CLASSROOM INFORMATION SHEET

Full Name:_____
(Last) (First) (Middle) (Nickname)

Birth Date:_____

Primary Hours of Care: From_____To_____Days of the week: **M T W TH F**

Family Information:

Mothers Name:_____Father's Name:_____

Home Phone:_____Home Phone:_____

Cell Phone:_____Cell Phone:_____

Work Phone:_____Work Phone:_____

Emergency Contacts:

Name:_____Cell/Work_____Home_____

Name:_____Cell/Work_____Home_____

Name:_____Cell/Work_____Home_____

Medical Information:

Regular Medication_____Allergies:_____

Please list any/all Special Health Concerns, Chronic Illness, Broken Bones, Surgeries, or Hospitalizations:

_____

I Herby give permission that my child,__, may be given emergency treatment by a qualified staff / provider at **Giggling Guest Childcare INC, Giggling Guest Childcare Too, or Giggling Guest Childcare Again.** When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedure to be performed for my child by a licensed physician, health care provider, hospital or aid care attendant when deemed necessary or advisable by the physician or air car attendant to safeguard my child's health. I waive my right to Informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify (or declare) under penalty of perjury under the laws in the State of Washington that the foregoing is true.

_____ _____

Parent / Guardian Signature Date Parent / Guardian Signature Date

Incoming Child Get-To-Know-You Sheet

Our Teachers like to form personal relationships with each of their students. By filling out this brief get-to-know-you sheet, your child's teacher can better prepare for his or her arrival in the classroom.

Child's name:_____ Birth date:_____

Favorite foods:_____

_____

Least favorite foods:_____

_____

Naptime Routine:_____

Time of day when my child is most happy and active (i.e.: morning, afternoon, evening):

_____

Fears and anxieties: _____

_____

Favorite toys and activities:_____

_____

Our Family's favorite time or activity to do together is: _____

_____

Bathroom or diaper routine (Please share with us any words you use with your child during this time):

_____

_____

Ways of expressing anger and frustration:_____

_____

Typical methods of comforting your child:_____

_____

People in child's household (i.e.: Mom, Dad, Siblings, Grandparents, etc.)_____

_____

Languages spoken at home:_____

Any unique family situations that teachers should be aware of: _____

_____

Disorders, diseases, or health concerns:_____

_____

The best time to reach me during the day for non-emergency related phone calls (for sharing of information regarding my child or to set up parent conferences, etc.):_____

_____

We have lots of volunteer opportunities within the childcare program. Please let us know your areas of interest (Optional)

☐ Classroom Activities *(i.e. Story time, art craft projects)*

☐ Field Trips/Walking Trips

☐ Classroom Parties/Celebrations

☐ Center Activities (Special Events, Fundraising, Leaderships)

☐ Parent Committee

☐ Other_____

Thank you for completing this sheet! Please return with enrollment packet.

Giggling Guest Childcare

CHILD CARE APPLICATION FOR ENROLLMENT

Student / Child Information: **Date of Birth:**_____ **Sex: M F**

Date of Enrollment:_____

Full Name: _____

(Last) (First) (Middle) (Nickname)

Child's Physical address:_____

Primary Hours of Care: From_____**To** _____

Days of the Week in Care: M T W TH F

Meals Typically Served While in Care: Breakfast AM Snack Lunch PM Snack

---

Family Information: Parents E-Mails:_____

E-Mails:_____

Mother's Name:_____ **Father's Name:** _____

Mother's Birthdate:_____ **Father's Birthdate:**_____

Address:_____ **Address:**_____

Home Phone:_____ **Home Phone:**_____

Cell Phone:_____ **Cell Phone:**_____

Employer:_____ **Employer:**_____

Work Phone:_____ **Work Phone:**_____

Mother's Entry Code:_____ **Father's Entry Code:**_____

Mother's Social Security #:_____ **Father's Social Security#:** _____

Contacts: Child will be release to the custodial parent or legal guardian and the person listed below. The following people will be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent or legal guardian cannot be reached. People picking up on a regular basis will need an entry code. (Please provide three LOCAL emergency contacts):

Name	Cell/Work#	Home#	Entry Code

Medical Information:

Doctor:_____ Address:_____ Phone:_____

Dentist:_____ Address:_____ Phone:_____

Date of Last Physical Exam:(___/_____/_____) Current Height: '_ _" ____Current Weight (_____LBS)

Regular Medications:_____ Allergies: _____

Please list any/all Special Health Concerns, Chronic illness, Broken Bones, Surgeries, or

Hospitalizations:_____

_____

_____

_____

I Herby give permission that my child,_____, may be given emergency treatment by a qualified staff / provider at Giggling Guest Childcare INC, Giggling Guest Childcare Too, or Giggling Guest Childcare Again. When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedure to be performed for my child by a licensed physician, health care provider, hospital or aid care attendant when deemed necessary or advisable by the physician or air car attendant to safeguard my child's health. I waive my right to Informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify (or declare) under penalty of perjury under the laws in the State of Washington that the foregoing is true.

_____ _____

Parent / Guardian Signature Date Parent / Guardian Signature Date

Hospital Preference:_____ Address:_____

Your signature below indicates that the information on this enrollment application is complete and accurate. By signing below you agree to provide current immunizations records or sign our medical/ immunization exemption form, as well as keep your entry code private.

_____ _____

Parent / Guardian Signature Date Parent / Guardian Signature Date

INDIVIDUAL HEALTH PLAN

Date:_____

Child's Name:

_____

(First) **(Last)**

Circumstance for plan: (Allergies, Medications, Parent Preference, or Health Concerns)

_____

_____

_____

Plan of action: (What would you like us to do in the event of the above)

_____

_____

_____

Please List a daily routine for your child: (Child's home routine)

_____

_____

_____

Comments:

_____

_____

_____

Date to review again:_____

Director's Signature:

_____**Date:**_____

Parents Signature:

_____**Date:**_____

Washington State Department of Health

DOH 348-106 June 2011

Certificate of Exemption

For School, Child Care and Preschool Immunization Requirements[1]

DIRECTIONS: All exemptions must have a licensed health care provider sign & date Box 1 ('Provider Statement').[2] Exception: Box 1 is not required for religious exemptions when Box 2 ('Demonstration of Religious Membership') is completed. All exemptions must also have a parent/guardian sign & date Box 3 ('Parent/Guardian Statement').

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (mm/dd/yyyy)**:**	**Sex:**	**Parent/Guardian Name** (please print):

Parent/Guardian, please choose the exemption(s) that apply to your child below.

☐ **Temporary Medical Exemption**

☐ **Permanent Medical Exemption**

_____ Until _____

Vaccine(s) Date (or Permanent)

_____

Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X _____ X _____

Signature of Licensed Health Care Provider Date

☐ **Personal/Philosophical Exemption (see Box 1)**

☐ **Religious Exemption (see Box 1)**

☐ **Religious Membership Exemption (see Box 2)**

I do not want my child to get the following vaccine(s):

☐ Diphtheria	☐ Hepatitis B	☐ Hib
☐ Measles	☐ Mumps	☐ Pertussis (whooping cough)
☐ Pneumococcal	☐ Polio	☐ Rubella
☐ Tetanus	☐ Varicella (chickenpox)	

☐ Other (indicate):

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

[1] RCW 28A.210.080-090 states that before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption, signed by a parent or guardian and a licensed health care provider.

[2] A letter may substitute for a signed 'Provider Statement' on this certificate. To be accepted, the letter must reference the child's name on this certificate, confirm that the child's parent or guardian got information on the risks and benefits of immunization to their child, and be signed by a licensed health care provider.

Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy)**: Sex:**

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only

Parent/Guardian Name (please print)**:**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● *Haemophilus influenzae* type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission:

Printed Staff Name	Date	Printed Staff Name	Date
Printed Staff Name	Date	Printed Staff Name	Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) ❑ Chickenpox disease verified by printout from CHILD Profile Immunization Registry

2) ❑ Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP signed here and print name below:

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)

HCP Printed Name: _____

3) ❑ Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves:_____(initial)

4) ❑ Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
Age/Date of disease:_____

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	
❑ Hib	❑ Tetanus	_____
❑ Measles	❑ Varicella	

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)

HCP Printed Name: _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

Vaccine	Dose	Date		
		Month	Day	Year
◆ **Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)**				
DTaP	**1**	01	12	2011
DTaP	**2**	03	20	2011
DTaP	**3**	06	01	2011

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).

2) ❑ If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.

3) ❑ If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.

4) ❑ If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Reference

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrcl)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

Child Care Agreement

Child's name: First Middle Last							
Parent or guardian name: First Middle Last							
Parent or guardian name: First Middle Last							
Days and times my child will receive care:							
Check days of care	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
Arrival time							
Departure time							

Fee: $ per: ☐ Hour ☐ Day ☐ Week ☐ Month	Date payment due: Source of payment: ☐ Parent ☐ Other (specify):
Overtime rate: $ per	Late fee: $ per
Other Fees: $ Description:	

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

I have read, understand and agree to comply with the policy and procedures and information for parents given to me by

_____

Name of licensee

Parent or guardian signature Date	Parent or guardian signature Date

I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.

Licensee signature Date

Street address City State Zip code

Comments

Child and Adult Care Food Program
Giggling Guest Childcare Centers

Dear Parents:

Our center does not charge separately for meals because it participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). This program pays centers for nutritious meals served to all children while in care.

How much does the center receive in payment for meals served to my child while in care?
The amount of payment received is based on the income status of the families in our center. We receive a higher payment for those families that are low-income.

How do you determine the income status of my family?
The information you provide on the enclosed Enrollment/Income-Eligibility Application determines the income status and payment level.

I'm not sure if my family income qualifies. How do I decide?
If your gross income (before deductions) is the same as or less than the amount on the line for your family size on the income guidelines table below, the center is eligible for the higher payment for your child(ren). When self-employed, net income may be reported. Please complete and return the Enrollment/Income-Eligibility Application to our office as soon as possible. Every child is required to have a form on file even if you feel you do not qualify by income. Please fill out all sections fully.

Income Guidelines
Reduced-Price Meals

Effective July 1, 2016–June 30, 2017

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	$ 21,978	$ 1,832	$ 916	$ 846	$ 423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,874	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
Each additional household member add:	+ 7,696	+ 642	+ 321	+ 296	+ 148

If I receive payment from DSHS for child care, should I complete these forms?
Yes. DSHS payments for child care do not qualify a family for the higher payment.

If my household income is greater than the income guidelines for reduced-price meals, or if I choose not to report my income, what should I do?
You should complete Parts 1 and 5 and may write "above-scale" in Part 4.

If I choose not to report my household income, do I still need to return the Enrollment/Income-Eligibility Application?
Yes. If you choose not to fill out the income portion of the Enrollment/Income Eligibility Application (E/IEA), you must still complete Part I, the "Children's Information" section, and Part 5. Federal regulations require that all child care centers collect information on the normal days and hours child(ren) are expected to be in care and the expected meals to be received.

Is there another way for the center to receive the higher payment other than using my family income?
Yes. Your child(ren) may be eligible for the higher payment based on one of the following:

1. You receive Basic Food, Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) for any member of your household.
2. Your child is a foster child.

If a household member currently receives benefits from one of these programs, or I believe my family income would qualify my child, what should I do?
Complete the attached Enrollment/Income-Eligibility Application, following the directions on the form. There is a separate section for each way your child may qualify.

Will this information be kept confidential?
Yes. The information will be made available only to a limited number of our staff or employees of the Office of Superintendent of Public Instruction, U.S. Department of Agriculture, or the U.S. General Accounting Office when they are reviewing our program.

Will the center make menu substitutions for my child?
If your child has been determined by a doctor to be disabled, and the disability would prevent the child from eating the regular meals at the center, we will make any substitutions prescribed by the doctor at no extra charge.

What do I need to bring to the center if my child needs menu substitutions?
You must bring the doctor's note that prescribes the alternative foods needed and verifies special meals are needed due to the disability.

Whom should I contact if I have any questions?
Contact our office at 509 483-5155.

Thank you for helping us provide healthy meals for your child.

Sincerely,

_____

Signature of Center Director

☐

In the operation of the child feeding programs, no child will be discriminated against because of race, color, national origin, sex, age, or disability.

Child and Adult Care Food Program
Enrollment/Income-Eligibility Application

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours______to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours______to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours______to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours______to ______	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and

☐ 5.) One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month – Tell us how much and how often (or net income if self-employed) (if None, Write "0")			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
Jane Smith (example)	*$1000 /month*	*$300 /month*	$	$
1.	$ /	$ /	$ /	$ /
2.	$ /	$ /	$ /	$ /
3.	$ /	$ /	$ /	$ /
4.	$ /	$ /	$ /	$ /
5.	$ /	$ /	$ /	$ /
6.	$ /	$ /	$ /	$ /

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing	☐ I do not have a Social Security Number
		Social Security Number (last four digits) XXX-XX-	

Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, sex, age, or disability.

Race:

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

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

CENTER USE ONLY

☐ Child(ren) are categorically ☐ ☐ Basic Food ☐ TANF ☐ FDPIR

☐ Foster child(ren) have been identified on this form and qualify for the ☐ free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:

Check one: ☐ Free
☐ Reduced-Price
☐ Above-Scale

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

_____ _____
Signature of Institution's Representative Date

Invalid without signature and date.
EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.

☐