

Children First

A Ministry of Waycross First United Methodist Church

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“Let the little children come to Me...” NKJV Mark 10:14

Application Packet for Infants/Crawlers

___ Registration Fee Paid

___ Immunization Records

___ CACFP Food Grant IEC

___ Special Needs

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Entrance Date _____ Withdrawal Date _____

Child's Name _____ Sex _____ Age _____ Date of birth _____

Home Address (Street) _____

City _____ State _____ Zip _____

Home Phone Number _____

Father's Name _____ Home Phone Number _____

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

City _____ State _____ Zip _____

Father's Place of Employment _____ Work Phone _____

Employer's Street Address _____ City _____ State _____ Zip _____

Mother's Name _____ Home Phone Number _____

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

City _____ State _____ Zip _____

Mother's Place of Employment _____ Work Phone # _____

Employer's Street Address _____ City _____ State _____ Zip _____

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

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

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

*Name _____ Address _____
(Street-City-State-Zip)
Telephone Number _____ Relationship to child _____
Relationship to Parent(s) or Guardian _____
Other identifying information (if any) _____

*Name _____ Address _____
(Street-City-State-Zip)
Telephone Number _____ Relationship to child _____
Relationship to Parent(s) or Guardian _____
Other identifying information (if any) _____

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

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name of Public or Private School child attends, if any: _____

Child's doctor or clinic name _____

Doctor/clinic phone # _____

My child has the following special needs _____

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

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

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name) _____ Date of birth _____
suffer an injury or illness while in the care of (Facility name) _____
and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention
and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian: _____ Signature _____

Date: _____

Facility Administrator/Person-In-Charge _____ Signature _____

Date: _____

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Father's Name _____

Home Phone _____ Work Phone _____

Mother's Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if _____
Name of Facility

cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

Children First Childcare Payment Contract

Parent/Legal Guardian: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Name of Children for whom Children First will care:

1. _____ Birthday: _____
2. _____ Birthday: _____
3. _____ Birthday: _____

Part time: _____ Full time: _____ _____ M _____ T _____ W _____ TH _____ F	Fee: \$ _____ per: _____ Date Payment due: _____	Source of payment: _____ parent _____ other	Late payment: \$25.00 weekly
Other Fees: \$100.00 Description: Registration Fee	Late pick up: \$1.00 per minute after 10 minutes \$10.00 per minute	Yearly Activity Fee: \$50.00	Return Ck Charge: \$49.00

For all participating children, full payment is due every Friday for the following week. Accounts that are paid weekly or on a monthly basis must be paid in advance. A late charge will be added for late payment of daycare receipts. Children First may exercise the right to decline the care of a child if the account is not current. Parents/legal guardian will then be notified by the financial office of the Waycross First United Methodist Church.

Payments are made for the reservation of childcare only and will be forfeited if not used. No refunds nor credits are given at this time.

If a check is returned for insufficient funds, an additional fee will be charged to the account. If a check is returned, Children First may require future payments to be made in cash, by certified check, or online @ www.waycrossfirst.com

To reserve an opening at Children First during an extended absence due to vacations or illness, the parent/legal guardian must continue to pay the tuition. If the tuition is not paid during the absence, the center has the right to refuse services.

Children First policy regarding a) hours that the center is open, b) the earliest a child can be dropped off, c) the latest a child may be picked up, d) meals and special foods, e) accommodations for medical conditions or special needs, f) drop off and pick up time procedures for individuals that are not parents or legal guardians, and g) all other policies that oversee this agreement are in the Children First Parent Handbook and is now incorporated into this contract through reference.

I agree to promptly notify Children First of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand and agree to comply with the policy and procedures and information for parents, given to me by _____ Director of Children First.

Parent/ Legal Guardian signature _____ date

Safe Sleep Practices Policy

Child's name: _____ Date of birth: _____

Parent/Guardian name: _____


Safe Sleep Practices/Policies:

- 1) Infants will be placed on their backs in a crib to sleep unless a physician's written statement authorizing another sleep position for that infant is provided. The written statement must include how the infant shall be placed to sleep and a time frame that the instructions are to be followed.
- 2) Cribs shall be in compliance with CPCS and ASTM safety standards. They will be maintained in good repair and free from hazards.
- 3) No objects will be placed in or on the crib with an infant. This includes, but is not limited to, covers, blankets, toys, pillows, quilts, comforters, bumper pads, sheepskins, stuffed toys, or other soft items.
- 4) No objects will be attached to a crib with a sleeping infant, such as, but not limited to, crib gyms, toys, mirrors and mobiles.
- 5) Only sleepers, sleep sacks and wearable blankets provided by the parent/guardian and that fit according to the commercial manufacturer's guidelines and will not slip up around the infant's face may be worn for the comfort of the sleeping infant.
- 6) Individual crib bedding will be changed daily, or more often as needed, according to the rules. Bedding for cots/mats will be laundered daily or marked for individual use. If marked for individual use, the sheets/covers must be laundered weekly or more frequently if needed. This facility will adhere to the following practice:

- 7) Infants who arrive at the center asleep or fall asleep in other equipment, on the floor or elsewhere, will moved to a safety-approved crib for sleep.
- 8) Swaddling will not be permitted, unless a physician's written statement authorizing it for a particular infant is provided. The written statement must include instructions and a time frame for swaddling the infant.
- 9) Wedges, other infant positioning devices and monitors will not be permitted unless a physician's written statement authorizing its use for a particular infant is provided. The written statement must include instructions on how to use the device and a time frame for using it.

I acknowledge that the director or designee has advised me of the safe sleep practices followed by the facility.

Signature _____ Date _____

Infant Affidavit 

Name of Sponsor (if applicable) _____

Name of Provider/Center Children First

Name of Infant: _____

Infant Date of Birth: _____

Name of Parent/Guardian: _____

According to USDA regulations, as an institution participating in the Child and Adult Care Food Program must provide meals to all infants enrolled for care in the center/facility.

Center/provider will provide the following milk-based iron-fortified formula: _____

Center/provider will provide the following Iron-fortified infant cereal: _____

Center/provider will provide the following brand of infant foods: gerber rice+oatmeal
gerber fruits or vegetables

Parents/Guardians,

Please check one of the following options below and sign this form:

_____ I would like the provider/center to provide ALL meal components to my infant and I will provide clean, sanitized, and labeled bottles daily.

I will provide the following meal component to my infant and the center will provide all other meal components:

- Formula* Meat/Fish/Poultry/Eggs/Beans/Peas
- Cereal Cheese/Cottage Cheese/Yogurt
- Fruit Bread/Crackers/Breakfast Cereal
- Vegetable

Parent/Guardian Signature

Date

*Any parent requesting any formula other than a USDA approved milk-based or soy-based iron-fortified formula be provided to their infant or any parent who provides any formula other than a USDA approved milk-based or soy-based iron-fortified formula for their infant must provide a doctor's note indicating the required use of the formula. If a parent elects to have the center or day care home provider supply meals to their infant, the infant will be fed according to its individual feeding plan that is provided by the parent or guardian. The center or day care home provider may only claim reimbursement for no more than breakfast, lunch or supper, and a snack.

**Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement***

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)				
	Head Start	Foster Child	Migrant	Runaway	Homeless	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income¹ - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here. Child Income/How often? \$ _____/_____

B. Other Household Members¹. List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Welfare, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. _____	\$ _____/_____	\$ _____/_____	\$ _____/_____	\$ _____/_____
2. _____	\$ _____/_____	\$ _____/_____	\$ _____/_____	\$ _____/_____
3. _____	\$ _____/_____	\$ _____/_____	\$ _____/_____	\$ _____/_____
4. _____	\$ _____/_____	\$ _____/_____	\$ _____/_____	\$ _____/_____
5. _____	\$ _____/_____	\$ _____/_____	\$ _____/_____	\$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.
Last four Digits of Social Security Number XXX-XX _____ I do not have a Social Security Number

PART III: Enrollment Information: Children Only

My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. (✓) Check here if only before/after school care is provided.
Circle the days your child will normally attend the center: Sunday Monday Tuesday Wednesday Thursday Friday Saturday
Circle the meals your child will normally receive while in care: Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature

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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. If not completed fully and signed, the participant will be placed in the Paid category.

Signature: X _____ Print Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

*This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.

PART V: Participant's Ethnic and Racial Identities (optional)

Check (✓) one ethnic identity: Hispanic/ Latino Not Hispanic/ Latino
Check (✓) one or more racial identities: Asian White Black or African American Indian or Alaska Native Hawaiian or other Pacific Islander

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ Per: Week Every 2 weeks Twice a month Monthly Year Household Size: _____
Categorical Eligibility: check (✓) if applicable Eligibility: check (✓) one Free Reduced Paid
Day Care Homes Only: check (✓) one Tier I Tier II

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ Date: _____
Confirming Official's Signature: _____ Date: _____
Follow Up Official's Signature: _____ Date: _____

INFANT FEEDING PLAN

Child's full name _____ Date _____

Date of birth _____

Does child take bottle? Yes [] No []
 Is the bottle warmed? Yes [] No []
 Does the child hold own bottle? Yes [] No []
 Can the child feed self? Yes [] No []

Does the child eat: (Check all that apply)
 Strained foods [] Whole milk []
 Baby foods [] Table foods []
 Formula [] Other []
 Breast Milk []

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk: _____ Date: _____
 Amount: _____ Date: _____
 Amount: _____ Date: _____
 Amount: _____ Date: _____

Does the child take a pacifier? Yes [] No [] If yes, when? _____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula) _____

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods _____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

PARENTS' SIGNATURE: _____ Date: _____