrative Rules of Montana
37.114.701-721: Immunization of K-12, Preschool and Post secondary Schools
37.95.140: Day Care Center Immunizations
Group Day Care Homes – Health
Family Day Care Homes – Health

If you have any questions about: 1) the use of this form; 2) obtaining copies of immunization forms, laws, or rules; or 3) whether or not a person meets attendance requirements, please contact your local health department or the Montana Immunization Program, DPHHS, Cogswell Building, Helena, MT 59620. Phone (406)444-5580.

https://immunization.mt.gov

FORM No. IZ HES101 (Revised 06/2018)

DPHHS-QAD/CCL-120
(Revision 11/19)

NON-INGESTIBLE OVER THE COUNTER MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____ Date of Birth____/____/____

Program Name _____

****

I give permission for the administration of the following non-ingestible over the counter medications (mark all that apply):

- ☐ Diaper Rash Cream/Ointments _____
- ☐ Insect Repellent _____
- ☐ Sunscreen _____
- ☐ Cortisone/Anti-Itch Creams/Ointments _____
- ☐ Medicated Lip Treatments _____
- ☐ OTC Antibiotic Creams/Ointments _____
- ☐ Burn Creams/Sprays _____
- ☐ Other Non-Ingestible OTC's: (Please Specify) _____

_____

_____

To administer a non-ingestible over the counter medication:

- The medication must be brought to the day care facility from the parent;
- The medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

Special handling/storage Instructions_____ Refrigeration? ____

Parent/Guardian Signature (required)_____ Date: ____/____/____

* **This document must be updated on an annual basis.**

Unused Medication: (check one) Returned to Parent Y☐ N☐ Discarded appropriately Y☐ N☐

By: _____ **Date:** ____/____/_____

***Keep in the child's file when medication is finished.**

DPHHS-QAD/CCL-121
(Revision 10-06)

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth____/___/___
Program Name_____Today's Date____/___/___

****

To administer a prescription medication:

- The medication must be in it's original container, with a legible label from the pharmacy indicating the child's name, date, name of medicine, dosage, and time, number of days medication is to be given, and expiration date of medication, doctor's/nurse practitioners name, pharmacy name and telephone number
- Samples must be accompanied by a doctor's written prescription
- Medications are to be given only to the child indicated on the label (twins and siblings can not share.)
- A separate authorization is required for *each medication* and *each episode* of illness
- Label constitutes the physicians/nurse practitioner's order
- Parent/Guardian is to give as many doses as possible at home.

Medication:_____
Reason for medication:_____
Start date____/___/___ End date___/___/____
Dosage:_____ Times to be given at child care:_____AM_____PM

First dose was given at_____AM/PM on date___/___/____ (Medication Log needs to reflect Parent's first dose for each day.)
Route: by mouth, skin (location)_____, eye (R/L)

Possible side effects:_____

Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____
Physician/Nurse Practitioners Signature_____

****

Non-Prescription Medication:

- Parent is required to bring these medications from home.
- Medication must be in an original container, with child's name on the container.

Medication:_____Health Care Provider_____
"For children under 2, list the name of the health care provider who recommended this medication."

Reason for medication:_____
Start date____/___/___ End date___/___/____
Dosage:_____ Times to be given at child care:_____AM_____PM

First dose was given at_____AM/PM on date___/___/____ (Medication Log needs to reflect Parent's first dose for each day.)
Route: by mouth, skin (location)_____, eye (R/L)
Possible side effects:_____
Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

Unused medication: Returned to Parent Y/N Date ____/____/____ or Discarded appropriately Y/N Method _____

By: _____ Date ____/_____/_____

***Keep in the child's file when medication is finished.**

GATHERING PLACE
A children's learning center for all.

Sleeping Permission

I give my child _____, permission to sleep on a cot/mat, provided by The Gathering Place: Early Learning Center, during rest time. I understand that each cot/mat is individually assigned, has clean linens and is only used by my child.

Parent/Guardian Name (Print) _____

Parent/Guardian Name (Sign) _____

Date _____

GATHERING PLACE
A children's learning center for all.

Sleeping Permission

I give my child _____, permission to sleep on a cot/mat, provided by The Gathering Place: Early Learning Center, during rest time. I understand that each cot/mat is individually assigned, has clean linens and is only used by my child.

Parent/Guardian Name (Print) _____

Parent/Guardian Name (Sign) _____

Date _____

Walking Field-Trip Permission Form

To enhance the learning and play experiences of all children, there are times that teachers would like to take the children on walks to neighborhood businesses and/or parks. When these times occur, teachers will notify parents/guardians in advance with the time and location. Please sign below, to allow your child to participate in these learning experiences. If you do not wish for your child to participate, an alternative activity will be planned for your child. Walking Field-Trips follow the guidelines in The Gathering Place Family Handbook.

_____ Yes, I allow my child to participate in Walking Field-Trips.

_____ No, I do not allow my child to participate in Walking Field-Trips.

Child Name:

Parent Name:

Parent Signature:

Date:

GATHERING PLACE
A children's learning center for all.

Photo Release Form

no names will be applied to photos

Do you give permission for your child's photograph to be used within The Gathering Place: Early Learning Center publications?

Ex. Newsletters, classroom, portfolios, SmartCare

____ Yes, I give permission for my child's photograph to be used.

____ No, I do not give permission for my child's photograph to be used.

Do you give permission for your child to have public photo release?

Ex. Bozeman United Methodist Church, Field trip locations, School/Church website

____ Yes, I give permission for my child's photograph to be used.

____ No, I do not give permission for my child's photograph to be used.

Child Name:

Parent Name:

Parent Signature:

Date:

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CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Institution or Facility Name:

Part 1. Name of Child(ren) Enrolled:

	☐
	☐
	☐
	☐
Full names of all household members	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.

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR] or [TANF cash assistance], 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. If any child you are applying for is homeless, a migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)

Total number in household: _____

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** *(if $0, please write $0. Any field left blank will be accepted as representative of "no income"* 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	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

This section required for all forms listing income in Part 4:

Last four digits of Social Security Number: X X X - X X - _ _ _ _ ☐ I do not have a Social Security Number

Part 5. Signature (Adult must sign)

An adult household member must sign this form.

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: _____

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

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

Part 7. Decline to provide information

I choose not to provide information about my household size and income.

_____ _____

Signature of Adult Household Member Date

*****This Section is to be completed by the Child Care Institution – Determination of Eligibility*****

Completion of this section is <u>required</u> for the institution to claim meals at the free or reduced rate for the child/children listed in Part 1: Name of Child(ren) Enrolled.

Number of persons in the household: _____

Total income $ _____ Per: ❑Week ❑Every 2 Weeks ❑Twice A Month ❑Month ❑Year
(Annual Income Conversion: weekly x 52, every 2 weeks x 26, twice a month x 24, monthly x 12)

Categorical Eligibility: ❑Free ❑Reduced ❑Paid ❑Tier I ❑Tier II

Required: Determining Official's Signature: _____ Date: _____

Additional official signatures are recommended but not required.

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), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant 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 <u>USDA Program Discrimination Complaint Form</u>, (AD-3027) found online at: <u>http://www.ascr.usda.gov/complaint_filing_cust.html</u>, 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: <u>program.intake@usda.gov.</u> This institution is an equal opportunity provider."

Head Start: Children who are enrolled in the Federal Head Start Program receive meal benefits in the CACFP without further application or eligibility determination. Acceptable documentation includes a current approved Head Start application or a written, signed and dated statement or roster from a Head Start official. [USDA Memos CACFP 7-2008 and CACFP 10-2008]

Revised 9/12

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

INFANT FEEDING SCHEDULE

Infant/Child's Name: _____ Date of Birth: _____

Parent's Name: _____

An individual form must be completed for all infants, ages 0 to 18 months.

Note the type of breast milk, infant formula, milk, and other foods that the infant normally uses and the average daily amount they consume. **This needs to be updated any time food is added to an infant's diet.**

	Type	Average Daily Amount
Breast Milk:		
Infant Formula:		
Milk:		
Other Foods:		

List the approximate times that the infant eats, what the infant normally eats at each designated time, and the approximate amount (i.e. ounces):

Time:	Breast Milk, Infant Formula, Milk, and Other Foods

List any special considerations, (i.e. food allergies):

_____

_____

_____

_____

_____ _____

Parent Signature Date Provider Signature Date

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
State of Montana -- Pediatric Health Statement

Infant/Child's Name: _____ **Date of Birth:** _____

Parent's Name: _____

EXAMINATION:

Known Health Conditions: _____

Allergies (specific): _____

Special Medication: _____

Immunizations Current: _____

Restrictions: _____

Comments: _____

_____

_____

I have examined _____ **and find no unusual health risks to him/her or to other children in the day care setting.**

_____
(PLEASE PRINT - Provider's Name)

_____ **Date:** _____
(Signature)

PLEASE CONSULT: ARM 37.95.128

 # DPHHS-DCH-200, revised 12/2004

SPECIAL NEEDS HEALTH CARE PLAN

-To be approved by a Health Care Provider-

Today's Date	
Child' Full Name	Date of Birth
Parent's/Guardian's Name	Telephone No. ( )
Primary Health Care Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Diagnosis(es)	
Allergies	

ROUTINE CARE

Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects

List medications given at home:

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

Classroom Activities: _____

Naptime/Sleeping: _____

Toileting: _____

Outdoor or Field Trips: _____

Transportation: _____

For Behavior Changes: _____

Additional comments: _____

_____

SPECIAL NEEDS HEALTH CARE PLAN

-continued-

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

_____

_____

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

_____

_____

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

_____

_____

_____

SUGGESTED SPECIAL TRAINING FOR STAFF

_____

_____

_____

Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)

_____

_____

_____

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider to discuss any of the information contained in this care plan.

Parent/Guardian Signature	Date

Important: *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of the child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*