SHINING STAR
CHILD REGISTRATION FORM

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

PARENT(S)/GUARDIAN(S)

Father	Place Employed	Business Phone
Home Address		Home Phone
Mother	Place Employed	Business Phone
Home Address		Home Phone
Person(s) or Agency Having Legal Custody of Child		
Home Address		Home Phone
Business Address		Business 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 must be included, upon the request of such noncustodial parent, as an emergency contact for events occurring during 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 immediate 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 Date

Date Child Entered Care: ____________________ Date Left Care: ____________________

** 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 63.2-1809 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.

Please read and sign the waiver below

In agreeing to participate in the activity, as a participant, parent or guardian of participant, I affirm that the general health of the participant is good and that the participant is not adversely affected by exercise, and is capable of performing an activity of this nature. All activities are to be age appropriate, for example: trips to county library, neighboring schools, or businesses etc.

In consideration for participating in the activity, I do hereby assume all risk of injury to the participant and will indemnify and hold harmless, from any and all liability, actions, cause of action, claims and demands of every kind of nature whatsoever that the participant has or which arises in connection with his/her participation in this activity, JABA's Shining Star Pre-School, all of its officers, employees, staff, and volunteers.

It is likewise assumed and agreed that the participant will wear proper clothing and protective equipment during the activity and that it is the responsibility of the participant's parent or guardian to see that this criteria is met. I grant permission to transport (bus, van, car, walking) the participant from the event when required and hold harmless those assigned to transport.

I also agree to follow transportation of the participant to the nearest physician or hospital for medical treatment and agree to allow for immediate first aid to injured person when deemed appropriate.

____ ____________________

Signature of Parent/Guardian Date

____

Print Name of Parent/Guardian

Due to new standards, we must ask you to read and sign the statement below:

I understand that I must notify Shining Start Pre-School within 24 hours if my child is/or was diagnosed with any exposure to any communicable disease.

____ ____________________

Signature of Parent/Guardian Date

Child's name: ______________________________________

Medical Release Form

I/We hereby give any faculty member or staff worker of Shining Star Pre-School permission to seek medical attention for my/our child in the event of accident, injury, or illness.

I/We further release JABA's Shining Star Pre-School from any liability due to injury, illness, or accident.

Student's Name: ______________________________

Father/Guardian: ______________________________

Mother/Guardian: ______________________________

Family Medical insurance company: ______________________________

Family Medical insurance number: ______________________________

Family Doctor: ______________________________

Family Doctor phone number: ______________________________

Hospital of Choice

1. ______________________________
2. ______________________________

Emergency Phone Numbers

Father's Daytime phone number: ______________________________

Mother's Daytime Phone Number: ______________________________

Please list any known allergies, medical conditions, special medications, etc.

____

____

____

______________________________ Signature of Parent/Guardian

______________________________ Date

This form is our record until the state required "School Entrance Health Form" is received.

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

Child Information for Classroom

Child	Nickname	Date of Birth/Age	Sex
Address		Home Phone	
Date of Enrollment:			

Parent(s) or Guardian(s)

Mother's Name: ______________________

Home/Cell: ______________________

Place of employment: ______________________

Business Address: ______________________

Business Phone: ______________________

Automobile make, model, color:

____

License plate number: ______________________

Father's Name: ______________________

Home/Cell: ______________________

Place of employment: ______________________

Business Address: ______________________

Business Phone: ______________________

Automobile make, model, color:

____

License plate number: ______________________

Physician's Name: ______________________ Phone #: ______________________

Address: ______________________

May we call another physician if unable to contact the one above? ______________________

If yes, list name and number: ______________________

Allergies and/or other conditions: ______________________

____

Family Medical insurance company: ______________________

Family Medical insurance number: ______________________

People to contact if you cannot be reached

Name: ______________________

Home/Cell: ______________________

Address: ______________________

Name: ______________________

Home/Cell: ______________________

Address: ______________________

List of people AUTHORIZED to pick up your child (They will need to provide ID upon arrival!)

Name	Relationship	Phone #
1.		
2.		
3.		

List of people NOT AUTHORIZED to pick up your child

Name	Relationship	Phone #
1.		
2.		
3.		

JABA's Shining Star Pre-School

PUBLISHED CHILD INFORMATION

Shining Star Pre-School publishes a variety of information about our schools and their activities to the public through various media, including television, internet, and print. We may wish to include your child's name and/or photograph. The information might be published in order to recognize achievement, in conjunction with the use of your child's work, in a recruiting brochure, newsletter, or other display. Your signature below acknowledges permission for this information to be published.

My child's name may be published. YES _____ NO _____

Photographs of my child, which may be accompanied by their name may be published. YES _____ NO _____

My child's work may be published. YES _____ NO _____

I hereby give the above permission and release Shining Star Pre-School from liability resulting from or connected with the publication of this information.

Child's name: ______________________________

First, MI, Last name (PRINT): ______________________________

Parent/Guardian Signature: ______________________________

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 longer 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: __________

Name of Mother or Legal Guardian: ______________________ Phone: ___-___-____ Work or Cell: ___-___-____

Name of Father or Legal Guardian: ______________________ Phone: ___-___-____ Work or Cell: ___-___-____

Emergency Contact: ______________________ Phone: ___-___-____ Work or Cell: ___-___-____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, etc.):

____

____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

____

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)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) ____ FAMIS ____ Private/Commercial/Employer sponsored

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 person completing this form: ______________________ Date: ___/___/____

Signature of Interpreter: ______________________ Date: ___/___/____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I
To be completed by a physician, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

(A copy of the immunization record signed or stamped by a physician or designee 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.)
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:______________________________ Date of Birth: |___|___|___|
Last First Middle Mo. Day Yr.

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

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* (Minimum requirements are listed in Section III).

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

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Student's Name:____Date of Birth: |___|___|___|

Section II
Conditional Enrollment and Exemptions

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:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

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

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- ☐ 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
- ☐ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ☐ 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
- ☐ Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
- ☐ Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
- ☐ 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ☐ 1 Mumps – on/after 12 months of age
- ☐ 1 Rubella - on/after 12 months of age
  Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ☐ Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- ☐ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- ☐ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

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

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred

Mantoux results: ______________mm

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	☐	☐	☐

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.

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

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

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other 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

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

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 ☐ epi pen ☐ other: __________

___**Individualized 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):

Name : ______________________ **Signature:** ______________________ Date: ___/___/_____

Practice/Clinic Name: ______________________ **Address:** ______________________

Phone: _____-_____-__________ **Fax:** _____-_____-__________ **Email:** ______________________

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CACFP Child Care Center Enrollment Form

(Name of child) ____________________ AGE/DOB ____________ is enrolled at:

Shining Star Pre-School at JABA
674 Hillsdale Drive
Charlottesville, VA 22901

Starting on: ____________________

Normal Days in pre-school/child care: M T W TH F (circle all that apply)

Normal Hours in care: from ____________ to ____________

Normal Meals expected to be served daily:
____Breakfast ____AM snack ____Lunch ____PM snack ____Dinner

Please explain any unusual circumstances relate to child's attendance at center:

____

____

____

______________________________ ______________
Signature of Parent/Guardian Date

Optional fields for parent/guardian:

Address: ____________________ Telephone #: ____________________

____

____

You are not required to answer these questions. If you choose to do so:

Please mark on of the following ethnic identities: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Please mark one or more of the following racial identities: ☐ American Indian or Alaskan Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

---

For Center Use Only:

Participant withdrew on ____________________
(date)

ADULT - INCOME ELIGIBILITY STATEMENT
Child and Adult Care Food Program

PART 1
Adult's Name: ______________________________
Last *First* *M.I.*

PART 2A – HOUSEHOLDS NOW GETTING FOOD STAMPS, SSI, MEDICAID, OR FDPIR: Complete this part and sign the statement in Part 3 – DO NOT complete Part 2B.

Food stamp case number: ______________ SSI identification number: ______________
Medicaid assistance identification number: ______________ FDPIR identification number: ______________

PART 2B – ALL OTHER HOUSEHOLDS: If you did not write a food stamp, SSI, Medicaid, or FDPIR number or if you did not complete Part 2A, complete this part and sign the statement in Part 3.

NAMES	CURRENT INCOME/FREQUENCY			
Names of Family Members (Participant, Spouse, Dependent Children)	Job income (Before Deductions)/ per week, month, etc.	Welfare, Child Support, Alimony / per week, month, etc.	Payments from Pensions Retirement, Social Security/ per week, month, etc.	Earnings from Job 2 or any Other Income / per week, month, etc.
1. ________	$ ______/______	$ ______/______	$ ______/______	$ ______/______
2. ________	$ ______/______	$ ______/______	$ ______/______	$ ______/______
3. ________	$ ______/______	$ ______/______	$ ______/______	$ ______/______
4. ________	$ ______/______	$ ______/______	$ ______/______	$ ______/______
5. ________	$ ______/______	$ ______/______	$ ______/______	$ ______/______
6. ________	$ ______/______	$ ______/______	$ ______/______	$ ______/______
7. ________	$ ______/______	$ ______/______	$ ______/______	$ ______/______

PART 3 – SIGNATURE: Section 9 of the National School Lunch Act requires that, unless a food stamp, SSI, Medicaid, or FDPIR number is provided for the adult for whom benefits are sought, you must include the social security number of the adult household member or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved for free or reduced meals. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp, SSI, Medicaid, or FDPIR office to determine current certification for receipt of food stamps, SSI, Medicaid, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss of reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the food stamp, SSI, Medicaid, or FDPIR number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of adult: ______________________ Social Security number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Printed name of adult: ______________________

______ *Date signed* ______ *Home telephone* ______ *Work telephone* ______ *Home address* ______ *Zip code*

PART 4 – RACIAL/ETHNIC IDENTITY: You are not required to provide this information.

Step1: Mark only one of the following ethnic categories that best identifies the child listed in Part 1:
☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

Step 2: Mark one or more of the racial categories that
☐ WHITE ☐ BLACK ☐ ASIAN ☐ NATIVE HAWAIIAN /PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN NATIVE

For Institution Use Only: Food stamp/SSI/Medicaid/FDPIR household categorically eligible free: ☐ Yes ☐ No

MONTHLY INCOME CONVERSION: WEEKLY X 4.33, EVERY 2 WEEKS X 2.15, TWICE A MONTH X 2

Total family income: ______________________ Family Size: __________

Eligibility classification: ☐ Free ☐ Reduced ☐ Paid

Signature of Determining official: ______________________ Date: __________

The Child and Adult Care Food Program is an equal opportunity program. If you believe you or anyone has been discriminated against because of race, color, national origin, sex, age, or disability, write immediately to: USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382