ENROLLMENT PACKET

Connections
Child Care & Learning Center

125 Mallow Lane
Covington, VA 24426

Phone: 540-962-0051
Fax: 888-877-7879

Email
office@connectionsinfo.com

Director/Owner
Mindy Gardzinski

Website
www.connectionsinfo.com

We are so excited that we are open and working with your child and family!

I wanted to let you know that we have been approved as a subsidy provider.

- **The income levels have been raised** to receive assistance.
- You may qualify even if your family meets the following monthly income:

3 Person	4 Person	5 Person
$6,787	$8,080	$9,372

To apply go to:

1) https://commonhelp.virginia.gov/access/

2) Scroll down to the red block, "Apply for all benefits"

3) You will be asked to enter information and even if not seeking assistance other than childcare, you will have to fill out this information.

4) From here, the Department of Social Services has 30 days to make a determination, but it has been taking only about a week.

*I would suggest following up in about a week and a half if you haven't heard anything.

Covington/Alleghany-540-965-1780 ext 266
Botetourt County-540-529-8212

	5 day/ week	3 Day/ Week	Drop in per day	Before School Weekly	After School Weekly	Before & After School Weekly
Infant	$185.00	$130.00	$55.00			
16 months- 2 years	$170.00	$125.00	$50.00			
3-5 years	$150.00	$115.00	$45.00			
Full Day Preschool Only/ No Childcare ** (9:00 am-3:00 pm)	$100.00	$80.00				
5-8 years			$35.00	$75.00	$95.00	$150.00
9-12 years			$35.00	$75.00	$95.00	$150.00

*Those with 2 or more children will receive a 10% discount on monthly tuition credited towards the next month.

**Children here for daycare will receive a full day preschool program included as part of their tuition.

We are a SUBSIDY provider. **We can help you fill out the application. Contact us for more information.**

VIRGINIA DEPARTMENT OF EDUCATION
CHILD REGISTRATION

Child	Nickname	Date of Birth	Sex
Address			Home Phone
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed			
Previous Child Day Care Programs and Schools Attended			
If Child Attends this Center and Another School/Program, Give Name of School/Program			Grade or Class Level

PARENT(S)/GUARDIAN(S)

Parent	Place Employed	Work Phone
Home Address		Home Phone
Parent	Place Employed	Work Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Work Address		Work Phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency		
Child's Physician		Phone
Two People To Contact if Parent(s) Cannot Be Reached 1.	Address 1.	Phone 1.
2.	2.	2.
Person(s) Authorized To Pick Up Child		
Person(s) NOT Authorized To Pick Up Child*		

- Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
- NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center (i) shall not be denied the opportunity to participate in any of the student's school or day care activities in which such participation is supported or encouraged by the policies of the school or day care center solely on the basis of such noncustodial status and (ii) shall be included, upon the request of such noncustodial parent, as an emergency contact for the student's school or day care activities.

AGREEMENTS

1. The child day center agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain emergency medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_____ _____

Parent(s) or Guardian(s) ***Date***

_____ _____

Administrator of Center ***Date***

First Date of Attendance: _____ Last Date of Attendance: _____

** If there is an objection to seeking emergency medical care, a statement should be obtained from the parent(s) or guardian(s) that states the objection and the reason for the objection.

OFFICE USE ONLY
IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

Place of Birth	**Birth Date**	**Birth Certificate Number**	**Date Issued**
Other Form of Proof		**Date Documentation Viewed**	**Person Viewing Documentation**

Date of Notification of Local Law-Enforcement Agency (when required proof of identity is not provided):

_____

Date

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Section § 22.1-289.049 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction, or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding, (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means..

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/____/_____ Sex: _____ State or Country of Birth:_____Main Language Spoken: _____

Student's Address_____ City_____ State_____ Zip Code_____

Name of Parent or Legal Guardian 1:_____Phone:_____-_____-_____Work or Cell: _____ - _____-_____

Name of Parent or Legal Guardian 2:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Emergency Contact:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Private/Commercial/ Employer Sponsored☐ _____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐ Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I_____(do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian:_____Date:_____/_____/_____

Signature of Interpreter: _____Date_____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** **Hispanic** **Non-Hispanic**

IMMUNIZATION	**RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN**				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	**1**	**2**	**3**	**4**	**5**
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	**1**	**2**	**3**	**4**	**5**
Tdap Vaccine booster	**1**				
Poliomyelitis Vaccine (IPV, OPV)	**1**	**2**	**3**	**4**	**5**
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	**1**	**2**	**3**	**4**	
Rotavirus Vaccine (RV) only for children < 8 months of age	**1**	**2**	**3**		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	**1**	**2**	**3**	**4**	
Varicella Vaccine	**1**	**2**	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	**1**	**2**			
Measles Vaccine (Rubeola)	**1**	**2**	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	**1**	**2**	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	**1**	**2**	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	**1**	**2**	**3**	**4**	
Hepatitis **A** Vaccine	**1**	**2**			
Meningococcal **ACWY** Vaccine	**1**	**2**			
Meningococcal **B** Vaccine	**1**	**2**	**3**		
Human Papillomavirus Vaccine (HPV)	**1**	**2**	**3**		
Influenza (Yearly)	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____**Date (*Mo., Day, Yr.*):** ___/___/____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[_____]; RV:[____]; Measles :[_____];

Mumps:[____]; Rubella :[____]; VAR:[_____]; Men ACWY:[____]; Men B:[____]; Hep A:[_____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |_____|_____|_____|.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth:_____/_____/_____Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

- ❑ Age / gender appropriate history completed
- ❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date:_____ TST Reading____ mm TST/IGRA Result: □ Negative □ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ □ Normal □ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Referred

	1000	2000	4000
R			
L			

□ Referred to Audiologist/ENT □ **Unable to test – needs rescreen**

□ Permanent Hearing Loss Previously identified: □ Left □ Right

□ Hearing aid or another assistive device

Vision Screen

□ With Corrective Lenses (Check if yes)

Stereopsis □ Pass □ Fail				□ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

□ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

Dental Screen

□ Problems Identified: Referred for Treatment

□ No Problem: Referred for prevention

□ No Referral: Already receiving dental care

☐ **Unable to perform**

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):

□ Well child; no conditions identified of concern to school program activities

□ Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

____**Allergy:** □ food:_____□ insect:_____ □ medicine:_____ □ other:_____

Type of allergic reaction: □ *anaphylaxis* □ *local reaction Response required:* □ *none* □ *epinephrine auto-injector* □ other::_____

____In**dividualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

____**Restricted Activity Specify:** :_____

____**Developmental Evaluation** □ Has IEP □ Further evaluation needed for: _____

____**Medication.** Child takes medicine for specific health condition(s). □ Medication must be given and/or available at school.

____**Special Diet Specify:** _____

____**Special Needs Specify:**_____

Other Comments:_____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name:_____ **Signature:**_____**Date:**_____

Practice/Clinic Name: _____ **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____

Connections
Child Care & Learning Center

Physician: Please complete this form if an allergy is noted on the physical form.

ALLERGY CARE PLAN FOR A CHILD WITH DIAGNOSED FOOD ALLERGIES

Child's Name:	**Child's Date of Birth:**
Name of the Child's Health Care Provider:	
Food Allergies:	

Steps to be taken in the event of a suspected or confirmed allergic reaction:

Signature of Authorized Program Representative: I understand that it is my responsibility to follow the above plan. This plan was developed in close collaboration with the child's parent and the child's health care provider. I understand that staff who provide all treatments and administer medication to the child listed in the allergy care plan must have received Medication Administration Training; is CPR and first aid certified; or has a license that exempts them from training; and have received any additional training needed.

Provider/Facility Name:	**Facility address:**	**Facility Telephone Number:**
Authorized child care provider's name (please print)		**Date:**
Authorized child care provider's signature:		

Signature of Parent or Guardian:	**Date:**
Signature of Health Care Provider:	**Date**

Connections
Child Care & Learning Center

Authorization Form for
Non-prescription Over-the-Counter Skin Products
8VAC20-780-520

INSTRUCTIONS:
This form must be completed by the parent/guardian to authorize the use of:

- Sunscreen
- Diaper ointment or cream
- Insect repellent

Connections Childcare & Learning Center has my permission to apply the non-prescription over-the-counter (OTC) skin product listed below to my child _____
Child's Name

Product Name: _____

Known Adverse Reactions (if any): _____

- All OTC products must:
  - Be in the original container and, if provided by the parent, labeled with the child's name
  - Be used according to manufacturer's recommendation and instructions for application
  - Not be used beyond the expiration date of the product
- Sunscreen:
  - Must have a minimum sunburn protection factor (SPF) of 15
  - Shall be inaccessible to children under 5 yrs. & children in therapeutic or special needs programs
  - Children nine yrs. and older may self administer sunscreen if supervised
- Diaper ointment/cream and Insect repellents:
  - Shall be kept inaccessible to children
  - Record of use shall be kept that includes the child's name, date of use, frequency of application and any adverse reactions

This authorization is effective from: _____until: _____
(Today's Date/Start date) **(End date/1 year from start date)**

Parent's Signature: _____ **Date:** _____

Additional Permissions

Child's Name: _____

Parent's Name: _____

An agreement must be on file for each child enrolled and will be updated annually.

Parent Handbook Contract Agreement

I have read the Connections Parent Handbook and agree to support the philosophy and policies of Connections Childcare and Learning Center.

_____ _____
Parent/Guardian's Signature Date

Consent to Medical Treatment

I consent to have staff perform basic first aid and in the case of an emergency, for the staff at Connections Childcare & Learning Center to call 911 for emergency medical treatment which may involve, in rare circumstances, transporting my child to the hospital via ambulance. A Connections staff member will accompany my child if myself or one of my designees isn't there before the child is transported to the hospital.

I understand that I (the parent/guardian) will be responsible for all charges not covered by insurance.

_____ _____
Parent/Guardian's Signature Date

Agreement to Pick up Child if they are Sick

I agree to pick up my child if they become sick during the day. I agree that myself or one of emergency contacts should arrive as soon as possible but must be picked up within 1.5 hours of initial contact by the Director or Designee

_____ _____
Parent/Guardian's Signature Date

Communicable Disease Notification

I agree to inform the center immediately but no more than 24 hours later if my child or any member of the immediate household have developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately. (See the handbook or VDH.gov for a list of communicable diseases)

_____ _____

Parent/Guardian's Signature Date

Media Release

Occasionally, photos will be taken of the children at the center for use within the center or on our website, social media, and/or newsletters. Please indicate that you authorize the use and reproduction of photographs of your child in conjunction with the program.

Please initial if your choice below:

_____ I authorize the use and reproduction of photographs of my child in conjunction with the program

_____ I DO NOT authorize the use and reproduction of photographs of my child in conjunction with the program

ProCare Pictures

I consent to have staff send me pictures of my child throughout the day using the ProCare Communication System.

_____ _____

Parent/Guardian's Signature Date

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (IEF) FOR CHILD CARE CENTERS and FAMILY DAY CARE HOMES

Center Name Connections Child Care & Learning Ctr

1 All Household Members

	NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last	Check if NO income	Ages of children in care	2 FOSTER CHILD Skip to Part 6 if all are foster children.	3 SNAP, TANF or FDPIR CASE # Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. SNAP and TANF MUST BE NINE (9) DIGITS
1.		☐		☐	
2.		☐		☐	
3.		☐		☐	
4.		☐		☐	
5.		☐		☐	
6.		☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison or Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc.	
	Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number box.*

X X X - X X - _____

Social Security Number

☐ **I do not have a social security number.**

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.

Date | *Printed Name of Adult Household Member* | *Signature of Adult Household Member*

7 Contact Information (Optional)

Work Telephone Number (Include Area Code) | ( ) *Home Telephone Number (Include Area Code)* | *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS*, the complete health insurance program for every child in Virginia ? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS.

Date _____ Sign Here _____

CHILD CARE REPRESENTATIVE USE ONLY - ELIGIBILITY DETERMINATION - COMPLETE SECTIONS A and B BELOW

SECTION A

Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

Convert income only if different frequencies of pay are reported.

TOTAL INCOME Per $_____ ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:**_____

☐ **FREE** based on:	☐ **REDUCED** based on:	☐ **DENIED** Reason:
☐ foster child ☐ migrant ☐ SNAP, TANF, FDPIR ☐ homeless ☐ runaway ☐ household income	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/TANF

SECTION B

Signature of Determining Official: _____ **Date:** _____

Nondiscrimination statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Virginia Child and Audit Care Food Program (CACFP)
(Child) Annual Enrollment Form (AEF)

CENTER/PROVIDER COMPLETE THIS SECTION

Connections Child Care & Learning Ctr

Center/Provider Name

125 Mall Road	Covington	VA	24426
Street Address	*City*	*State*	*Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement to provide nutritious meals for children. Federal CACFP regulations require all parents/guardians to complete and sign a separate Annual Enrollment Form for each child when enrolling their child (ren) with this provider, and every 12 months thereafter. **The parent or guardian must complete and ensure accuracy of Sections 1 through 6 below.**

This form is required for:	This form is NOT required for:
Child Care Centers, Family Day Care Homes	Outside School Hours Care Centers, Emergency Shelters

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)

Child's First Name

Child's Last Name

Date of Birth (mm/dd/yyyy)

Age

2 DAYS OF WEEK IN ATTENDANCE

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

3 TIMES CHILD NORMALLY ATTENDS CARE DURING THE WEEK

TIME IN	TIME OUT	SPORADIC SCHEDULE (not set schedule of days)

NOTES:

4 MEALS RECEIVED

- ☐ Breakfast
- ☐ AM Snack
- ☐ Lunch
- ☐ PM Snack
- ☐ Supper
- ☐ EV Snack

5 Parent/Guardian Signature and Date: ***By signing this form, I certify that I am the parent/legal guardian of the child named in Section 1 of this Annual Enrollment Form and that the information contained on this form is true and correct.***

Printed Name:	*Signature:*
Street Address:	*City, State, Zip Code:*
Phone Number HOME / WORK / CELL (circle one):	*Date:*

Nondiscrimination statement: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form . To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:
(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

6 Ethnic and Racial Identification: ***Parent/Guardian to complete. Please select ONE Ethnicity; Please select ONE OR MORE Races***

ETHNIC IDENTIFICATION

- ☐ **Hispanic , Latino or Spanish Origin:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- ☐ **Not Hispanic, Latino or Spanish origin**
- ☐ **I decline to answer.**

RACIAL IDENTIFICATION

- ☐ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains culture identification through tribal affiliation or community attachment (includes Aleuts and Eskimos).
- ☐ **Asian:** A person having origins in any of the original peoples of the Far East , Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **Black, African American, or Haitian:** A person having origins in any of the black racial groups of Africa .
- ☐ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- ☐ **I decline to answer.**

VIRGINIA CACFP
Child and Adult Care Food Program

PARENT/GUARDIAN CHOICE FORM (INFANT)

NAME OF INFANT:	_____ *(First Name, Middle Initial, Last Name)*	DATE OF BIRTH:	_____ *(mm/dd/yyyy)*

This center/provider participates in the Child and Adult Care Food Program (CACFP) and receives Federal USDA funding for serving nutritious meals to infants and children. Participation in the CACFP requires caregivers to follow specific meal patterns according to age group classifications detailed in forms *CACFP-009 Child Meal Pattern* and *CACFP-010 Infant Meal Pattern.*

(Center/Provider) Connections Child Care & Learning Ctr agrees to feed your infant breast milk provided by parent/guardian. The center/provider will provide iron-fortified infant formula. The formula provider is _____

Federal regulations require centers/providers participating in the CACFP to offer iron-fortified formula to infants who are in care during meal service times. Parents/guardians may decline the center/provider offered formula and supply the infant's formula, provide expressed breastmilk, or breastfeed on site.

PLEASE INDICATE PREFERENCES *(Choose all options that apply by initialing and dating in the appropriate space(s))*	**BIRTH - 5 MONTHS**	**6 MONTHS - 11 MONTHS**
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED FORMULA	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 2: PARENT/GUARDIAN WILL PROVIDE FORMULA	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 3: PARENT/GUARDIAN WILL PROVIDE EXPRESSED BREASTMILK	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 4: BREASTFEEDING WILL OCCUR ON SITE	INITIALS: DATE: _____	INITIALS: DATE: _____

BREASTFEEDING FRIENDLY CENTERS/PROVIDERS ARE ENCOURAGED!

Many centers and providers now have designated space onsite for breastfeeding.

Ask your center representative or day care home provider for details!

Federal regulations also require centers/providers participating in the CACFP to provide iron-fortified infant cereal and other foods when the child is developmentally ready.

PLEASE INDICATE PREFERENCES	**BIRTH - 5 MONTHS**	**6 MONTHS - 11 MONTHS**
OPTION 1: CENTER/PROVIDER OFFERED IRON-FORTIFIED CEREAL AND OTHER FOODS BASED ON THE CACFP MEAL PATTERN	INITIALS: DATE: _____	INITIALS: DATE: _____
OPTION 2: PARENT/GUARDIAN WILL PROVIDE CEREAL AND SOLID FOODS WHEN THE TIME IS APPROPRIATE	INITIALS: DATE: _____	INITIALS: DATE: _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

1. THIS FORM MUST BE KEPT **CURRENT, ACCURATE AND ON FILE** FOR EACH INFANT ENROLLED IN CHILD CARE UNTIL THE INFANT REACHES 1 YEAR OF AGE OR IS NO LONGER ON BREASTMILK OR INFANT FORMULA.
2. BREASTMILK IS AN ACCEPTABLE MILK SUBSTITUTE FOR CHILDREN OF ANY AGE WITHIN THE CONTEXT OF THE CACFP.
3. AS SITUATIONS CHANGE, SUCH AS A MEDICAL AUTHORITY CHANGING AN INFANT'S FORMULA, A NEW FORM MUST BE COMPLETED.
4. IF THE PARENT/GUARDIAN DECLINES THE FORMULA AND THE CENTER/PROVIDER PROVIDES AT LEAST ONE **REQUIRED** MEAL AND/OR SNACK COMPONENT, THE MEAL OR SNACK MAY BE CLAIMED FOR REIMBURSEMENT.
5. IF THE PARENT/GUARDIAN DECLINES INFANT MEALS/SNACKS, THEY MAY NOT BE CLAIMED FOR REIMBURSEMENT.

This institution is an equal opportunity provider.

Acknowledgement of Financial Agreement

Child's Name: _____

Parent's Name: _____

Payment of Deposit

_____I have read the Connections Parent Handbook and understand and agree that the deposit (currently $100) is an **annual** deposit due at enrollment and that, once paid, the deposit is non-refundable for any reason. (The fee will be collected annually during the initial enrollment month.)

_____ _____

Parent/Guardian's Signature ` Date

Payment for Tuition

_____ I understand and agree that Tuition is to be pre-paid weekly as outlined in the Connections Parent Handbook.

_____ I further understand and agree that in the event my child is unable to attend childcare for any reason for the week that tuition has been pre-paid**, no refund will be made, nor will any transfer of payment be made to later dates.**

_____ _____

Parent/Guardian's Signature ` Date

Acknowledgement of Financial Agreement for Subsidy Recipients

Child's Name: _____

Parent's Name: _____

Subsidy Recipients:

I understand and agree that my responsibilities as a recipient of subsidy payments on behalf of my child for childcare are as follows:

1. _____ to keep in my possession my child's subsidy recipient number for check-in and check-out at the Center.
2. _____ to check-in and check-out using the subsidy card or phone system when picking up or dropping off my child. I understand it is my responsibility to give this information to the individual dropping off or picking up my child in my absence.
3. _____ to register ABSENCES by card or phone system **within 8 calendar days** of any date that my child is unable to attend childcare.
4. _____to register HOLIDAYS by card or phone system **within 8 calendar days** of the date of the holiday.
5. _____to prepay any COPAYMENTS **prior** to the week my child will attend childcare using the ProCare system. The Director may approve other means of payment of co-payments, but arrangements must be made, and payment delivered prior to attendance.

_____I further understand and agree that if I am unable or unwilling to register attendance, absences or holidays within the time period above, then charges for those dates become my personal responsibility and I agree to pay the full amount for any unregistered day on which my child attended childcare or for any unregistered absence or holiday.

_____I agree and understand that failure to pay for co-payments or for charges which become my responsibility due to unregistered attendance, absences or holidays will result in my child being ineligible to continue receive childcare at Connections.

_____ _____

Parent/Guardian's Signature Date