Dr. Day Care's Child Development Center Enrollment

Mailing Address: 462 Smithfield Avenue, Pawtucket, RI 02860
Toll Free- 1-877-333-1393 Fax Number 401- 475-4832
Mary Ann Shallcross Smith, Ed.D, President
Dr. Day Care

Today's Date ______________ Start Date: _______________

Child's Name _____________________________________ Nickname: _____________________ ❑ Female ❑ Male
Date of Birth ___________________ Social Security # _______________________________________
Address____
City____ State____________ Zip_____________________
Child's School __________________________________Home Telephone #____________________________
Referred By ____

PARENT INFORMATION:

Parent/Guardian :	Parent/Guardian :
Name _____________________________________	Name _____________________________________
Address ___________________________________	Address ___________________________________
License# __________________________________	License# __________________________________
Health Insurance ____________________________	Health Insurance ____________________________
Coverage Number ___________________________	Coverage Number ___________________________
Employed By _______________________________	Employed By _______________________________
Business Telephone # ________________________	Business Telephone # ________________________
Home Telephone # ___________________________	Home Telephone # ___________________________
Cell Telephone# ____________________________	Cell Telephone# ____________________________
Email Address ______________________________	Email Address ______________________________

PARENT'S AUTHORIZATION OF OTHER PERSON (S) CHILD MAY BE RELEASED TO FOR DEPARTURES AND/OR EMERGENCIES:

(Please note: Photo ID is required for pick up of your child)

- Name _________________________________ Address ____
  License # ________________________________ City/Town State Zip
  Telephone Number _______________________________ Relation to Child ________________________________
- Name _________________________________ Address ____
  License # ________________________________ City/Town State Zip
  Telephone Number _______________________________ Relation to Child ________________________________
- Name _________________________________ Address ____
  License # ________________________________ City/Town State Zip
  Telephone Number _______________________________ Relation to Child ________________________________

Does your child have any special needs? ❑ Yes ❑ No
Does your child have any allergies? If so please list here: ____
____
Are there any circumstances regarding your child's release?❑ Yes ❑ No
Any special instructions, such as custody or restraining orders <u>must be attached to this application and discussed personally with the director. All information will be kept confidential.</u>

<u>PARENT AUTHORIZATION FOR EMERGENCY TREATMENTS</u>

In consideration of the admittance, I ______________________________ hereby authorized Dr. Day Care, Inc. to
Parent
arrange for medical examination and/or treatment of my child, _________________________ should an emergency arise
Name
at school or on a field trip. It is understood that a conscientious effort will be made by the school to contact me at the emergency numbers I have provided below, before any medical action is taken. I would prefer to have my child, if the need arises, taken to________________________. (*Choice of hospital may be limited by service of local rescue.)
*Hospital
If your child is presently taking any medications, please list the name of the medication and dosage: _______________
____
(If child will need to take medication while at Dr. Day Care's Child Development Center, please request medication form from Director)

____ ____________________
Parent Signature **Date**

____
Director's Initials & Date

Parent Agreement Contract

Start Date:_______________ Child's Name ___________________________ Site____________________

- **Please fill in the hours needed for the program on the corresponding day (i.e. Tues 2:45-6:00pm).**
  AM: Monday ______ Tuesday _____ Wednesday _____ Thursday ______ Friday _______
  PM: Monday ______ Tuesday _____ Wednesday _____ Thursday ______ Friday _______
  *The tuition for services will be: $ __________ per week, based on the above schedule.
  (Full-time child care shall not exceed 50 hours per week.)
  Weekly Method of Payment: (circle) Cash Check EFT
- To secure a space for your child, a non-refundable registration fee and first week's tuition is required.
- A one time registration fee is $35 per child/$50 per family. An annual activity fee of $33 per child will be charged the 3rd week of September.
- The tuition and registration payment is due on or before the first day your child begins care. Thereafter tuition is due the Friday before the upcoming week of service. If paying by check, please write your child's name on the memo portion of your check and the week your payment is for.
- Our billing system automatically charges a $10.00 fee to any account not paid by closing Friday.
- Accounts in arrears may be subject to termination and parent/guardian is responsible for litigation.
- There will be a $25.00 charge for all returned checks.
- Late departures after closing are subject to a one dollar per minute late fee. After closing, if Dr. Day Care's is unable to contact you or the emergency contacts provided, local authorities will be called after a reasonable amount of time has passed.
- No child will be cared for when sick with an infectious illness, for the well being of your child, as well as others. Credit cannot be issued for a child who is out sick. For extended absences due to illness, parents may choose to use their one week's vacation credit. Please speak with site director or call our billing department (401-723-2277).
- When terminating a child's enrollment, a two-week notice must be given in writing to the site director. If no notice is given, your account will be billed accordingly.
  Vacation Credit - 2 weeks are allowed per year (Sep. – Aug.) at ½ of your regular tuition rate or you may have your child attend ½ time. See Director for more information.
- To maintain proper staff/student ratio, agreed upon dates and times on this contract can only be altered when another contract is completed.
- Please contact your Director ASAP if you need to change any of your personal information or schedule (Examples: emergency person, address, home/work telephone numbers, times, fees, medical info, etc)
- Dr. Day Care's will be closed all Rhode Island holidays. The weekly tuition payments will remain the same. Note: part-time enrollees, if your child is scheduled to attend on a holiday another day cannot be substituted because of staff/student ratio. Our program policy is to remain open unless the Governor declares a state of emergency.
- Inclement Weather/ Professional Days/ Election Days- (this section is only applicable for children in our school age program) If Dr. Day Care's is open for a full day in the event of inclement weather, teacher professional day or election day and your child normally attends either before or after school that day, you will be charged an additional $15 to your regular rate if your child attends for the full day. If a child is not scheduled for a given day and requires full day care, they will be charged the daily vacation rate.
- I hereby release Dr. Day Care, Inc., its officers, directors, and employees from all liability for injury to my child, in excess of the amount payable under the insurance carried by Dr. Day Care Inc.

Dr. Day Care's programs are designed to enhance and reinforce each stage of your child's development. If concerns or questions should arise regarding your child's participation, all parties will reach a solution. Dr. Day Care's enjoys your child and provides a happy, healthy, educational and enriching environment for them and hopes to meet your expectations.

Dr. Day Care's does not discriminate on the basis of race, color, sex, handicap, religion or national origin. Dr. Day Care's reserves the right at their sole discretion to refuse an application or dismiss a child from our program.

____
Parent Initials & Date

____
Director's Initials & Date

Electronic Funds Transfer / Electronic Credit Card Charge
Automatic Payment Agreement

Child(ren)'s name(s) ____

____
Dr. Day Care Site

Payment Plan I – Automatic Bank Draft (weekly draft from checking or savings account)

____ ____ Checking
Print Name on the Account ____ Savings

____
Address City State Zip

____
Name of Bank

______________________________ ______________________________
Routing Transit Number Account Number (attach voided check)

____ ________________
Authorized signature Date

Payment Plan II – Credit Card (weekly charge to credit card)

Type of account to be charged (check one): ____ Discover ____ MasterCard ____ Visa

____
Credit Card Number

________________________________ ___________________________
Expiration Date 3 Digit Security Code from Back of Card

____
Name as it Appears on the Account

____
Address City State Zip

____ ________________
Authorized signature Date

Bank Authorization

I authorize Kids Klub, Inc./Dr. Day Care to deduct $______________ on Friday of each week prior to the week of service from my account with the financial institution named above for payment of my weekly child care tuition. I understand that I have the right to stop these automatic payments upon 14 days written notice to Kids Klub, Inc./Dr. Day Care prior to the time my account is charged. I also understand that Kids Klub, Inc. reserves the right to end this payment plan and my participation therein. I understand that transactions returned unpaid by my financial institution will result in a $25 returned fee being added to my Kids Klub Inc./Dr. Day Care account.

Please start with the billing cycle beginning ______________ (month) ________ (day) __________(year).

______________________________________ ________________
Authorized signature Date

Payment Plan III I will pay weekly on Friday to Director by cash or check ____

____
Director's Initials & Date

Parent Authorization Page

<u>Field Trip Permission</u>: Field trips will be planned as part of the Dr. Day Care's Program for children over the age of 4. This will include walking to nearby areas as well as outdoor activities involving bus and/or van transportation. Every possible precaution will be exercised to assure the safety and welfare of your child. However, all authorized agents shall not be responsible, financially or otherwise, should any accidents occur. This checked box gives Dr. Day Care's staff permission to take your Child on any field trips and participate in any special presentations (example: puppet shows, storytellers, etc.). **If <u>any special circumstances, regarding field trips or presentations, apply to your child please notify your director in writing immediately.</u>** ❑ **yes** ❑ **no**

<u>Hospital/ Emergency Permission:</u> I authorize Dr. Day Care's to act as the agent of the parents in an emergency situation for the health and welfare of my child. I am responsible for the expenses involved if the services of a physician or hospital are required. ❑ **yes** ❑ **no**

<u>Photograph and Video Permission:</u> I give Dr. Day Care's staff permission to take photographs and/or videos of my child for public relations and /or marketing purposes. Photos will remain archived at Dr. Day Care's Home Office and can be used for promotional purposes without notification. ❑ **yes** ❑ **no**

<u>School Department Permission:</u> (*for school age children only*) I give Dr. Day Care's staff permission to obtain medical and federal food program forms from the elementary school's designee. I give Dr. Day Care's staff permission to communicate with school department teachers/ staff regarding homework and tutoring assistance for my child. ❑ **yes** ❑ **no**

<u>Sunscreen Permission:</u> Dr. Day Care Staff has permission to apply sunscreen to my child. ❑ **yes** ❑ **no**

Check one:

❑I will supply a labeled sunscreen for each of my children enrolled at Dr. Day Care.
The brand I will provide for my child's use is: ____
I understand that it is my responsibility to maintain an adequate supply of sunscreen for my child.

❑I would like Dr. Day Care to provide Rocky Mountain brand sunscreen for my child for a fee of $5.00 for the entire summer. The $5.00 will be added directly to my invoice.

____

Child's Name

If you have any concerns about any of the above listed, please make a note here.

____

____

____

____

Parent Initials & Date

____

Director's Initials & Date

CHILD'S PHYSICAL DESCRIPTION

Please fill in below or include child's photo here

Child's Name ______________________________________

Eye Color ______________________________________

Hair Color ______________________________________

Height ______________________________________

Weight ______________________________________

Birthmarks ______________________________________

Bone Structure ______________________________________

Racial/Ethnic Identity ______________________________________

In order to provide the utmost quality care for your child, please be sure to include in the following space provided any important information regarding your child (i.e. emotional, social, physical or behavioral information which would be important for us to know):

____

____

____

____

____

____
Director's Initials & Date

DHS Absenteeism Form Letter

(This form is to be filled out by families which receive the child care subsidy from the Dept. of Human Services. If you do not receive DHS financial assistance you do not need to fill out this form)

To Whom It May Concern:

During the week of ______________________________

my child(ren) ______________ ______________

______________ ______________

did not attend Dr. Day Care, Inc. at ______________ because of
(name of site)

____
(reason for absence)

Sincerely,

______________________ ______________
(parent signature) (date)

- -

DHS Absenteeism Form Letter

(This form is to be filled out by families which receive the child care subsidy from the Dept. of Human Services. If you do not receive DHS financial assistance you do not need to fill out this form)

To Whom It May Concern:

During the week of ______________________________

my child(ren) ______________ ______________

______________ ______________

did not attend Dr. Day Care, Inc. at ______________ because of
(name of site)

____
(reason for absence)

Sincerely,

______________________ ______________
(parent signature) (date)

____
Director's Initials & Date

DHS Family Consent Form

(This form is to be filled out by families which receive the child care subsidy from the Dept. of Human Services.
If you do not receive DHS financial assistance you do not need to fill out this form)

Today's Date: _______________

To Whom It May Concern:

I ____ authorize the staff and members of the Dr. Day Care, Inc. to
(parent name who is applying - please print)
advocate on my behalf with officials at the Rhode Island Department of Human Services.

Further, I authorize the Department of Human Services to release and discuss any and all relevant information about my case with these representatives of the day care.

My childs(ren) names: 1. _________________________ Certificate Number: ______________________

2. _________________________

3. _________________________

4. _________________________

Please contact me with any questions or concerns.

____ ______________________________________
Parent's Signature Parent Name (please print)

____
Address

__________________________________ ____________________ ______________________
City State Zip Code

____ ____
Home Telephone Number Cell Phone Number

____
Director's Initials & Date

School Name & Address:	STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM	Health Care Provider Name and Address: Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex M [ ] F [ ]

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript). The requested information is in accordance with the State of Rhode Island *Rules and Regulations for: Immunization and Testing for Communicable Disease, School Health Programs, and Lead Poisoning Prevention.* Website: www.rules.state.ri.us/rules

IMMUNIZATIONS					
Hepatitis B	___/___/___	___/___/___	___/___/___		
Diphtheria-Tetanus- Pertussis DTP/DTaP	___/___/___ Check [ ] if DT	___/___/___ Check [ ] if DT	___/___/___ Check [ ] if DT	___/___/___ Check [ ] if DT	___/___/___ Check [ ] if DT
Pneumococcal Conjugate PCV	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___ [ ] IPV or [ ] OPV	___/___/___ [ ] IPV or [ ] OPV	___/___/___ [ ] IPV or [ ] OPV	___/___/___ [ ] IPV or [ ] OPV	
Haemophilus Influenzae Type B Hib	___/___/___	___/___/___	___/___/___	___/___/___	
Measles-Mumps-Rubella MMR	___/___/___	___/___/___			
Varicella	___/___/___	___/___/___	[ ] Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap	___/___/___				
Tetanus-Diphtheria Td	___/___/___	___/___/___	___/___/___		
Meningococcal	___/___/___	___/___/___			

Immunization Exemption: Medical [ ] Religious [ ]

[ ] Hepatitis B [ ] DTaP [ ] PV [ ] Hib [ ] PCV [ ] MMR [ ] Varicella [ ] Td/Tdap

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height __________ Weight__________ BP__________

Please note any health problem, chronic health condition, or disability that may affect behavior or health at school:

ASTHMA: No [ ] Yes [ ] DIABETES: No [ ] Yes [ ] OTHER: ____________________

Significant Systems Findings: ____________________

ALLERGIES: No [ ] Yes [ ] (Please explain) ____________________ EPINEPHRINE AUTO-INJECTOR REQUIRED: No [ ] Yes [ ]

Treatment Plan: ____________________

MEDICATION (REQUIRED AT SCHOOL): No [ ] Yes [ ] (Please list) ____________________

Other medication(s) that may affect behavior or health at school: ____________________

RESTRICTIONS: Can participate in physical education: Fully [ ] With limitation [ ] ____________________

Can participate in sports: Fully [ ] With limitation [ ] ____________________

LEAD SCREENING (Required for children < 6 years of age only)	VISION SCREENING (Required for children entering kindergarten)	SCOLIOSIS SCREENING
Student is in compliance with lead screening requirements: Yes [ ] No [ ]	[ ] Pass [ ] Failed and referred for comprehensive exam [ ] Not screened and referred for comprehensive exam	Yes [ ] No [ ]

TUBERCULOSIS (If required by school district) Date of TB test:	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

HEALTH CARE PROVIDER SIGNATURE: ____________________ DATE: __________

PRINT NAME: ____________________ Revised 11-05

____
Director's Initials & Date

Dear Parent/Guardian:

Children need healthy meals to learn and to grow. This child care program provides meals everyday to all enrolled children.

Your child is enrolled in a child care program participating in the USDA's CACFP through an agreement with our agency. Under this agreement, the child care center receives reimbursement for meals served to your child while in care. The amount of reimbursement received by the center depends on the eligibility status of the households of children in care. **Please return the Meal Benefit Form to the child care center.** Please complete, sign and return the form to us as soon as possible. All children enrolled in our center receive their meals at no separate charge, but the determination of eligibility category affects the amount of Federal funding received by the child care center.

Current Federal and State supported benefit programs meeting the criteria for categorical eligibility with an eligibility limit that does not exceed eligibility standards for free/reduced price meals are: Food Stamps and the Family Independence Program (FIP). If your household currently receives benefits under the Food Stamp Program or the Family Independence Program (FIP), you need to list the child's name and food stamp or FIP case number on the form. You must also have an adult sign and date the form. **If you received a Direct Certification Letter from the Department of Human Services, please give us a copy of the letter (or the actual letter) instead of completing a Meal Benefit Form.**

However, if your household does not receive benefits under the Food Stamp Program or FIP, please complete the Meal Benefit Form and make sure you provide the names of all household members and their income by source and have an adult sign, date and provide his/her social security number, or indicate that the individual does not have a social security number at this time.

For all households: USDA defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., shared living expenses). Therefore, the income reported on the Meal Benefit Form must include the gross income of all members of your household, by source, for the prior month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as basis to make this projection.

INCOME ELIGIBILITY GUIDELINES
FOR FREE AND REDUCED PRICE MEALS
Effective July 1, 2008 - June 30, 2009

Household Size	Annual	Monthly	Weekly
1	$19,240	1,604	370
2	25,900	2,159	499
3	32,560	2,714	627
4	39,220	3,269	722
5	45,880	3,824	883
6	52,540	4,379	1,011
For each additional Family Member, add	+6,660	+555	+129

You may apply at any time during the year if your household size goes up, income goes down, or if you start getting Food Stamps, FIP or other benefits. You should also notify us if you become unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

Foster children: For households with foster children, please refer to the instructions on How to Complete the Meal Benefit Form or contact us for additional information.

Confidentiality of Information on the Meal Benefit Form: We may inform officials of other child nutrition, health and education programs of the information on your form to determine benefits for those programs.

Program Discrimination Clause: In accordance with Federal law and the U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer. In addition, the State of Rhode Island, this institution is prohibited from discriminating on the basis of sexual orientation and religion. If you feel you have been discriminated against on the basis of sexual orientation or religion, write Rhode Island Department of Education, Director, Office of Equity and Access, 255 Westminster Street, Providence, RI 02903 or call (401) 222-4600.

Thank you for your cooperation.
Sincerely,
Tracey Cheney 8/15/08
Vice President

Director's Initials & Date

MEAL BENEFIT FORM for Child Care

Discharge Date: _______

PART 1. CHILDREN IN DAY CARE (USE A SEPARATE APPLICATION FOR EACH FOSTER CHILD)		
Names of all children in day care (First, Middle Initial, Last)	Date of Birth	Food Stamp or FIP case # (if any)

If you listed a Food Stamp/FIP case number for EACH child, skip to Part 4.

PART 2. FOSTER CHILD

Is this a child who is the legal responsibility of a welfare agency or court? Yes __ No __
If "yes," list the amount of the child's personal use monthly income: $_______. Skip to Part 4.

PART 3. TOTAL HOUSEHOLD INCOME FROM LAST MONTH – YOU MUST TELL US HOW MUCH AND HOW OFTEN

1. Name (List everyone in household)	**2. Last month's gross income and how often it was received** *Example: $100/monthly $100/twice a month $100 every other week $100/weekly*				3. Check if **NO** income
	Earnings from work before deductions	Welfare, alimony, child support	Pensions, retirement, social security	Other	
1.					□
2.					□
3.					□
4.					□
5.					□
6.					□
7.					□
8.					□
9.					□

PART 4. SIGNATURE AND SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this form.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the childcare program will get Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, I may be prosecuted.

Sign here: X____ Date: ____________

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ □ I do not have a Social Security Number

PART 5. CHILDREN'S RACIAL AND ETHNIC IDENTITIES (OPTIONAL)

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

DON'T FILL OUT THIS PART. THIS IS FOR OFFICIAL USE ONLY.

Monthly Income Conversion: Weekly X 4.33, Every 2 Weeks X 2.15, Twice A Month X 2

Monthly Income: _________ Household size: _____ FS/FIP: _____ Foster Child: ____
Eligibility: Free ____ Reduced ____ Denied ____ Reason: _________________________
Temporary: Free ___ Reduced ___ Time Period: _____________ (expires after ____ days)

Determining Official's Signature: __________________________________ Approval Date: ___________

____
Director's Initials & Date

Instructions for Completing Meal Benefit Form

Use a separate application for each foster child. List other children together on one form.

In certain cases, foster children are eligible for free and reduced-price meals regardless of household income. If you wish to apply for meals for a FOSTER CHILD living with you, follow these instructions:

Part 1: List the child's name and date of birth.
Part 2: List the child's personal use monthly income, if any.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is not necessary.
Part 5: Answer this question if you choose to.

If your household gets FOOD STAMPS OR FIP, follow these instructions:

Part 1: List each child's name, date of birth, and Food Stamp or FIP case number.
Parts 2 & 3: Skip these parts.
Part 4: Sign the form. A Social Security Number is not necessary.
Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List each child's name and date of birth attending this day care center.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from last month.

Column 1- Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children. Attach another sheet of paper if you need to.

Column 2- Last month's income and how often it was received: List the types of income your household got last month and how often you got them. *Employment income*: List the **gross income** each person earned last month OR each person's normal monthly income. It is not the same as the take home pay. **Gross income is the amount earned before taxes and deductions.** It should be listed on your pay stub, or your boss can tell you. Next to the amount, write often you got it (weekly, every other week, twice a month, or monthly). ***Other income:*** List the total amount each person got last month from **all other sources**. Include welfare, child support, alimony, pensions, retirement, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it.

Column 3- Check if no income: If the person does not have any income, check the box.

Part 4: An adult household member must sign the form and list his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 5: Answer this question if you choose to. We request this information solely for the purpose of determining compliance with Federal civil rights laws, and your response will not affect consideration of your application. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

Privacy Statement Act: This explains how we will use the information you give us. The 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 children for free or reduced price meals (if the daycare program has a separate charge for meals) or the day care center may not receive maximum federal funds for providing a meal program (if the daycare program provides meals at no charge). The Social Security Number of the adult household member who signs the application is required unless you list the Food Stamp or FIP case number for all the children you are applying for, OR if you are applying for a foster child. You must check the "I do not have a Social Security Number" box if the adult household member signing the application does not have a Social Security Number. We WILL use your information to see if your children are eligible for free or reduced price meals, to run the program, and to enforce the rules of the program. 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 misuse of program rules.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202)-720-6382 (TTY). USDA is an equal opportunity provider and employer.

In addition, the RI Department of Education does not discriminate on the basis of sexual orientation or religion. To file a complaint of discrimination with the RI Department of Education, write RI Department of Education, Director, Office of Equity and Access, 255 Westminster Street, Providence, RI 02903 or call 401-222-4600.

Need low or no cost health insurance for your children? Call RiteCare at 462-5300

Director's Initials & Date

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternative Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternative Grains or breads Fruit or vegetable

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Healthy Schools! Healthy Kids!
Child Nutrition Programs
Office of Integrated Social Services
RI Department of Education
255 Westminster Street
Providence, RI 02903
401-222-4600

USDA is an equal opportunity provider and employer

Director's Initials & Date

Dr. Day Care's Child Development Center Enrollment

Mailing Address: 462 Smithfield Avenue, Pawtucket, RI 02860
Toll Free- 1-877-333-1393 Fax Number 401- 475-4832
Mary Ann Shallcross Smith, Ed.D, President
Dr. Day Care

Medication Permission Form

I authorize Dr. Day Care to administer ________________________________ to
Medication name

____
Student's Name

Dosage____________________ Date Begin: ________________ Date End: ________________

Times/ Times to be given: ______ ______ ______ ______ ______

Parent's Signature:_______________________________________ Date:___________________

Name of Physician prescribing medication: _______________________________________

**ALL medication must have Student's name & dosage clearly marked

DATE	TEMP (When Applicable)	MED TIME	DOSE	MEDICATION NAME	STAFF NAME AND SIGNATURE	TIME CALLED PARENT

Note: Yes a standard order of non-aspirin/aspirin can be administered if dates and times of medicine is signed, dated, and supplied by parent.

Valid for six months only. Date of Expiration __________________________

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Director's Initials & Date

Dr. Day Care Family

• Be You Coaching & Counseling • Child Care Consultants & Facilities Management •
• Dr. Day Care's Child Development Centers • Therapeutic Child Care Services •

Dear Dr. Day Care,
With the rising cost of child care tuition and the economy in such a slump do you have any ideas of how to save money in child care?
Signed,
Need Ideas for Subsidizing My Child Care Tuition.

Dear Need Ideas for Subsidizing My Child Care Tuition,
This is an excellent question and I highly suggest you begin by checking in with your work's Human Resource Department to see if they offer a FLEX /TASC plan know as a Dependent Care Assistance Account Program (DCAP). This is the very best way to save up to 25% per week on your child care weekly tuition.

One of the most beneficial ways to save on tuition and put it back in your pocket book is to utilize the Dependent Care Assistance Account (DCAP) through a company FLEX plan. The guidelines to a DCAP plan reported to me through Anthony Scorpio CPA, are: 1) children must reside in your home more than half the year and be under the age of thirteen and 2) are members of your household for whom you claim expenses on your federal income tax form 2441(Credit for Child and Dependent Care Expenses). The child care expenses are paid before federal income taxes or social security are with held. The savings could be up to twenty-five percent of your child care expenses based on your tax bracket. Have a conversation as soon as possible with your employer **because this benefit usually begins on January 1st of each year so you can arrange for this benefit.**

Here are some other ways to save on weekly child care tuition payment:

<u>Scholarships</u>

Check with your child care provider and ask if they are providing scholarships or if they know of local agencies that provide this type of financial assistance.

<u>Cabrini Fund</u>

The Cabrini Fund is a scholarship program available to the general public from the Dioc

Providence. You can call 401.421.7833 to apply.

<u>Gift Certificates</u>

Families who have grandchildren, relatives or friend's children in childcare should suggest at "gift giving time" (Christmas, Hanukah, birthday) that friends/family purchase a gift certificate from the child care center the child attends to assist in the tuition payments.

<u>Military Subsidy Program</u>

The US military will reimburses child care centers full tuition of a child(ren) enrolled in their facility when a family member is deployed. The website is www.naccrra.org/militaryprograms to sign on for the free childcare subsidy.

Under the military subsidy, Rhode Island also offers a childcare subsidy for a child's family while a family member is deployed. When a parent is already utilizing the RI CCAP (childcare assistance program) before they are deployed they continue to be eligible for the childcare subsidy.

Director's Initials & Date ____________