Enrollment Packet Checklist:

___ Children's Alley Enrollment Form

___ Children's Alley Income Verification Information with documentation (copies of paycheck remittance, tax return, etc.)

___ Child and Adult Care Food Program (IEF) form (required for all families regardless of income)

___ General Health Appraisal Form (to be completed and SIGNED by Health Care Provider within 30 days of enrollment)

___ Immunization Records or Letter of Exemption

___ Parent Handbook and Registration Fee Acknowledgement

___ Infant Only Forms: Formula Decision, Infant Food Plan Forms, and Optional Pacifier Opt-Out

Date Received: ______________________

Received by: ______________________
YWCA CHILDREN’S ALLEY ENROLLMENT FORM

Today’s Date: ______________________________

<table>
<thead>
<tr>
<th>Child's First Name</th>
<th>Child's Last Name</th>
<th>Birthday</th>
<th>Age</th>
<th>Gender</th>
<th>Race*: (select one or more)</th>
<th>Ethnicity*: (select one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Asian □</td>
<td>A/Indian/AN □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Asian □</td>
<td>A/Indian/AN □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Asian □</td>
<td>A/Indian/AN □</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Asian □</td>
<td>A/Indian/AN □</td>
</tr>
</tbody>
</table>

*RACE ABBREVIATIONS: A=Asian; A/Indian/AN=American Indian or Alaskan Native; B/AA=Black or African American; H/PI=Native Hawaiian or other Pacific Islander; W/C=White/Caucasian; O=Other Race

Primary Parent/Guardian Name: ______________________________
Relationship to Child ______________________________
Cell: __________________ Work: __________________
Home Phone: ______________________________ Circle Primary C H W
Street: __________________________ City: __________________________ State: __________________________
Zip: ___________ County ______________________________________
Email: ______________________________________________________
Employer: ___________________________________________________
Employer Address: _____________________________________________

Second Parent/Guardian Name: ______________________________
Relationship to Child ______________________________
Relationship to Primary Parent ______________________________
Cell: __________________ Work: __________________
Home Phone: ______________________________ Circle Primary C H W
Street: __________________________ City: __________________________ State: __________________________
Zip: ___________ County ______________________________________
Email: ______________________________________________________
Employer: ___________________________________________________
Employer Address: _____________________________________________

Race: □ Asian □ Black/African American □ Hawaiian/Pacific Islander □ Other Race

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Child lives with: Mother ___ Father ___ Other ______ Address ______________________________

Check if contacts listed above are Married ___ Divorced ___ Single Mom ___ Single Dad ___

Number in Household __________ # Children in Household ______
Total Gross Annual Household Income _________________ verification required (paystub, tax document, etc)

EMERGENCY CONTACTS/PICKUP PERMISSION

We require two (2) emergency contacts OTHER than the parent(s) or doctor while your child is at Children’s Alley. THEY MUST BE LOCAL NUMBERS. In all situations we will first attempt to reach the parent(s)/guardian.

Name: __________________________ Phone: 1 __________ 2 __________
Address: __________________________ City: ____________
Relationship to Child __________________________

Name: __________________________ Phone: 1 __________ 2 __________
Address: __________________________ City: ____________
Relationship to Child __________________________

Children will be released ONLY to the persons listed on this form unless otherwise authorized by the parent/guardian. Please notify us IMMEDIATELY of any custody arrangements and provide us the copies of any legal documents you may have.
MEDICAL CONTACTS

Physician: ___________________ Phone: _______________ Address: ___________________

Dentist: ___________________ Phone: _______________ Address: ___________________

Hospital: ___________________ Phone: _______________ Address: ___________________

How did you hear about Children’s Alley?  □ Parent/Friend  □ Website  □ Sign  □ Yellow Pages
□ Other ___________________

PERMISSIONS

1. Occasionally the teachers may take a group of children on a walking field trip; I would
like my child to participate in this activity.

2. I give the YWCA Children’s Alley permission to allow my children to participate in a video
viewing activity.

3. I give the YWCA Children’s Alley permission to use my child’s photograph in their
newsletter or other promotional materials.

4. I have read and understand the terms under the philosophy and procedures of
Children’s Alley and agree to the parent responsibilities in the parent handbook.

General

Yes  No

Over-the-counter medicine

In the interest of your child’s health, the state has enacted rules about non-prescriptive (over-the-counter)
medications. All prescription and non-prescription medicines require a Medical Authorization Form from your
doctor. The following exceptions can be made with the parent’s permission. I give the YWCA Children’s Alley
permission to administer the following over the counter medications:

5. Sunblock (SPF 30, hypo-allergenic, and PABA free)  Yes  No

6. Diaper rash cream/ointment (supplied by the parent)  □  □

7. Lotion for chapped skin (supplied by the parent)  □  □

8. Lip protection for chapped lips and teething remedies (supplied by the parent)  □  □

Authorization for CPR/First Aid and Emergency Medical Treatment of a Minor

While my child/children are in attendance at the YWCA I, the undersigned, give my consent for Children’s Alley
staff members, who are properly trained and certified, to provide CPR and/or First Aid should his/her condition
require it in my absence. I also give my consent for staff members of Children’s Alley to secure medical care and
surgical care of this/these minors at the nearest hospital by a licensed Colorado physician should his/her
condition require it in my absence. I understand that in such a case, reasonable attempts would first be made to
contact me, time and conditions permitting. I will not hold the YWCA of Boulder County financially or legally
responsible for the emergency care and/or transportation for such child.

Parent/Guardian Signature ___________________________ Date ______________

Printed Name ______________________________________

The information on this enrollment form is still correct and valid for another year.

Updated Parent/Guardian Signature ___________________________ Date ______________

Updated Parent/Guardian Signature ___________________________ Date ______________
We collect this information to better care for your child. Please complete one per child as needed.

Today’s Date __/__/__ Child’s Name ___________________________ Age _______ DOB __/__/__

Is your child on any medications? __________________________________________________________

Allergies (to food, animals, insects, medications, etc.)

Allergy ________________________________ Severity: □ Mild □ Moderate □ Severe
Treatment/Comment ________________________________________________________________

Allergy ________________________________ Severity: □ Mild □ Moderate □ Severe
Treatment/Comment ________________________________________________________________

Note: Due to state regulations all milk allergies must be accompanied by a doctor’s note.

Food Restrictions ______________________________________________________________________

Does your child have special needs? □ Yes
Comments to staff about health conditions, disabilities and/or sensitivities. (behavioral, physical, social, emotional, developmental). Include limitations for emergency medical treatment, if any.

____________________________________________________________________________________

Infant and Toddlers Only

Is your child potty trained? □ Yes □ No □ In Training

What does your child need for comfort? Blanket, toy, etc.

____________________________________________________________________________________

How do you put your child down to sleep? Please list usual naptime and wakeup time.

____________________________________________________________________________________

Other Instructions:

____________________________________________________________________________________

Infant Only

How many bottles per day and times?

____________________________________________________________________________________

How many ounces per feeding? __________________________________________________________

Circle the foods that have NOT been introduced to your child yet: Wheat  Eggs  Dairy  Citrus
(Note: we never serve peanuts at Children’s Alley)

Do they need food to be puréed? □ Yes □ No

Does your child feed themselves? □ Yes □ No Using a spoon? □ Yes □ No

Can your child: □ Roll  □ Crawl  □ Sit  □ Stand  □ Walk
We collect this information to better care for your child. Please complete one per child as needed.

Today's Date __/__/__  Child's Name ___________________________  Age ______  DOB __/__/__

Is your child on any medications?

Allergies (to food, animals, insects, medications, etc.)

Allergy ___________________________________________  Severity: □ Mild □ Moderate □ Severe
Treatment/Comment _______________________________________

Allergy ___________________________________________  Severity: □ Mild □ Moderate □ Severe
Treatment/Comment _______________________________________

Note: Due to state regulations all milk allergies must be accompanied by a doctor's note.

Food Restrictions _______________________________________

Does your child have special needs?  □ Yes

Comments to staff about health conditions, disabilities and/or sensitivities. (behavioral, physical, social, emotional, developmental). Include limitations for emergency medical treatment, if any.

___________________________________________________________________________________

Infant and Toddlers Only

Is your child potty trained?  □ Yes  □ No  □ In Training

What does your child need for comfort?  Blanket, toy, etc.

___________________________________________________________________________________

How do you put your child down to sleep? Please list usual naptime and wakeup time.

___________________________________________________________________________________

Other Instructions:

___________________________________________________________________________________

Infant Only

How many bottles per day and times?

___________________________________________________________________________________

How many ounces per feeding?  _______________________________________________________

Circle the foods that have NOT been introduced to your child yet: Wheat  Eggs  Dairy  Citrus

(Note: we never serve peanuts at Children's Alley)

Do they need food to be puréed?  □ Yes  □ No

Does your child feed themselves?  □ Yes  □ No  Using a spoon?  □ Yes  □ No

Can your child:  □ Roll  □ Crawl  □ Sit  □ Stand  □ Walk
# CHILDREN’S ALLEY INCOME VERIFICATION INFORMATION

Due to our public funding and sliding scale fees, family income must be verified by submitting a document like a copy of the most recent tax return or one month pay stubs. Anyone claiming $0 income is required to resubmit information 45 days after first visit or when financial situation changes, whichever comes first.

Guardian Name: __________________________  Child’s Name __________________________

**CHOOSE ONE OF THE FOLLOWING:**

<table>
<thead>
<tr>
<th>TAX RETURN</th>
<th>Attached is a copy of the most recent tax return for my household. (Use “gross Income” before deductions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAY STUB</td>
<td>Attached is a copy of my employment pay stub(s) for one month for my household.</td>
</tr>
<tr>
<td>UNEMPLOYMENT</td>
<td>At this time, I am unemployed and/or my situation is such that my household is receiving no income. I understand that I will need to provide income verification when my circumstances change and will need to reapply 45 days from my child’s first visit.</td>
</tr>
<tr>
<td></td>
<td>Signature________________________________________ Date___________</td>
</tr>
<tr>
<td>STUDENT</td>
<td>The income reported is equal to financial assistance <strong>not</strong> used for the cost of tuition, fees, books, supplies and other educational expenses. $________ per month is the portion of financial assistance used for living expenses.</td>
</tr>
<tr>
<td>WAIVER TO PAY THE HIGHEST RATE</td>
<td>I, __________________________, agree to pay the highest rate on the YWCA Children’s Alley sliding fee scale rather than disclose my income.</td>
</tr>
<tr>
<td></td>
<td>Signature________________________________________ Date___________</td>
</tr>
<tr>
<td>SOCIAL SECURITY</td>
<td>Attached is a copy of my social security benefits: including SSI and SSDI</td>
</tr>
</tbody>
</table>
| PUBLIC ASSISTANCE | I am on another form of public assistance that can vouch for my income:  
Examples include: Department of Social Services, TANF, Food Stamps, Public Housing or Section 8. Referral from EFFA or Family Resource Schools  
I give permission to the YWCA Children’s Alley to contact the following specified agency/employer for the purpose of verifying my income. |
|            | Name of agency/employer: __________________________ |
|            | Contact person and phone number: __________________________ |
|            | Signature________________________________________ Date___________ |
Dear Parent or Guardian,

Congratulations! You have chosen a childcare provider that participates in the Child and Adult Care Food Program (CACFP). Participating in the CACFP means that the provider cares about good nutrition for children, will introduce and serve a variety of nutritious foods for your child to eat, and will serve foods appropriate for your child's nutritional needs. The provider you have chosen cannot charge a separate fee for meals, nor ask you to provide food for your child for meals claimed for reimbursement from the CACFP, except in some special cases. Depending upon the hours in care, your provider will be serving your child breakfast, morning snack, lunch, afternoon snack, supper and/or late snack.

Please complete, sign and return this Income Eligibility Form (IEF) to the center as soon as possible. This information is required for the center to receive CACFP reimbursement for the meals served to your child. The Colorado Department of Public Health and Environment assures that this form is confidential and the information you provide will not be used elsewhere.

If no person in your household receives benefits from Temporary Assistance For Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), also known as Food Stamps, or the Food Distribution Program on Indian Reservations (FDPIR), or is not the beneficiary of the Other Source Categorical Eligibility programs, please list your household's total gross income from the current month, the amount projected for the first month the application is made for, or the month prior to the application. The U.S. Department of Agriculture, which funds the CACFP, defines a household as a group of related or unrelated individuals who are living as one economic unit and who share housing and all significant income and expenses.

If no person in your household receives benefits from Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), you must provide the last four digits of your Social Security Number according to regulations. The disclosure of the Social Security Number is voluntary; however, the last four digits of the Social Security Number, or an indication of "none," is required for the approval of this form.

If any of the children living in the household are beneficiaries of the Other Source Categorically Eligible programs (Foster, Head Start/Early Head Start or Even Start Program, Homeless, Migrant or Runaway), the children are eligible for free meals and there is no need to complete an application - just mark the box next to the program that applies. The institution collecting the form will need to verify the child's participation in the program by requesting documentation from the placement office if the child is a foster child, from the Even Start or Head Start official if the child or the pregnant mother is enrolled Head Start or Early Head Start or the child is a Head Start participant, and from the Migrant, Homeless or Runaway program officials, if the child is a migrant, homeless or runaway child. For Even Start, documentation from the Even Start official confirming that the child has not yet entered Kindergarten.

If any person in your household receives benefits from the Temporary Assistance For Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), income reporting and the disclosure of the last four digits of the Social Security Number (SSN) in Step 3 is not required.

### Household Income Chart

If your household's income is less than or the same as the amounts indicated for your household's size on the chart below, the center will receive more meal reimbursement from the Child and Adult Care Food Program (CACFP) to help provide the best meals possible for the children in care.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>For each additional person add:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yearly</td>
<td>22,459</td>
<td>30,451</td>
<td>38,443</td>
<td>46,435</td>
<td>54,427</td>
<td>62,419</td>
<td>70,411</td>
<td>78,403</td>
<td>+ 7,992</td>
</tr>
<tr>
<td>Monthly</td>
<td>1,872</td>
<td>2,538</td>
<td>3,204</td>
<td>3,870</td>
<td>4,536</td>
<td>5,202</td>
<td>5,868</td>
<td>6,534</td>
<td>+ 666</td>
</tr>
<tr>
<td>Weekly</td>
<td>432</td>
<td>586</td>
<td>740</td>
<td>893</td>
<td>1,047</td>
<td>1,201</td>
<td>1,355</td>
<td>1,508</td>
<td>+154</td>
</tr>
</tbody>
</table>

This chart is not to be used for determining eligibility by center staff, but is a guide for families completing the form.
## Child Meal Patterns

### Breakfast (select all three components for a reimbursable meal)

<table>
<thead>
<tr>
<th>Food Components and Food Items</th>
<th>Ages 1-2</th>
<th>Ages 3-5</th>
<th>Ages 6-12</th>
<th>Ages 13-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluid milk</td>
<td>4 ounces</td>
<td>6 ounces</td>
<td>8 ounces</td>
<td>8 ounces</td>
</tr>
<tr>
<td>Vegetables, fruits, or portions of both</td>
<td>1/4 cup</td>
<td>1/3 cup</td>
<td>1/3 cup</td>
<td>1/3 cup</td>
</tr>
<tr>
<td>Grain*</td>
<td>1 slice</td>
<td>1 slice</td>
<td>1 slice</td>
<td>1 slice</td>
</tr>
<tr>
<td>Whole grain-rich or enriched bread</td>
<td>1 serving</td>
<td>1 serving</td>
<td>1 serving</td>
<td>1 serving</td>
</tr>
<tr>
<td>Whole grain-rich, enriched or fortified cooked breakfast cereal, cereal grain and/or pasta</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
</tr>
<tr>
<td>Whole grain-rich, enriched or fortified ready-to-eat breakfast cereal (dry, cold)</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
</tr>
<tr>
<td>Flaked or rounds</td>
<td>1 cup</td>
<td>1 cup</td>
<td>1 cup</td>
<td>1 cup</td>
</tr>
<tr>
<td>Pulled cereal</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
</tr>
<tr>
<td>Granola</td>
<td>1 cup</td>
<td>1 cup</td>
<td>1 cup</td>
<td>1 cup</td>
</tr>
</tbody>
</table>

*Grains substituted with a meat/meat alternate* (may be used to meet the entire grain requirement a maximum of three times per week.

### Lunch and Supper (select all five components for a reimbursable meal)

<table>
<thead>
<tr>
<th>Food Components and Food Items</th>
<th>Ages 1-2</th>
<th>Ages 3-5</th>
<th>Ages 6-12</th>
<th>Ages 13-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluid milk</td>
<td>6 ounces</td>
<td>6 ounces</td>
<td>8 ounces</td>
<td>8 ounces</td>
</tr>
<tr>
<td>Meat/meat alternates</td>
<td>1 ounce</td>
<td>1 1/2 ounce</td>
<td>2 ounces</td>
<td>2 ounces</td>
</tr>
<tr>
<td>Tofu, soy product, or alternate protein products</td>
<td>1 ounce</td>
<td>1 1/4 ounce</td>
<td>2 ounces</td>
<td>2 ounces</td>
</tr>
<tr>
<td>Cheese</td>
<td>1 ounce</td>
<td>1 1/4 ounce</td>
<td>2 ounces</td>
<td>2 ounces</td>
</tr>
<tr>
<td>Large egg</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cooked dry beans or peas</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
<td>1/4 cup</td>
</tr>
<tr>
<td>Peanut, soy/must or seed butters</td>
<td>3 TBSP</td>
<td>3 TBSP</td>
<td>4 TBSP</td>
<td>4 TBSP</td>
</tr>
<tr>
<td>Yogurt, plain or flavored unsweetened or sweetened</td>
<td>4 ounces/ 1/4 cup</td>
<td>6 ounces/ 1/4 cup</td>
<td>8 ounces/ 1 cup</td>
<td>8 ounces/ 1 cup</td>
</tr>
</tbody>
</table>

---

### USDA Nondiscrimination 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, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.
**CACFP Child Care Income Eligibility Form (IEF) for 2018-2019**

**STEP 1** List ALL children in day care

<table>
<thead>
<tr>
<th>Child's First Name</th>
<th>Age</th>
<th>Child's Last Name</th>
</tr>
</thead>
</table>

*Children in Foster care or Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals and require additional documentation to verify their eligibility status. Review the Dear Parent Letter for more details.*

- Foster Child
- Migrant
- Runaway
- Homeless
- Head Start

**STEP 2** Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

**IF NO > Go to STEP 3**

**IF YES >** Write case number here and proceed to STEP 4 (Do not complete STEP 3)

**CASE NUMBER:**

Write only one case number in this space

**STEP 3** Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

**A. Child Income**

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

**B. All Adult Household Members (Including yourself)**

List all household members not listed in STEP 1 (including yourself) even if they do not receive income. For each household member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents). If they do not receive income from any source, write "0". If you enter "0" or leave any fields blank, you are certifying (promising) that there is no income to report.

<table>
<thead>
<tr>
<th>Name of Adult Household Members (First and Last)</th>
<th>Earnings from Work</th>
<th>How often?</th>
<th>Welfare/Child Support/Alimony</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
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</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Household Members (Children and Adults)**

**Last Four Digits of Social Security Number (SSN) of primary wage earner or other adult household member:**

- X
- X
- X
- X

Check if no SSN

**STEP 4** Contact information and adult signature.

*I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.*

**Print Name of Adult Signing the Form**

**Signature of Adult**

**Today's Date**

**Address**

**City**

**State**

**Zip**

**Phone/Email**
### Sources of Income

#### Sources of Income for Children

<table>
<thead>
<tr>
<th>Sources of Child Income</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings from work</td>
<td>A child has a regular full or part-time job where they earn a salary or wages</td>
</tr>
<tr>
<td>Social Security - Disability Payments - Survivors Benefits</td>
<td>A child is blind or disabled and receives Social Security benefits. A parent is disabled, retired, or deceased, and their child receives Social Security benefits.</td>
</tr>
<tr>
<td>Income from person outside of household</td>
<td>A friend or extended family member regularly gives a child spending money</td>
</tr>
<tr>
<td>Income from any other source</td>
<td>A child receives regular income from a private pension fund, annuity, or trust</td>
</tr>
</tbody>
</table>

#### Sources of Income for Adults

<table>
<thead>
<tr>
<th>Source of Income for Adults</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings from Work</td>
<td>Salary, wages, cash bonuses. Net income from self-employment (farm or business).</td>
</tr>
<tr>
<td>Public Assistance/Alimony/Child Support</td>
<td>If you are in the U.S. Military, Basic pay and cash bonuses do NOT include combat pay, FSSA, or privatized housing allowances.</td>
</tr>
<tr>
<td>Pensions/Retirement/All other sources of income</td>
<td>Unemployment benefits. Workers compensation. Cash assistance from State or local government.</td>
</tr>
</tbody>
</table>

### STEP 5 - Children's Ethnic and Racial Identities

We are required to ask for information about your children's race and ethnicity. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care. Check all boxes that apply to the child(ren) in your care. If this information is left blank, the institution may complete it based on visual identification.

**Ethnicity:**
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino

**Race:**
- [ ] American Indian or Alaskan Native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White (Includes Hispanic or Latino)

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, the funds your child cares center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or if you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FPDR) case number or other FPDR identifier for your child 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 the meal reimbursement for your child care center/provider. 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 violations of program rules.

DO NOT FILL OUT For center staff use only

**Annual Income Conversion:** Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12. This form expires 12 months after the month in which the institution makes the determination.

<table>
<thead>
<tr>
<th>Total Income</th>
<th>How often?</th>
<th>Household size</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual</td>
<td>Monthly</td>
<td>Weekly</td>
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Determining Official's Signature   Month/Year   Expiration Date (Month/Year)  Date

Revised 7/18
GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name: ___________________________ Birthdate: ___________________________

Allergies: ☐ None or Describe ___________________________

Type of Reaction ___________________________

Diet: ☐ Breast Fed ☐ Formula ☐ Age Appropriate ☐ Special Diet ___________________________

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

☐ Preventive creams/oils/ointments/sunscreens may be applied as requested by parent unless skin is broken or bleeding.

1. ___________________________ give consent for my child’s care health provider, school child care or camp personnel to discuss my child’s health concerns. My child’s health provider may fax this form (with applicable attachments) to my child’s school, child care or camp personnel. FAX #: ___________________________ DATE: ___________________________

Parent/Guardian Signature ___________________________

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: ___________________________ Weight @ Exam: ___________________________

Physical Exam: ☐ Normal ☐ Abnormal (Specify any physical abnormalities) ___________________________

Allergies: ☐ None or Describe ___________________________

Type of Reaction ___________________________

Significant Health Concerns: ☐ Severe Allergies ☐ Reactive Airway Disease ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Hospitalizations ☐ Developmental Delays ☐ Behavior Concerns ☐ Vision ☐ Hearing ☐ Dental ☐ Nutrition ☐ Other ___________________________

Explain above concern (if necessary, include instructions to care providers): ___________________________

Current Medications/Special Diet: ☐ None or Describe ___________________________

Separate medication authorization form is required for medications given in school, child care or camp.

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

☐ Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose ___________________________ or see the attached age-appropriate dosage schedule from our office

☐ Ibuprofen (Motrin, Advil) may be given for pain or fever over 102 degrees every 6 hours as needed

Dose ___________________________ or see the attached age-appropriate dosage schedule from our office

Immunizations: ☐ Up-to-Date ☐ See attached immunization record ☐ Administered today: ___________________________

Health Care Provider: Complete if Appropriate

**ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE**
** Height @ Exam ____ ** B/P _____ ** Head Circumference (up to 12 months) _____ **
** HCT/HGB _____ ** Lead Level ☐ Not at risk ☐ Level __________
** TB ☐ Not at risk ☐ Test Results ☐ Normal ☐ Abnormal
** Screenings Performed: ☐ Vision: ☐ Normal ☐ Abnormal ☐ Hearing: ☐ Normal ☐ Abnormal ☐ Dental: ☐ Normal ☐ Abnormal - Recommended Follow-up ___________________________

Provider Signature ___________________________

Next Well Visit: ☐ Per AAP guidelines* or ☐ Age: ___________________________

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider (certifying form was reviewed) ___________________________ Date: ___________________________

Office Stamp ___________________________

Or write Name, Address, Phone #: ___________________________

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07.

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

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February 1, 2018 | version 1

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July 2018

Dear Children's Alley Families,

We are excited!

Children's Alley is one of only 34 Colorado Early Childhood Centers chosen for a Kid Connects on-site consultant. Our consultant, Laura Free, will be at our school twice a week starting in July.

The goal of Kid Connects is to ensure that children's health and developmental needs are met by promoting social and emotional development and enhancing relationships between children/parents/center staff.

Laura can help with things like friendship skills, temper tantrums, new siblings and other developmental or family concerns. She will work with our teachers as she supports classrooms that promote children's overall well-being. Additionally, she can help parents and teachers think about how to respond to children who are experiencing challenges at home or at the school.

No individual work with your child will take place without your knowledge and specific consent for further intervention. Signing the attached release form allows Laura to engage with all children in the classroom with the goal of supporting our staff and families. A separate release form must be signed for each child.

We believe that our involvement with this valuable program will assist us in our mission to respond to the social, emotional, physical and cognitive needs of the children.

Sincerely,

Karen Hada
Operations Director

Laura Free
Kid Connects Consultant

Laura Free, LCSW

Laura’s Children’s Alley schedule: Tuesdays 12pm – 3:30pm and Fridays 9:30am – 1:30pm
Laura is available for individual appts and questions at 303-817-0374 or lfree@mhpcolorado.org
EARLY CHILDHOOD SERVICES
PERMISSION FORM

In its desire to provide high quality care for children and families, your early care and educational setting partners with Kid Connects, a program of the Early Childhood Services team at Mental Health Partner’s. Kid Connects provides onsite mental health consultation to early childhood education providers and children’s parents or caregivers to improve health and developmental outcomes through child identification, consultation, trainings and referral to community resources as needed.

Our goals are to promote children’s development, to support quality early child care settings, and to enhance relationships among children, parents, and center staff. The Kid Connects consultant provides support to center staff, as well as to the parents of young children. In addition, direct intervention services with families can be requested.

In our continuing efforts to improve our program, and to renew our funding, without identifying either the center/home or child, we document the kinds of issues being addressed in each center, such as child behavioral concerns. The consultant will ask parents and teaching staff to assist us by providing feedback on the consultation services on an annual basis.

Anything discussed between you, your child, the consultant, and center/home staff is confidential, as protected by law. State and Federal laws indicate the following exceptions, for example, to the confidentiality policy: suspected child abuse and neglect, harm to self, or imminent harm to others.

By signing this form, I am informed that a consultant from the Early Childhood Services Team will regularly provide on-site early childhood mental health consultation which may include observation and interaction with teaching staff as well as the children within the program. I also understand that the consultant and center staff may exchange information about my child as outlined above in the effort to create a healthier learning environment for all children. I acknowledge that the consultant will work with the staff in their efforts to understand and address my child’s needs in the child care program and that I can request additional consultation if I desire. In addition, your child may be entered into the Office of Early Childhood information systems. This is for administrative and aggregate purposes only. If you have any questions or concerns, please call us at: 720-879-3844.

Name of Child (each child needs own form)  Child’s Date of Birth

Parent/Guardian Signature  Parent/Guardian Phone #

YWCA Children’s Alley  Today’s Date

Name of Child Care Center

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I, ______________, have read and understood YWCA Boulder County Children’s Alley Parent Handbook.

I understand there is an annual registration fee of $15 per family that is due at the time of enrollment.

☐ I have already paid by phone
☐ I will pay when I turn in the forms

____________________________  _____________
Signature of Parent or Guardian  Date