



Welcome to Kiwanis Day Care Center!

Please feel free to visit our webpage, KiwanisDayCare.com and our Facebook page Facebook.com/kiwanisdaycarecenter for up to date information.

The following documents are required for enrollment and admission of your child to the Kiwanis Day Care Center:

- Physical Examination
- Current Immunization Record
- Completed Enrollment Packet
- Copy of Medical Insurance Card
- Link Certificate for eligible families
- One Month Proof of Income (if applying for sliding fee discount)

Please note that all forms with all required documentation must be completed and turned in prior to your child's first day of attendance.

Parents are also required to send your child with the following:

- Change of clothes
- Diapers/Pull-ups and wipes (if applicable)
- Formula (if applicable) and baby bottles

If you have any questions or concerns, please stop by our office or call 304.525.8701. We are glad to have you and your child at Kiwanis Day Care Center!

Dear Parent,

The Kiwanis Day Care Center has several policies which we feel need to be emphasized when your child is enrolled. The following policies and procedures can be found in your "Parent Handbook" and have been explained to you at the time of enrollment. Please take the time to review these Policies/Procedures and initial beside each one that you have had these explained to you:

- ____ Introduction of your child's classroom staff
- ____ Required 15 day attendance policy for LINK parents
- ____ Required payment of weekly fees
- ____ Medication Procedures
- ____ Center's procedure to follow when a child becomes ill at the Center
- ____ Center's procedure to administer medication to children
- ____ Parent's Right to file a Grievance
- ____ Type of care and programs offered by the Center
- ____ Goals & Objectives of the Center
- ____ Daily Schedule of Activities for Children
- ____ Center's licensing capacity
- ____ Ages of children served
- ____ Schedule of days and hours of operation
- ____ Center's admission and discharge policy
- ____ Center's Liability Insurance Coverage
- ____ Center's policy for parent access to facility
- ____ Center's policy on reporting suspected child abuse
- ____ Center's Anti-Corporal Punishment Policy
- ____ Parent's Right to Confidentiality and Access to Information pertaining to their child.

Child's Name

Parent's Signature

Date

Parent(s) agrees to:

- Bring my child consistently, instead of now and then, so that he/she can learn the daily routine and become part of the group.
- Sign my child in upon arrival and out upon departure daily.
- Sign in any prescription medication on appropriate medication form and be sure staff is aware that the medication needs to be given.
- Not to ask staff to give non-prescription or outdated medicine or medicine prescribed for another child in the family.
- Read the Parent Handbook carefully and ask questions for clarification on any matters not understood.
- Notify the center in advance of the time my child is to be withdrawn so the space may be filled with another child on the waiting list.
- Pick up my child consistently at the end of the work day/school day, which is at _____ p.m. or let the center know if I am going to be late.
- Always see that my child is picked up by center closing time, which is 5:30 p.m. I realize that no employee is paid beyond 5:30 and that I will be charged a fee of a \$1.00 per minute per child in the event I arrive late to pick up my child.
- Let the center know by 10:00 a.m. if my child is going to be absent or will be arriving later. I understand that the lunch count goes to the cook at this time and staff needs to have an accurate attendance count by then.
- Keep an extra set of clothing at the center for my child and replace them promptly each time they are used. I am also aware that I need to check my child's cubby periodically to make sure the extra clothes are appropriate for the season.
- Bring child dressed in clothes he/she can manage by him/herself at toilet time. No belts or suspenders unless my child can manipulate these. Dress my children in appropriate clothes for the weather. I realize that the children go outside in winter and my child will need mittens, a coat, and hat daily and boots for snow or slush.
- Keep the center informed of my home, work, or school phone number or address changes.
- I will pay my tuition fee each week. I realize that not paying my tuition fees weekly will result in a late fee as outlined in the fee schedule.
- If I am receiving state subsidy for child care, sometimes known as Link, my child must be in attendance at least 13 days per month. I realize that if I use more hours than what my certificate allows, that the center will charge me an hourly rate and/or if I bring my child on a day that the certificate will not cover, I will be charged an hourly rate.

Parent Signature

Date

KIWANIS DAY CARE CENTER

PARENT SURVEY

In an effort to better serve the children and parents who attend our day care center, we would like you to take a few minutes to complete the following questionnaire.

1) How did you hear about Kiwanis Day Care Center?

Referred by a friend or relative _____
Referred by Link _____
Former Student _____
Other _____

2) Were you treated with respect when you first contacted Kiwanis Day Care Center?

Yes _____ No _____

3) Why do you need day care services?

Child Care while Working _____
Child Care while at School _____
Child Care to increase child's socialization _____
Other (Please Explain) _____

4) Which of the following was most important to you when you chose Kiwanis Day Care Center?

Center close to home _____
Center close to work or school _____
Close to public transportation _____

5) What other things would you like to see offered at Kiwanis Day Care Center?

Extended Hours _____
Summer Program for School Aged Children _____
After School Program for School Aged Children _____
Other (Please Explain) _____

ALL ABOUT YOUR CHILD

Date _____ Person completing form: _____

Child's Full Name _____ Nickname _____

I have _____ brother(s) and _____ sister(s). Their names and ages are _____

Others in Family / Household	Relationship	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child been in daycare before? Yes _____ No _____

If yes, name of provider or center _____

Provider/Center Address/Phone Number _____

Dates care was provided, from _____ to _____

Reason care was terminated _____

Does your child prefer playing alone? _____ Or with other children? _____

List names of favorite playmates? _____

What is your child's favorite toy? _____

List your child's pets and names of pets: _____

Does your child use the toilet on his/her own? Yes _____ No _____

What skills do you want your child to learn? _____

Eating Habits:

Does your child have a special diet? Yes _____ No _____

*If yes, please list the food and the reason _____

Does your child have any food allergies? Yes _____ No _____

*If yes, please list what foods and what kind of reaction (in detail). _____

*(Note that Notation about special dietary form must be on file)

Does your child have any food allergies? Yes _____ No _____

Your child's favorite foods _____

Least favorite foods _____

Does your child eat independently? Yes _____ No _____

Infants:

What brand of formula do you use? _____

Baby Cereal: Yes _____ No _____ Rice _____ Oatmeal _____ Mixed _____

If your child is on baby food, number of hours between each meal: _____

Does your child take their bottle immediately after eating food? Yes _____ No _____

If no, how long after eating does your child take his/her bottle? _____

Does your child have any food allergies? Yes _____ No _____

***If yes, please explain in detail what foods and what reaction? _____

Sleeping Habits:

_____ Yes _____ No

What time does your child usually go to bed at night? _____

Does your child take naps? Yes _____ No _____

If yes, how long does your child usually nap? _____

Does your child have any problems getting to sleep or staying asleep? Yes _____ No _____

If yes, please explain _____

Health Concerns:

Does your child have any known health concerns? Yes _____ No _____

If yes, please describe _____

Does your child take any medications on a regular basis? Yes _____ No _____

If yes, list the medication(s), dosage, and how often taken _____

Are there any hearing or vision problems? Yes _____ No _____

If yes, please describe _____

Does your child have any known allergies? Yes _____ No _____

If yes, please list the allergy and how it is dealt with _____

List any communicable diseases your child has had _____

Does your child suffer from any of the following on a *regular* basis (check all that apply)?

Nosebleeds _____ Headaches _____ Sore throats _____ Stomachaches _____ Runny nose _____

Behavior:

How do you "reward" or "discipline" your child?

Anything else about your child that you feel we should know?



1900 Kanawha Boulevard, East, Building 6 • Charleston, WV 25305
wvde.us

June 4, 2018

Child and Adult Care Food Program (CACFP) Sponsors

2018 – 2019 Free and Reduced Price Meals Family Application

Enclosed you will find a copy of the 2018 – 2019 Free and Reduced Price Meals Family Application. Also included in this mailing are the following:

- Prototype Letter to Households;
- Instructions for Applying; and
- 2018 – 2019 Free and Reduced Application.

Application forms may be duplicated from the attached document or obtained from the OCN download site at <https://wvde.state.wv.us/child-nutrition/cacfp/forms-reference-tools.html>. Free and Reduced eligibility status may be effective for the entire year regardless of changes in the household's income status. Participants are always at liberty to apply for benefits throughout the year. Please be reminded that it is essential the confidentiality of participant's eligibility be protected and that information be released only for the purposes permitted by federal rules or granted by parent or guardian signatures.

The 2018 – 2019 Free and Reduced Price Meals Family Application is effective July 1, 2018. If you have questions or need further assistance, please call Tracy Sayre, CACFP Coordinator at (304) 558-3396 or email her at trcsayre@k12.wv.us.

Sincerely,

A handwritten signature in blue ink, which appears to read "A. Harrison", is written over the printed name.

Amanda Harrison, Executive Director
Office of Child Nutrition
West Virginia Department of Education

AH/TS/ja

Enclosures

06012018jaTS_FY2019 FREApps

Dear Parent or Guardian:

This center participates in the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP). Please help us comply with the requirements of the CACFP by completing, signing and returning the attached statement as soon as possible. The statement will be filed as confidential information. The names of the participants for which free or reduced price meals may be claimed shall not be published, posted or announced in any manner; this information is necessary to determine the amount of federal funding received by our center for the meal served to children. Higher reimbursement will contribute to the overall quality of care your provider maintains.

If you received Food Stamps or benefits under the West Virginia Temporary Assistance to Needy Families (TANF) on behalf of your child, then please list either your 10 digit Food Stamp case number or your TANF case number in Section 2 and sign and date the statement in Section 5. This means that your child is "categorically eligible" and will automatically qualify for reimbursement.

If a Food Stamp or TANF case number is not reported, Section 4 must be completed. You must include your total current household income by source and the names of all household members. CACFP defines a household as a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses). The reported income should be what each member received last month. If last month's income does not accurately reflect your circumstances, provide a projection of your income using last year's income as a basis. Please remember to put the name and social security number of the primary wage earner underneath the chart. You must also sign and date Section 5.

If this application is for a foster child, please read carefully the directions found on the "Instructions For Applying" sheet. If you have a foster child and have further questions, please contact our office for additional information before completing the application.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil right 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, audiotope, 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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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 and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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.

Thank you for your cooperation: _____
Institution Representative

Program Year 2018-2019
West Virginia Department of Education
FREE AND REDUCED PRICE SCHOOL MEAL FAMILY APPLICATION
INSTRUCTIONS FOR APPLYING

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

- Part 1:** List child(ren)'s name, date of birth, grade, and school, center, or camp.
Part 2: Check the appropriate box and list the 10-digit Food Stamp or TANF case number.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is not necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.
Part 8: (Found on back of application.) Call number listed to request WVCHIP or Medicaid information.

If you are applying for a child who is HOMELESS, MIGRANT, or a RUNAWAY, follow these instructions: check the appropriate box and call your county contact at the phone number listed in Part 3 of the application. Fill out the rest of the application by following instructions for ALL OTHER HOUSEHOLDS.

If you are applying for a FOSTER CHILD, follow these instructions:

If all children in the household are foster children:

- Part 1:** List all foster children, date of birth, grade and school, center, or camp.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.

If some children in the household are foster children:

- Part 1:** List all children in the household (including foster children), date of birth, mark box if foster child, grade, and school, center, or camp.
Part 2: If the household does not have a case number, skip this part.
Part 3: If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call the contact number listed.
Part 4: Follow these instructions to report total household income from last month.

Column 1—Name: List all household members.

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

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

- Part 5:** An adult household member must sign the form and list the last 4 digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.
Part 8: (Found on back of application.) Call number listed to request WVCHIP or Medicaid information.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

- Part 1:** List each child's name, date of birth, grade and school, center, or camp.
Part 2: Skip this part.
Part 3: Check a box only if it applies.
Part 4: Follow these instructions to report total household income from last month.
Column 1—Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends). **You must include yourself and all children.** Attach another sheet of paper with household members if required.
Column 2—Last month's income: List the types of income your household received last month. *Employment Income:* List the **gross income** each person earned last month. It is not the same as take home pay. **Gross income is the amount earned before taxes and deductions.** It should be listed on your pay stub, or your boss can tell you. *Other Income:* List the total amount each person received last month from **all other sources.** Include welfare, child support, alimony, pensions, retirement, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, withdrawals from savings, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income.
Last Column—Check if no income: If the person does not have any income, check the box.
Part 5: An adult household member must sign the form and list the last 4 digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.
Part 8: (Found on back of application.) Call number listed to request WVCHIP or Medicaid information.

Free and Reduced-Price Household Application for 2018-2019 – West Virginia Dept. of Education
 USE BLACK OR DARK BLUE INK. PRINT NEATLY, COMPLETE ONE APPLICATION PER HOUSEHOLD

1. Names of ALL Children in School, Center, or Camp

Last Name	First Name	MI	Date of Birth MM/DD/YY	Mark if Foster	Grade	School, Center, or Camp
			/ /	☐		
			/ /	☐		
			/ /	☐		
			/ /	☐		
			/ /	☐		

2. SNAP/TANF NUMBER

If any member of your household receives SNAP or TANF, indicate which program and provide the 10-digit case #
 (If any, SKIP TO PART 5)

SNAP	TANF								
☐	☐								

3. HOMELESS, MIGRANT, RUNAWAY

If the child you are applying for is **homeless, migrant, or runaway**, check the appropriate box and call your county contact at _____

Homeless	Migrant	Runaway
☐	☐	☐

4. HOUSEHOLD MEMBERS AND GROSS INCOME FROM LAST MONTH

List each person in the household. For each person who receives income, write the amount received and fill in how often it is received.

Name (Last, First) List everyone in the Household. Attach a separate sheet if needed.	Monthly Earnings from Work (Before Deductions)	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security	Other Monthly Income	Check if no Income
	\$	\$	\$	\$	☐
	\$	\$	\$	\$	☐
	\$	\$	\$	\$	☐
	\$	\$	\$	\$	☐
	\$	\$	\$	\$	☐
	\$	\$	\$	\$	☐

Total Number of Persons in Household _____ **Total Monthly Income Before Deductions \$** _____

5. Signature and Social Security Number (Adult must sign.)

An adult household member must sign the application. If Part 4 is completed, the adult signing the form must also list the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school system may get federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my child(ren) may lose milk benefits, and I may be prosecuted.

Today's Date	Last 4 Digits of Social Security Number	
		☐ I do not have a Social Security Number

Signature _____

Printed Name _____

Home Phone Number _____

Work Phone Number _____

Mailing Address _____

City _____

State _____

ZIP Code _____

6. Children's Race and Ethnicity - (You do not have to complete this part to receive free and reduced price milks.)

Mark one or more racial identities from this group:

☐ Asian
 ☐ American Indian or Alaska Native
 ☐ White
☐ Black or African American
 ☐ Native Hawaiian or Other Pacific Islander

And mark one ethnic identity from this group:

☐ Hispanic or Latino
 ☐ Not Hispanic or Latino

7. Other Benefits - (You do not have to complete this part to receive free and reduced price milks.)

☐ Yes, school officials may use the information provided on this application to determine my child(ren)'s eligibility for free textbooks, workbooks, and other school supplies.

Do not fill out this part. This is for sponsor's use only. Annual Income Conversion: Weekly X 52, Every 2 Weeks X 26, Twice A Month X 24, Monthly X 12

Categorically Eligibility: ☐ -Or- Income Eligibility: ☐ ☐ Free Milks
☐ Reduced Milks
 Denied: Reason: _____

Signature/Stamp of Approving Official _____ Date Approved _____ Date Withdrawn _____

Verification: Confirming Official's Signature _____ Date _____

Follow-up Official's Signature _____ Date _____

Free and Reduced-Price Household Application for 2018-2019 – West Virginia Dept. of EducationUSE BLACK OR DARK BLUE INK, PRINT NEATLY, COMPLETE ONE APPLICATION PER HOUSEHOLD**8: Free and Low-Cost Health Care**

If your children get free or reduced price school milks, they may also be able to get free or low-cost insurance through Medicaid or the West Virginia Children's Health Insurance Program (WVCHIP). Children with health insurance are more likely to get regular health care and are less likely to miss school because of sickness.

If you would like information about WVCHIP or Medicaid, please call toll-free anytime at 1-877-982-2447 or visit www.chip.wv.gov. You may also apply online at www.wvinroads.org.

Your children may qualify for free or reduced price milks if your household income does not exceed the limits on this chart.

FEDERAL INCOME CHART For School Year July 1, 2018 – June 30, 2019					
Household size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	\$22,459	\$1,872	936	864	432
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	70,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
Each additional person:	7,992	666	333	308	154

Privacy Act Statement: This explains how we will use the information you give us.

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 your child for free or reduced price milks. 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 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 or other FDPIR 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 if your child is eligible for free or reduced price milks, and for administration and enforcement of the lunch and breakfast programs. 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.

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, 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 and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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.

Backpack Program

We at Kiwanis Day Care Center offer a "Backpack Program" that supplies families with food if they present a need. We know that it can sometimes be difficult for parents to buy groceries for their family after the bills are paid and pay day is another week away. This program benefits children and helps families because we understand that times are tough. Food is placed in children's cubbies on the majority of Fridays throughout the year. If you would like to be added to or removed from our "Backpack Program" list, please return the bottom half of this paper, at any time, to your child's teacher or to Ms. Brenda, Ms. Tiffany, or Ms. Amy.

Your name _____

Child(ren)'s name _____

Number of family members _____

Addition to list?

Yes

No

Removal from list?

Yes

No

Signature _____ Date _____

Backpack Program

We at Kiwanis Day Care Center offer a "Backpack Program" that supplies families with food if they present a need. We know that it can sometimes be difficult for parents to buy groceries for their family after the bills are paid and pay day is another week away. This program benefits children and helps families because we understand that times are tough. Food is placed in children's cubbies on the majority of Fridays throughout the year. If you would like to be added to or removed from our "Backpack Program" list, please return the bottom half of this paper, at any time, to your child's teacher or to Ms. Brenda, Ms. Tiffany, or Ms. Amy.

Your name _____

Child(ren)'s name _____

Number of family members _____

Addition to list?

Yes

No

Removal from list?

Yes

No

Signature _____ Date _____

GUIDELINES TO DETERMINE PARTICIPANT ELIGIBILITY FOR FREE AND REDUCED PRICE MEALS School Year 2017-2018

ANNUAL FAMILY INCOME BEFORE DEDUCTIONS

ELIGIBLE FOR FREE MEALS OR FREE MILK					
HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
ONE	\$15,678	\$1,307	\$654	\$603	\$302
TWO	21,112	1,760	880	812	406
THREE	26,546	2,213	1,107	1,021	511
FOUR	31,980	2,665	1,333	1,230	615
FIVE	37,414	3,118	1,559	1,439	720
SIX	42,848	3,571	1,786	1,648	824
SEVEN	48,282	4,024	2,012	1,857	929
EIGHT	53,716	4,477	2,239	2,066	1,033

ELIGIBLE FOR REDUCED PRICE MEALS				
YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
\$22,311	\$1,860	\$930	\$859	\$430
30,044	2,504	1,252	1,156	578
37,777	3,149	1,575	1,453	727
45,510	3,793	1,897	1,751	876
53,243	4,437	2,219	2,048	1,024
60,976	5,082	2,541	2,346	1,173
68,709	5,726	2,863	2,643	1,322
76,442	6,371	3,186	2,941	1,471

FOR EACH ADDITIONAL FAMILY
MEMBER, ADD

5,434	453	227	209	105
-------	-----	-----	-----	-----

7,733	645	323	298	149
-------	-----	-----	-----	-----

CONVERSION FACTOR

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

Kiwanis Day Care Center Child Care Nutrition Policy

Policy Statement

Good nutrition is vital to children's overall development and well-being. In an effort to provide the best possible nutrition environment for children in our facility, Kiwanis Day Care Center has developed the following child care nutrition policies to encourage the development of good eating habits that will last a lifetime.

Child Care Nutrition

Kiwanis Day Care Center follows the child care nutrition guidelines recommended by the USDA CACFP (Child and Adult Care Food Program) for all foods we serve. To provide a healthy and balanced diet that includes fruits, vegetables, and whole grains and limits foods and beverages that are high in sugar and/or fat, our nutrition policy includes the following:

Fruits and Vegetables

- ✓ We serve fruit at least 2 times a day.
- ✓ We offer a vegetable at least once a day.
- ✓ We offer a variety of fruits and vegetable of varying colors and types to help ensure adequate nutrient intake.

Grains

- ✓ We serve whole grain foods at least once a day.
- ✓ All grain products, including cereals, must contain < 6 grams of sugar per serving.
- ✓ Sweet grains/baked goods may only be served once per two week cycle as snack.

Beverages

- ✓ We serve only skim or 1% milk to children age 2 and older.
- ✓ Whole milk is served to children ages 12 - 24 months.
- ✓ We limit juice intake to once per day, no more than 4 ounces may be served. When served, the juice is 100% fruit juice.
- ✓ We do not serve sugar sweetened beverages.
- ✓ We do not offer juice for infants under 12 months of age.

Meats

- ✓ Lean and low-sodium meat, skinless poultry, fish, cooked beans and peas, nut butters, eggs, and fat-free or low-fat yogurt and cheeses will be emphasized when the menu is planned.
- ✓ Meat and meat alternatives served must meet the requirement of < 35 % of calories from total fat; no more than 10% of calories from saturated fat; and less than 0.5 grams of trans fat.
- ✓ High fat meats, such as bologna, bacon, and sausage are served no more than once per two week cycle.

Role of Staff in Nutrition Education

- ✓ Staff provides opportunities for children to learn about nutrition.
- ✓ Staff act as role models for healthy eating in front of the children.

Meal and snack times are planned so that no child will go more than four hours without being offered food. We provide a variety of nutritionally balanced, high quality foods each day. Children are not allowed to bring in packed lunches or individual snacks from home.

Menus

Our menus are carefully planned to follow child care nutrition guidelines at every meal. Each menu is designed to provide a wide variety of nutritious foods that are different in color, shape, size, and texture. All of our child care menus include foods that are culturally diverse and seasonally appropriate. We also like to introduce new and different foods and include children's favorite recipes in our menu planning. Menus are adapted to incorporate local and fresh in-season produce when available.

Nutrition and Punishment

Staff will never use food as a reward or as a punishment.

Celebrations

From birthday parties to holidays there are many opportunities for celebrations in our child care center. A birthday party will be held monthly in each classroom. If you would like to recognize your child's actual birthday, we request that you not send in treats or goody bags, but instead send a birthday book for the class to enjoy. For holiday celebrations, a sign-up sheet with specific foods and beverages will be placed on the classroom door. Please note that even during holiday celebrations, our nutritional guidelines need to be followed.

Infant Meal Planning

Infants will be fed upon their own individualized schedule. Our infant meals follow the Child and Adult Food Program guidelines. The guidelines are posted in our infant classroom and a copy is provided in your enrollment packet.

Professional Development

Annual nutrition training is required to ensure that all staff understand the important role nutrition plays in the overall well being of children. Additionally, all staff must go through a food handler's class.

My signature below indicates that I have received a copy of the nutrition policy, it has been reviewed with me, and I have read and understand this policy.

Signature _____

Date _____

Please circle as appropriate

STAFF

PARENT

If parent, name of child _____

The Bureau for Public Health recommends the following **minimum requirements** in accordance with ACIP age appropriate recommended vaccines. The vaccines listed are a guide for child care centers, family child care centers and in-home child care for evaluating children and their immunization records.

Age	Hep B	DTaP	Hib*	Polio	MMR	Varicella	Pevnar*	Hep A*	Rotavirus
2-3 months	1st dose	1st dose	1st dose	1st dose			1st dose		See Note
4-5 months	2nd dose	2nd dose	2nd dose	2nd dose			2nd dose		
6-14 months	2nd dose	3rd dose	3rd dose	2nd dose			3rd dose		
15-17 months	2nd dose	3rd dose	3rd dose	2nd dose	1st dose	1 dose or history	3rd dose	1st dose	
18 mo. - 5 years	3rd dose	4th dose	4th dose	3rd dose	2nd dose		4th dose	2 nd dose	

Note: Rotavirus vaccine series must be initiated **between 6 weeks and 14 weeks, 6 days of age**.

If not, the series should not be started at all. Subsequent doses should be administered at 4 to 10 week intervals.

No dose should be given after the end of 7th month of age.

Hep A	Hepatitis A – a serious liver disease	Hep B	Hepatitis B – a serious liver disease
DTaP	Diphtheria, tetanus (lockjaw) and pertussis (whooping cough)	Varicella	Chickenpox – an itchy rash of spots that look like blisters
Hib	Haemophilus influenzae type b (bacterial meningitis), a serious brain, throat and blood infection	PCV	Pevnar, pneumococcal conjugate vaccine protects against a serious blood, lung and brain infection.
IPV/Polio	Polio, a serious paralyzing disease	MMR	Measles, mumps and rubella
Rotavirus	Rotavirus is a virus that causes severe diarrhea, usually with fever and vomiting.		

- **Rules for Hib doses:** if #1 was given at 12-14 mo., give a booster dose in 8 wks.; give only 1 dose to unvaccinated children ≥ 15 mo. and < 5 yrs of age.
- **Rules for HibTITER and ActHib:** #2 and #3 may be given 4 wks after previous dose. If #1 was given at 7-11mo., only 3 doses are Needed. #2 is given 4-8 wks after #1, then boost at 12-15 mo.
- **Rules for PedvaxHib and Comvax:** #2 may be given 4 wks after dose #1.
- **Pevnar:** minimum interval between doses for infants < 12 mo. of age is 4 wks. For ≥ 12 mo. of age is 8 wks. For infants 7-11 mo. of age: if unvaccinated, give dose #1 now, give #2 dose 4-8 wks later, and boost at 12-15 mo. For children 12-23 mo. 1) If not previously vaccinated or only one previous dose before 12 mo., give 2 doses ≥ 8 wks. apart. 2) If child previously had 2 doses, give booster dose ≥ 8 wks after previous dose.
- **Rule for Hep A:** 1st dose at 12-23 months of age. 2nd dose 6 months after the 1st.
- **Influenza Vaccine:** recommended for all 6 -59 month olds annually.



1900 Kanawha Boulevard, East, Building G • Charleston, WV 25305
Steven L. Paine, Ed.D., State Superintendent of Schools
wvde.state.wv.us

Children with Disabilities and Special Dietary Needs

Schools participating in a federal school meal program (National School Lunch Program, School Breakfast Program, Fresh Fruit and Vegetable Program, Special Milk Program, and Afterschool Snack Program) are required to make reasonable accommodations for children who are unable to eat the school meals because of a disability that restricts the diet.

1. Licensed Medical Authority's Statement for Children with Disabilities

U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. School food authorities must provide modifications for children on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for School Food Service") may be used to obtain the required information from the licensed medical authority. For this purpose, a state licensed medical authority in West Virginia includes a:

- Physician, (MD or DO)
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the child's physical or mental impairment restricts the child's diet;
- An explanation of what must be done to accommodate the child; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Dietary Needs

School food service staff may make food substitutions for individual children who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Schools are encouraged to have documentation on file when making menu modifications within the meal pattern.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990 and the ADA Amendments Act of 2008, a person with a disability means any person who has a

physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

4. Individuals with Disabilities Education Act

A child with a disability under Part B of the Individuals with Disabilities Education Act (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to ensure that school food service staff is involved early in decisions regarding special meals. If an IEP or 504 plan includes the same information that is required on a medical statement (see section 1, above), then it is not necessary to get a separate medical statement.

School Nutrition Program Contact

For more information about requesting accommodations to school meals and the meal service for students with disabilities in Ohio County Schools, please contact: Renee Griffin, MS, RD, LD, 304-243-0477.

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, audiotope, 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, (AD3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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.

Medical Plan of Care for School Food Service
Please read pages 1 and 2 before completing this form.

Student's Name	Date of Birth	Grade Level/Classroom
Name of School/Site/County		WVEIS Number
Name of Parent/Guardian		Phone Number of Parent/Guardian
Signature of Parent/Guardian		Date
1 Provide an explanation below of how the student's physical or mental impairment restricts the student's diet:		
2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs:		
3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate. Foods to be omitted:		
Suggested substitutions:		
4. Other Restrictions:		
5. Indicate texture modifications, if applicable: ☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ Other: _____		
6. List any required special adaptive equipment:		
Name of Physician/Medical Authority & Title (Please Print)		Provider Phone Number
Signature of Physician/Medical Authority		Date
Signing the following section is optional, but may prevent delays by allowing the school to speak with the physician/medical authority. Health Insurance Portability and Accountability Act Waiver In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (school/program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person. Parent/Guardian Signature: _____ Date: _____		

Kiwanis Day Care Center

Discharge Policy

The Kiwanis Day Care Center reserves the right to discharge children, parents, and significant others from receiving continued daycare services when the Center can document the following actions/behaviors on the part of children, parents, and significant others:

- Physically assaultive, verbally assaultive or emotionally assaultive behavior which causes injury to others;
- Failure of the parent or significant other to provide information and/or documents essential to enrollment requested by Center Staff;
- Usage of inappropriate language and inappropriate actions in the presence of children and center staff;
- Failure to pay fees for services provided;
- Failure of parent or significant other to accept and abide by the policies and regulations of Kiwanis Day Care Center;
- Falsification of information provided to Kiwanis Day Care Center;
- Any and all other actions on the part of children, parents, and/or significant other which are deemed inappropriate and unacceptable by Center Staff, Center Director or Center Board of Directors;

The Kiwanis Day Care Center shall further reserve the right to dismiss any children and/or parent for just cause not listed in the above specified areas.

Please sign below indicating that you understand Kiwanis Day Care discharge policy.

Parent Signature

Date

Effective 04/2015

Kiwanis Day Care Center
71 Washington Avenue
Huntington, WV 25701
(304) 525-8701

Emergency Information Record

Child's Name: _____ Date of Birth: _____
Address: _____

Mother: _____ Home Phone: _____
Address: _____
Employer: _____ Phone: _____
Address: _____

Father: _____ Home Phone: _____
Address: _____
Employer: _____ Phone: _____
Address: _____

Person(s) To Contact if Parents are Unavailable

1st Contact: _____ Relation to Child: _____
Address: _____ Phone: _____

2nd Contact: _____ Relation to Child: _____
Address: _____ Phone: _____

Child's Physician: _____ Phone: _____
Address: _____

Child's Dentist: _____ Phone: _____
Address: _____

Hospital Preference: _____ Phone: _____
Address: _____

In the event that I cannot be reached, I hereby give my permission for my child to receive any necessary emergency medical care or treatment. I understand that every effort will be made to contact me or my spouse before such action is taken. I will be responsible for the payment for such care or treatment.

Date: _____ Signature of Parent: _____



Kiwanis Day Care Center

71 Washington Avenue
Huntington, WV 25701-1124

Phone 304-525-8701
Fax 304-525-4422

ENROLLMENT APPLICATION FORM

Date of Application: _____

Child's Name: _____ Gender: M ___ F ___

Social Security Number: _____ Date of Birth: _____

Address: _____ Phone # _____

Mother's Name: _____

Place of Employment: _____

Employer's Address: _____

Work Phone Number: _____ Home Phone # _____

Occupation: _____ SS#: _____

Father's Name: _____

Place of Employment: _____

Employers Address: _____

Work Phone Number: _____ Home Phone # _____

Occupation: _____ SS#: _____

Emergency Contact if Neither Parent Can Be Reached:

Name: _____ Phone# _____

Relationship to Child: _____

Other Children in Family (or Home):

Name	Date of Birth	School Attending
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Has your child attended any day care centers or in home provider in the past? _____ Where: _____

Does your child have any known allergies or special medical problems? Please list: _____

Mother's monthly income before taxes: _____

Father's monthly income before taxes: _____

IV. Truth of Statement

The facts set forth in this application are true and complete to the best of my knowledge. I understand and accept the fact that a false or incomplete statement on this application will be cause for rejecting my application, at which point I will be responsible for 100% of the normal weekly tuition rate for my child.

Parent's Signature

Date

V. Sliding Fee Disclosure

Re-evaluation for sliding fee is required if there is a change in your income status during the year. You are required to have your complete application updated twice a year, even if your income has remained the same or your fee will revert back to 100%.

VI. Summary

Mr./Mrs/Ms. _____ total yearly, monthly, or weekly income is \$ _____, the family size is _____, and therefore is eligible for a reduce rate in tuition. The reduced rate will be _____ weekly or daily and is due prior to receiving services.

Director's Signature

Date

YOUR NEXT SCHEDULED REVIEW DATE WILL BE, _____.

Insect Repellent Permission Form

Name of child: _____ Date of Birth: _____

Name of insect repellent: _____

_____ I will provide insect repellent and give permission for my child's teachers to apply it to bare surfaces including the face, neck, bare shoulders, arms, legs, and feet before outdoor activities. Insect repellent will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by a staff will be reported promptly to the parent/guardian. It is the parent's responsibility to provide insect repellent with DEET, it is recommended that a concentration containing between 10% and 30% DEET be used with children.

_____ I do not want my child to use any insect repellent. I recognize that insect bites pose a risk of an allergic reaction and disease. I understand that my child will be taken outside on a daily basis, weather permitting.

I will not hold Kiwanis Day Care Center liable for any insect bites, reactions to insect bites or repellent, or disease related to insect bites.

Parent/Guardian Name

Parent/Guardian Signature

Date

Infant Meal Notification

Child Care Center Name:

Iron-fortified Infant Formula offered by Center:

All children enrolled in this center, including infants, are eligible for meals through the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). Child care centers in the program are reimbursed to help with the cost of serving nutritious meals to enrolled children. The meals must meet CACFP nutrition guidelines for children and infants. To meet CACFP requirements this center will provide formula and other foods for infants.

To help provide the best nutritional care for your infant, please complete the following information and return it to the center:

Infant's First and Last Name:

Infant's Date of Birth:

I understand that the child care center will supply the above iron-fortified infant formula for infants according to the CACFP requirements. ***Note: Child care centers may request parents to supply clean, sanitized, and labeled bottles on a daily basis.**

If you *formula-feed* your infant, place a check mark (✓) by only ONE of the following:

- ☐ I prefer to have the child care center supply formula. **OR**
☐ I will supply formula for my infant.

If you *breastfeed* your infant, place a check mark (✓) by only ONE of the following:

- ☐ I will supply breast milk. **OR**
☐ I will supply breast milk and have the child care center supplement formula if necessary.
OR
☐ I will supply breast milk and/or formula.

I understand the child care center will supply infant cereal and other foods for infants 4 months and older as they are developmentally ready according to the CACFP requirements. Infant foods include fruits/vegetables, meat/meat alternates, enriched bread or snack crackers, and 100% full strength juice that are creditable to the USDA Infant Meal Pattern.

Place a check mark (✓) by only ONE of the following:

- ☐ I prefer to have the child care center supply infant cereal and infant foods. **OR**
☐ I will supply infant cereal and infant foods for my infant.

****This facility has not requested or required me to provide infant formula or food for my infant. I understand that I have the choice of having my infant participate in the CACFP.**

Parent/Guardian Signature

Date

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](http://www.ascr.usda.gov/complaint_filing_cust.html), (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 and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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.

Revision Date 12/15

Guidance Memo 12C, *Infants* Section

<http://dpi.wi.gov/community-nutrition/cacfp/child-care/memos>



CACFP Infant Meal Pattern Requirements (Birth through 11 Months)

To comply with the CACFP regulations, it is the responsibility of child care centers caring for infants to purchase all required meal components on the Infant Meal Pattern according to the different age groups in care.

The infant meal must contain each of the following components in at least the amounts listed for the appropriate age group in order to qualify for reimbursement. Food within the meal pattern should be the texture and consistency appropriate for the development of the infant and may be served during a span of time consistent with the infant's eating habits; for example, the food items for lunch might be served at two feedings between 12 noon and 2 p.m. Foods should be introduced gradually to infants when developmentally ready and instructed by the parent.

Within the meal chart below, food components marked with “●” MUST be offered to the infant in order to claim reimbursement for that meal. Food components listed under “When developmentally ready” must be offered as part of the meal only when the infant is developmentally ready to accept them.

Birth through 3 months	4 through 7 months	8 through 11 months
Breakfast		
● 4–6 fl oz formula¹ or breast milk^{2,3}	● 4–8 fl oz formula¹ or breast milk^{2,3} When developmentally ready ❖ 0–3 T infant cereal¹	● 6–8 fl oz formula¹ or breast milk^{2,3} and ● 1–4 T fruit or vegetable or both and ● 2–4 T infant cereal¹
Lunch/Supper		
● 4–6 fl oz formula¹ or breast milk^{2,3}	● 4–8 fl oz formula¹ or breast milk^{2,3} When developmentally ready ❖ 0–3 T infant cereal¹ and/or ❖ 0–3 T fruit or vegetable or both	● 6–8 fl oz formula¹ or breast milk^{2,3} and ● 1–4 T fruit or vegetable or both and ● 2–4 T infant cereal¹ and/or meat/meat alternates as follows: ○ 1–4 T meat, fish, poultry, egg yolk, cooked dry beans or peas; or ○ ½–2 oz cheese; or ○ 1–4 oz (volume) cottage cheese; or ○ 1–4 oz (weight) cheese food/spread
Snack		
● 4–6 fl oz formula¹ or breast milk^{2,3}	● 4–6 fl oz formula¹ or breast milk^{2,3}	● 2–4 fl oz formula¹ or breast milk,^{2,3} or fruit juice⁴ When developmentally ready ❖ 0–½ slice crusty bread⁵ or 0–2 crackers⁵

¹Infant formula and dry infant cereal must be iron-fortified.

²Breast milk or formula, or portions of both, may be served; however, it is recommended breast milk be served in place of formula from birth through 11 months.

³For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered with additional breast milk offered if the infant is still hungry.

⁴Fruit juice must be full-strength.

⁵A serving of this component must be made from whole-grain, enriched meal or flour.

Photo Release Form

On occasion, Kiwanis Day Care Center (KDCC) staff will take photographs of enrolled children. These photographs are primarily used for center purposes; to display in the center to show parents what the children have been involved in or to create keepsakes for the staff or children of their experiences. Occasionally we find the need to use a photo for marketing purposes: newsletter, website, twitter, or brochures. Also, news media outlets occasionally asks to take photographs of the children for a news story.

We can only use your child's photo if we have permission from you. Please indicate below if you do or do not authorize the use of photos of your child.

_____ Yes, I authorize Kiwanis Day Care Center to use photos of my child for the below purposes *Check all that apply*

- _____ Classroom Use
- _____ Newsletter
- _____ KDCC Website
- _____ KDCC Twitter
- _____ KDCC Face book
- _____ Local newspaper or media outlets

_____ No, I do not authorize Kiwanis Day Care Center to use photos of my child for any of the above named purposes.

Child's Name (please print)

Parent/Guardian's Name (please print)

Parent/Guardian's Signature

Date

KIWANIS DAY CARE CENTER
71 WASHINGTON AVENUE
HUNTINGTON, WV 25701
(304) 525-8701

PICK-UP PERMISSION FORM

NOTE: I hereby give permission for my child: _____
to leave the Kiwanis Day Care Center with the following persons named
below. I understand that it is my responsibility to notify the center, in
writing of any changes to this list.

NAME	RELATIONSHIP	ADDRESS	PHONE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DATE _____ SIGNATURE OF PARENT _____

Name of Persons who may not pick up the child

Is there a separation or divorce custody issue? If so, please attach all
documents which state the legal custodian of the child.

KIWANIS DAY CARE CENTER

71 Washington Avenue
Huntington, WV 25701

Please list the names, school attending, and telephone number of the school for all "School-Age Children" in the family:

Name

Age

School

Phone Number

[illegible]

SUN-SMART POLICY FOR Kiwanis Day Care Center

Our Sun-Smart policy has been developed to ensure that all children and staff participating in this program are protected from skin damage caused by the harmful UVB and UVA rays of the sun. This policy will be implemented throughout the year, but with particular emphasis from March through October.

Sun-Smart strategies:

- _ Encourage staff and children to wear hats with wide brims that protect their face, neck and ears whenever they are outside.
- _ Encourage staff and children to wear sun-protective clothing (i.e., tightly woven, loose-fitting, full length, light-colored and light-weight) when temperatures are reasonable.
- _ Encourage staff to wear sunglasses that block 100 percent of UVA and UVB rays(broad spectrum)whenever they are outside.
- _ Provide sufficient areas of shelter and/or trees providing shade on the play yard.
- _ Encourage children to seek and use available areas of shade for outdoor play activities.
- _ Children will be hydrated and encouraged to drink water before and during prolonged physical outdoor activities in warm weather.
- _ Staff and parents/guardians will model sun safety behaviors by:
 - _ Wearing appropriate hats and clothing when outdoors.
 - _ Using broad spectrum SPF 15 or higher sunscreen for skin protection.
 - _ Seeking shade whenever possible.
 - _ Parent to provide broad spectrum SPF 15 or higher
 - _ Sunscreen to be used on their child's exposed skin, except eyelids, 30 minutes before exposure to the sun and every two hours while in the sun.
 - _ Apply sunscreen before and after water play.
 - _ Do not apply sunscreen to toddler's hands or foreheads, since sweat can cause it to get in children's eyes.
- _ School-age children may apply sunscreen to themselves with adult supervision.
- _ Parents/guardians will complete and sign the *Parent/Guardian's Permission to Apply Sunscreen to His/Her Child* and it shall remain on file at the program.
- _ Include learning about the skin and ways to protect the skin from the UV rays of the sun into the program's curriculum and daily routines.

I give permission for Kiwanis Day Care Center to apply sunscreen (SPF 15 or higher) any time my child may be exposed for a period of time in the sun.

Child's Name: _____

Parent's Signature: _____ Date: _____

Kiwanis Day Care Center Tuition Rates
Effective January 1, 2015

FULL TIME

Children under the age of 2\$150.00/week
Children 2 years of age to 12 years of age\$125.00/week

PART TIME

Children under the age of 2\$32.00/day
Children 2 years of age to 12 years of\$27.00/day

Hourly rate for school age and pre k students for before and after school care.....\$4.00/hour

Hourly rate for those parents needing care over the hours provided by their child care subsidy,
(LINK)..... \$4.00/hour

Multiple children discount rate:

2nd child will receive a discount of\$15.00/week
3 or more children will receive a discount of\$20.00/week

*Parents who need assistance with child care costs may apply for subsidy help through LINK at River Valley Child Development Services, (304) 523-9540. Families who do not qualify for LINK, may apply through the day care center for the sliding fee scale program.

Kiwanis Day Care Center is a non-profit agency. The center depends on the fees paid by parents and Link to cover our expenses to operate our program. The center cannot operate without the timely payments made by parents. All fees are due weekly. The only bi-weekly and monthly payments the center will accept are "payments made in advance" of services provided. Parents are at risk of their children being discharged when tuition payments are not paid in full weekly.

Please sign and return this letter stating that you understand the following information:

1. If tuition is not paid on time, your account will be assessed a *late payment fee of \$10.00.*
2. If your check is returned, your account will be assessed a *returned check charge of \$35.00.*
3. If you need a second copy of your payments for taxes, your account will be assessed a *charge of \$5.00.*

If you have any questions, please see the director.

Signature of Parent

Date

Kiwanis Day Care Center

71 Washington Avenue
Huntington, WV 25701-1124

Phone (304) 525-8701
Fax (304) 525-4422

Dear Parent:

The teachers will be taking the children for walks when the weather is nice on various days.

If you want your child to be on these walks, please sign the permission form below.

**YES, I _____ GIVE MY PERMISSION FOR MY
CHILD _____ TO GO FOR WALKS WITH THE
KIWANIS DAY CARE STAFF AND CHILDREN.**

**NO, I _____ DO NOT WANT MY CHILD
_____ TO GO FOR WALKS WITH THE OTHER
CHILDREN OR STAFF OF KIWANIS DAY CARE AT ANY TIME.**

PARENT'S SIGNATURE: _____

CHILD'S NAME _____

CHILD HEALTH ASSESSMENT

Child's Name _____ Parent/Guardian _____
 DOB ____/____/____ Home Phone _____ Address _____
 Child Care Facility/School _____
 Child Care Facility/School Phone _____ Work Phone _____

Note: A copy of the Health Check exam report attached to a copy of the child's immunization record may be substituted for this form.

Health history and medical information pertinent to routine child care and emergencies:

Date Of Exam ____/____/____

Allergies to food or medicine:

Length/Height in/cm %ile _____	Weight in/cm %ile _____	Head Circumference in/cm %ile _____	Blood Pressure in/cm %ile _____
-----------------------------------	----------------------------	--	------------------------------------

Physical Examination	Normal	Abnormal/Comments				
Head/Ears/Eyes/Nose/Throat						
Teeth						
Cardiorespiratory						
Abdomen/GI						
Genitalia/Breasts						
Extremities/Joints/Back/Chest						
Skin/Lymph Nodes						
Neurologic/Tone						
Developmental (e.g. ddst)						
Immunizations	Birth to 1 Month	2 Month	4 Month	6 Month	12-18 Month	4-6 Yrs
DTP/DTaP						
Polio						
HIB						
HEP B						
MMR						
Varicella						
Other (PCV7)						

Note: Ages and number of boosters may vary when immunizations start at older ages.

Screening Tests (If completed)	Date	Normal	Abnormal/Comments
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Tuberculosis (TB)			
Hearing			
Vision			

Date of Last Dentist's Exam

Note: Age appropriate health services and immunizations must follow the schedule recommended by AAP

Health Problems or Special Needs	Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)

Medical Care Provider

Address

Phone

ECE-CC-3
12/04

MD
DO
PA
CRNP

Date

Signature of Physician or CRNP