Child's Personal Data Sheet

1. Name:_____DOB:_____
   Mother's Name:_____ Father's Name:_____
   Home Address:_____
   City:_____ State:_____ ZIP:_____ Phone:_____
   Mother's Employer:_____ Work Phone:_____ Work Hours:_____
   Father's Employer:_____ Work Phone:_____ Work Hours:_____
   Date enrolled in center:_____ Date withdrawn from center:_____
   Name of center:_____ Clock hours in care:_____

2. ***Emergency Contact Information***
   Mother Cell:_____ Father Cell:_____
   Name of person to call if parents cannot be reached:_____
   Relationship:_____ Phone:_____
   Address:_____City:_____State:_____ZIP:_____
   Is this person authorized to take child from the center? Yes/No
   List all other adults who are authorized to take the child from the center:

_____	_____
Name Relationship	Name Relationship
_____	_____
Address	Address
_____	_____
City State ZIP	City State ZIP
_____	_____
Phone Number	Phone Number

3. ***Medical Information***
   Child's Physician or emergency treatment facility:_____
   Address:_____City:_____State:_____Phone:_____
   I,_____Parent/Guardian of _____
   (Child's Name)
   do hereby give my consent to the Director of the Child Care Facility, or his duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents/guardians cannot be reached. Consent is also given for the Director or his duly appointed representative to transport said child for emergency medical treatment, if the parents/guardians cannot be reached.

   Signature:_____Date:_____Witness:_____Date:_____

I hereby give____/do not give___the Director of the Child Care Facility or his appointed representative permission to give________________________________acetaminophen. I understand I will be notified
(Child's Name)
that the medication has been administered.

Signature:____Date:____________________

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4. ***Immunizations: Please provide a copy of your Child's Immunization Record.***
Verified by Health Department Record:_________ Physicians Record:____________ Other:_________

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5. ***Disease History: List the dates of each:***
Measles:_____________Mumps:_____________ German Measles:____________
Chicken Pox:________Whooping Cough:_________Contracted Tuberculosis: Yes_______/No_______
Frequent Ear Infections: Yes_______/No_______ Frequent Throat Infections: Yes_______/No______
Defective Heart: Yes______/No_______ Other Conditions or Comments:_________________________

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6. ***Child's Developmental Needs:***
Physician or emotional problems the child might have:____
Child's special food needs*:* Formula:______________Diabetic diet:__________Allergies:__________
Special problems: Medications:____
Allergies:__________________________________Temper Tantrums:_____Diabetes:_____Frequent colds:_______Biting:_________Sun sensitivity:__________Seizures:_______Fainting spells:______Bedwetting:______Other____
Requires help in: Dressing:______Undressing:_____Toileting:_____Eating:____Washing hands:_____
Is child toilet trained? Yes_____/No_____ Words used in toileting:_______________________
Favorite: Games:______________________Toys:______________________Foods:_______________
Siblings? Yes_____/No_____ **Name(s) of siblings:**_____________________________________
Type of childcare used before:____
Other useful information:____

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7. I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed.

____ _____________________________
(Signature) (Date)

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Additional comments:____
____
____

PLEASE UPDATE THIS FORM A.S.A.P. IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

Student Checkout & Emergency Contact Form

In an attempt to protect your child while at school, the preschool will require **photo identification** on all persons checking out students. Unless this form is completed and on file with the classroom teacher, **children will be checked out only by the biological parent** as listed on the students birth certificate or to the **child's legal guardian.** If you wish to allow another person to check your child out of school, please complete this form below and return it to school as soon as possible. In case of parental separation or divorce, we will allow a child to be checked out by either biological parent unless there is a copy of a legal document on file at school prohibiting that person from checking out the student. Please ***print*** all information below.

Students Name:_____ Date:_____

Please allow the following persons listed below to check the above named child out of school:
(PLEASE LIST BIOLOGICAL and/or CUSTODIAL PARENTS ON LINES 1 & 2)

	Name	Relation to Student	Work/Cell Phone#	Home Phone#
1.				
2.				
3.				
4.				
5.				

The following persons may **NOT** check my child out of school:

	Name	Relation to Student
1.		
2.		
3.		

Custody papers are on file with the school? YES NO

PERSONS TO NOTIFY IN CASE OF AN EMERGENCY IF DIFFERENT THAN ABOVE:

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

_____ _____

Signature of person completing this form Relation to child

PLEASE UPDATE THIS FORM A.S.A.P. IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

ABSENT PARENT PERMIT FOR EMERGENCY MEDICAL/SURGICAL CARE

In the event that my child (listed below) may require medical and/or surgical care when I am unable to be reached, I hereby authorize evaluation, treatment and anesthetics, as deemed necessary by the _____ Hospital, and attending physician for the following child:

Child's Name:_____ DOB:_____ Age:_____

Allergies:_____

Present Medication:_____

Medical History:_____

Surgical History:_____

Other Pertinent Information:_____

Family Physician:_____Phone Number:_____

Family Medical Insurance Co:_____Policy #:_____

Person(s) able to provide authorizing signature when parent(s) are unable to be reached:

Name:_____ DOB:_____

Address:_____

Home Phone #:_____ Work Phone #_____

Relationship to the child:_____

This form is provided for parent's convenience in their absence. Authorization is valid beginning_____ and ending _____.

Authorizations must be renewed after one year from the date documented below:

Date of Permission Signature: _____.

Parents Signature: _____.

Address: _____

Home Phone #:_____ Work Phone #:_____

Mom's Cell #:_____ Dad's Cell #:_____

AUTHORIZATION IS TO BE LEFT WITH THE RESPONSIBLE ADULT AND PRESENTED TO THE HOSPITAL STAFF AT THE TIME EMERGENCY MEDICAL AND/OR SURGICAL CARE IS REQUIRED.

PLEASE UPDATE THIS FORM A.S.A.P. IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE SCHOOL YEAR

Bloom Pediatric Academy

Getting to Know You and Your Family

What language are you most comfortable speaking?

What are your cultural beliefs concerning gender roles, parenting roles and education?

What holidays do your family acknowledge and/or celebrate?

What are your beliefs concerning children and play?

What are your expectations concerning the care of your child?

Thank you for your involvement in the life of your child. The staff at Bloom Pediatric Academy want your child to feel welcome, comfortable and safe. We also want to partner with the families of our students so we can better serve them by tailoring our curriculum to their needs.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name _____ **Page 1**

PART 1. NAME OF ENROLLED CHILDREN ***OPTIONAL – Participant's ethnic and racial data**

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

NAME OF ENROLLED CHILDREN	AGE	DATE OF BIRTH	FOSTER CHILD?	HISPANIC OR LATINO Yes	HISPANIC OR LATINO No	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
				☐	☐					
				☐	☐					
				☐	☐					
				☐	☐					

ADDITIONAL HOUSEHOLD CHILDREN _____ **TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD:** _____

PART 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State 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**	
1. _____	_____	**NOTE: A Case number is not the number found on the EBT card or an individual's Social Security number.**
2. _____	_____	
3. _____	_____	

PART 3. 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

☐ Homeless ☐ Migrant ☐ Runaway

PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income.

*** Weekly / Every 2 Weeks / Twice a Month / Monthly / Annual ***

Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name _____ **Page 2**

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

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

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

Sign here: _____ Print name: _____

Date: _____ (form valid for one (1) year from this date)

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

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

(required)

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

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

Total Income_____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year Household Size: _____

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

Reason: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature:_____ Date:_____

Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid".

HNP Representative Initials/Date
(for use during CACFP Reviews)
_____

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

Non-discrimination Statement: 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 (including gender identity and sexual orientation), age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Special Nutrition Program
Child and Adult Care Food Program
Letter to Parents

Dear Parent/Guardian,

Bloom Pediatric Academy _____ participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary so that we may receive CACFP reimbursement for the meals served to children in our program. This form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of Federal funding received by us.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. Please contact us for additional information if you have a foster child enrolled in our program.

If you receive food stamps/SNAP, then you need to only list your food stamp case number. In addition, you must complete Section 5 of the form, including all required information with signature, Social Security Number of an adult household member, and date form was completed.

If food stamp/SNAP case number is not reported, you must complete Sections 4 and 5 on the eligibility statement. Section 4 should include the name of **all** household members and the total current household income by source. Section 5 must include all required information with signature, Social Security Number of an adult household member, and date form was completed.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your annual income, and you may use last year's income as a basis for making this projection if no significant changes have occurred. If your household's income is equal to or less than the amounts indicated for your household's size on chart below, the center will receive a higher level of reimbursement.

You are required to notify us if there is a change in household size or an increase in income that exceeds $50 per month or $600 per year. If you list a food stamp/SNAP case number, you must notify us when you no longer receive food stamps/SNAP. Similarly, you should notify us if you become unemployed and the loss of income during the period of unemployment causes your family to be within the eligibility standards.

USDA Child Nutrition Program Income Guidelines for July 1, 2023 – June 30, 2024

Household Size	Weekly Income	Bi-Weekly Income	Twice Monthly Income	Monthly Income	Annual Income
1	$365	729	790	1,580	18,954
2	$493	986	1,069	2,137	25,636
3	$622	1,243	1,347	2,694	32,318
4	$750	1,500	1,625	3,250	39,000
5	$879	1,757	1,904	3,807	45,682
6	$1,007	2,014	2,182	4,364	52,364
7	$1,136	2,271	2,461	4,921	59,046
8	$1,264	2,528	2,739	5,478	65,728
Each additional household member add	+$129	+257	+279	+557	+6,682

This Institution is an equal opportunity employer and provider.