SMILES & GIGGLES

CHILD DAY CARE and LEARNING CENTER

New Child Registration Package

Revised: February 27, 2016

Registration Package Parent Checklist

☐ 1. Child Registration Form (4 pages)
- Proof of identification will be required when returning completed package to the center. (social security card & birth certificate)

☐ 2. School Entrance Health Form (4 pages)
- Includes immunization form.

☐ 3. Child and Adult Care Food Program Form (3 pages)
- Required to be completed for each child whether or not qualifications are met.

☐ 4. Financial Agreement (2 pages)

☐ 5. General Child Care Policy Acknowledgement Form (2 pages)

Please Note:
All enclosed forms are required to be completely filled out and returned to the center with payment prior to your child beginning the chosen program.

SMILES & GIGGLES DAY CARE AND LEARNING CENTER
CHILD REGISTRATION FORM

INSTRUCTIONS:
ALL SECTIONS MUST BE COMPLETED. IF NOT APPLICABLE ENTER N/A

CHILDREN'S INFORMATION

Childs Full Name:	Nickname:	Date of Birth:	Sex:
Address (Street/City/State/Zip Code):			Home Phone:
Chronic Physical Problems/Pertinent Developmental Information/Special Accommodations Needed:			
Previous Child Day Care Programs and Schools Attended:			
If Child Attends this Center and Another School/Program, Give Name of School/Program:			Grade:

PARENT(S)/GUARDIAN(S) INFORMATION

Fathers Full Name:	Place Employed:	Business Phone:
Home Address (Street/City/State/Zip Code):		Home Phone:
Mothers Full Name:	Place Employed:	Business Phone:
Home Address (Street/City/State/Zip Code):		Home Phone:
Person(s) or Agency Having Legal Custody of Child:		
Home Address (Street/City/State/Zip Code):		Home Phone:
Business Address (Street/City/State/Zip Code):		Business Phone:

SMILES & GIGGLES DAY CARE AND LEARNING CENTER
CHILD REGISTRATION FORM

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication, etc., and Action to Take in an Emergency:		
Child's Physician		Phone:
Two People To Contact if Parent(s) Cannot Be Reached		
Full Name:	Address (Street/City/State/Zip Code):	Phone:
1.)	1.)	1.)
2.)	2.)	2.)
Person(s) Authorized To Pick Up Child:		
Person(s) NOT Authorized To Pick Up Child*:		

* Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child.
* NOTE: Section 22.1-4.3 of the *Code of Virginia* states that unless a court order has been issued to the contrary, the noncustodial parent of a student enrolled in a public school or day care center must be included, upon the request of such noncustodial parent, as an emergency contact for events occurring during school or day care activities.

SMILES & GIGGLES DAY CARE AND LEARNING CENTER
CHILD REGISTRATION FORM

PARENTAL AGREEMENT

1. The child day center agrees to notify the parent(s)/guardian(s) whenever the child becomes ill and the parent(s)/guardian(s) will arrange to have the child picked up as soon as possible if so requested by the center.

2. The parent(s)/guardian(s) authorize the child day center to obtain immediate medical care if any emergency occurs when the parent(s)/guardian(s) cannot be located immediately. **

3. The parent(s)/guardians agree to inform the center within 24 hours or the next business day after his child or any member of the immediate household has developed a reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

SIGNATURES

_____ _____
Parent(s) or Guardian(s) ***Date***

_____ _____
Administrator of Center ***Date***

Date Child Entered Care: _____ Date Left Care: _____

** If there is an objection to seeking emergency medical care, a statement from the parent(s) or guardian(s) that states the objection and the reason for the objection **MUST** be provided below.

Objection to seeking emergency medical care statement:

_____ _____
Parent(s) or Guardian(s) ***Date***

SMILES & GIGGLES DAY CARE AND LEARNING CENTER
CHILD REGISTRATION FORM

OFFICE USE ONLY
IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

Place of Birth:	**Birth Date:**	**Birth Certificate Number:**	**Date Issued:**
Other Form of Proof:		**Date Documentation Viewed:**	**Person Viewing Documentation:**

Date of Notification of Local Law-Enforcement Agency (when required proof of identity is not provided):

Date: _____

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia *and* the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Section 63.2-1809 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding,. (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means.
032-05-252/11 (06/05)

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/_____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

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

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

_____

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

_____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

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

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school****. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____Date: _____/_____/ _____

Signature of person completing this form: _____Date:_____/_____/_____

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

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

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |____|____|____|
Last *First* *Middle* *Mo. Day Yr.*

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

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

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

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____
_____
_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[____]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	□	□	□	Neurological	□	□	□	Skin	□	□	□
Lungs	□	□	□	Abdomen	□	□	□	Genital	□	□	□
Heart	□	□	□	Extremities	□	□	□	Urinary	□	□	□

TB Screening: □ No risk for TB infection identified □ No symptoms compatible with active TB disease
□ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result: □ Positive □ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ □ Normal □ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

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

□ Permanent Hearing Loss Previously identified: ___Left ___Right

□ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

Stereopsis	❑ Pass	❑ Fail		❑ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):
□ **Well child; no conditions identified of concern to school program activities**
□ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____
_____

___ **Allergy** □ food: _____ □ insect: _____ □ medicine: _____ □ other: _____
Type of allergic reaction: □ anaphylaxis □ local reaction Response required: □ none □ epinephrine auto-injector □ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** □ Has IEP □ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). □ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) **□ By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ Date: ____/_____/_____

Practice/Clinic Name: _____ **Address**: _____

Phone: _____-_____-_____ **Fax**: _____-_____-_____ **Email:** _____

CHILD AND ADULT CARE FOOD PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) / FISCAL YEAR 2016

PARENT LETTER

Dear Parent or Guardian:

This child care center participates in the United States Department of Agriculture Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information provided on the attached CACFP Meal Benefit Income Eligibility Form (IEF). Part of the USDA requirement is to complete the IEF. If household income is equal to or less than the income listed in the chart below for household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. Please return the completed IEF back to our center as soon as possible.

If a member of the family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) benefits or cares for a foster child(ren) that is the legal responsibility of Virginia Department of Social Services or the court, these children are eligible for meal benefits regardless of household income.

If the household income(s) is over the income guidelines listed below, the family is not required to complete this application. Instead, please write the child's name on the IEF and return it to our center. Please notify us if someone in the household becomes unemployed and the loss of income causes the household income to be within the income eligibility standards.

The information provided on the IEF will be used to determine the child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

***Family Access to Medical Insurance Security Plan* (*FAMIS*)**

FAMIS is Virginia's health insurance program for children. It provides access to quality health services for children who do not have health insurance. ***FAMIS Plus*** is Virginia's name for children's Medicaid. ***FAMIS Plus*** also provides great benefits and covers children in families with low or no income, even if the children are covered by health insurance.

By signing the section on the application for *FAMIS* or *FAMIS Plus*, the family is stating they do not want information shared with the local Department of Social Services. If IEF information is disclosed, it may be used to identify the child(ren) for the health insurance program. More information on *FAMIS* is available at 1-866-873-2647 – Interpreters are available. Log onto www.famis.org to apply online.

A household with income less than or equal to the income chart for reduced-priced meals below is eligible for free or reduced-priced meals:

Household Size	Yearly
1	$21,775
2	$29,471
3	$37,167
4	$44,863
5	$52,559
6	$60,255
7	$67,951
8	$75,647
Each additional person:	$7,696

Please contact our center with any questions or for additional help.

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS and FAMILY DAY HOMES

1 All Household Members | 2 | 3

NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last	Check if **NO** income	Ages of children at center	2 FOSTER CHILD Skip to Part 6 if all are foster children.	3 SNAP, TANF or FDPIR CASE # Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. **MUST BE SEVEN (7) DIGITS**
1.	☐		☐	
2.	☐		☐	
3.	☐		☐	
4.	☐		☐	
5.	☐		☐	
6.	☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison, Migrant Coordinator.

5 Total Household Gross Income (before deductions). You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp, Unemployment, SSI, etc. (All other income)	
	Amount	**How often?**	**Amount**	**How often?**	**Amount**	**How often?**	**Amount**	**How often?**
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.

X X X – X X – ___ ___ ___ ___
Social Security Number

☐ **I do not have a social security number.**

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

_____ _____ _____

Date *Printed Name of Adult Household Member* *Signature of Adult Household Member*

7 Contact Information (Optional)

_____ _____ _____

Work Telephone Number (Include Area Code) *Home Telephone Number (Include Area Code)* *Home Address (Number, Street, City, State, Zip Code)*

8 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS*, the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS. Date: _____ Sign here: _____

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 your child for free or reduced-price meals. You must include the last four digits of your 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 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 meals, and for administration and enforcement of the Child and Adult Care Food Program. 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: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

CHILD CARE REPRESENTATIVE USE ONLY – ELIGIBILITY DETERMINATION – COMPLETE SECTIONS A and B BELOW

SECTION A **Annual Income Conversion: Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12** **Convert income only if different frequencies of pay are reported.**

TOTAL INCOME $ _____ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

☐ **FREE** based on:	☐ **REDUCED** based on:	☐ **DENIED** reason:
☐ foster child ☐ migrant ☐ SNAP or TANF ☐ homeless ☐ runaway ☐ household income	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/TANF

SECTION B **Signature of Determining Official:** _____ **Date:** _____

Annual Enrollment Form

Virginia Child and Adult Care Food Program

Center Information			
Smiles & Giggles Child Care and Learning Center			
Center Name			
132 Fox Hill Rd.	Hampton	Va.	23669
Center Address	*City*	*State*	*Zip Code*

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for children. Federal CACFP regulations require all parents or guardians to complete and review an annual Enrollment Form when enrolling their child(ren) and 12 months thereafter. This information will help ensure all children receive appropriate meals during their care. **The parent or guardian must complete and ensure accuracy of Sections 1 through 5**.

This form is required for:	This form is NOT required for:
Child Care Centers, Head Start, and Even Start	At-Risk After-School, or Emergency Shelters, or Licensed Outside School Hours Programs

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS DURING WEEK			4 MEALS RECEIVED
		TIME IN	TIME OUT	SPORADIC SCHEDULE	
_____ *Child's First Name*	☐ Monday				☐ Breakfast
_____ *Child's Last Name*	☐ Tuesday				☐ AM Snack
	☐ Wednesday				☐ Lunch
	☐ Thursday				☐ PM Snack
_____ *Date of Birth*	☐ Friday				☐ Supper
	☐ Saturday				
	☐ Sunday	**Notes**			

5 Signature and Date

I certify the information above is correct.

_____ *Signature of Parent or Guardian*

_____ *Date*

_____ *Parent's Telephone Number*

NON-DISCRIMINATION STATEMENT: The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

SMILES & GIGGLES DAY CARE AND LEARNING CENTER
FINANCIAL AGREEMENT

_____ _____
Childs Full Legal Name Date of Birth

Registration Fee
I understand that a onetime non-refundable registration fee of $_____ shall be paid to enroll my child. In instances of agency reimbursement the registration fee is my responsibility if not paid by the agency.

_____ (Initials)

Re-Enrollment Fees
I understand that in order to continue my child's enrollment each year, I must pay an annual non-refundable re-enrollment fee of $_____ which is due no later than September 1st of each year.

_____ (Initials)

Tuition and Modification of Conditions
I have enrolled my child in the following program _____ at Smiles and Giggles Learning Center. My child is enrolled from _____ am/pm to _____ am/pm on (circle day(s)) Monday – Tuesday – Wednesday – Thursday – Friday for a maximum of nine hours each day. The current tuition rate for the program I have chosen is $_____ per week. I understand that rates are subject to change as conditions require. I will receive as much advance notice regarding any rate change as possible. .

_____ (Initials)

Payment of Tuition
I understand that tuition is due payable in advance. The payment of weekly tuition is due on or before the first scheduled day of each week. If payment is not received on that day, I agree to pay a late payment fee of $10.00 per week. I understand that if my account is two weeks delinquent, my child will be withdrawn. I understand that a processing fee of $40.00 will be added to my account for any returned check. If more than two checks are returned within one calendar year, I will be required to make tuition payments in cash or money order.

_____ (Initials)

SMILES & GIGGLES DAY CARE AND LEARNING CENTER
FINANCIAL AGREEMENT

Charges for Late Pick-up

I understand that my tuition makes the center available to my child from _____ am to _____ pm, Monday through Friday, January through December. I understand that if my children remain past the scheduled closing time, I will agree to pay an additional $2.00 per minute per child. If not picked up by 6pm a staff member will begin contacting the parent's place of employment, followed by the emergency contact numbers provided. We will strictly adhere to this policy.

_____ (Initials)

Virginia Child Subsidy Program (Social Services)

I understand that if I receive Virginia Child Subsidy Services I must swipe my payment card daily in order for my child care services to be paid. Three instances of failing to swipe payment card will result in termination from Smiles and Giggles Learning Center. I also understand that if my child is terminated from the Virginia Child Subsidy Program I must make arrangements to transition to being a cash paying parent or terminate my child from Smiles and Giggles Learning Center. _____ (Initials)

I have read, understand and will comply with the financial agreement as set forth by Smiles and Giggles Learning Center.

_____ _____
Signature Date

_____ _____
Center Director or designated representative Date

Office Use:

☐ Weekly

☐ Bi-Weekly

☐ Monthly

Notes:

SMILES & GIGGLES DAY CARE and LEARNING CENTER

GENERAL CHILD CARE POLICY
ACKNOWLEDGEMENT

Food
Smiles and Giggles will meet the child's nutritional needs for that part of the day they spend at the center. We ask that children do not bring in food or drink from home. This policy is in part due to the safety of other children who may suffer severe food allergies and ensures that these children do not feel deprived. The only exceptions are if the child is on a special diet or for religious reasons.

_____ (Initials)

Center Evacuation Plan
Fire practice drills are scheduled monthly to ensure that staff are prepared in the event of an emergency. Disaster and tornado drills are conducted every (6) months. In case of an actual emergency in which the center must be evacuated, children will be taken to the closest evacuation center and notification will be provided to parents as soon as possible.

_____ (Initials)

If Your Child is Bitten
Child development research indicates that approximately fifty percent of all children enrolled in childcare centers will be bitten. Toddlers will often use biting as a form of communication. Smiles & Giggles Day Care and Learning Center will strive to minimize biting accidents. If this should occur, we will do our best to comfort your child and care for their needs immediately. If your child is bitten, you may want to contact your doctor to determine whether the nature of the bite requires medical attention. We will also inform the parents of the biter and work with them and their child to correct the behavior.

_____ (Initials)

If Your Child Bites Another Child
Biting is very serious and unacceptable behavior. If your child bites Smiles & Giggles Day Care and Learning Center will work with you to develop s plan to correct the problem. However, if the biting is aggressive, breaks skin, does not lessen within a reasonable period of time, or diverts an inordinate amount of staff time away from other children and program implementation, Smiles & Giggles Day Care and Learning Center may have to temporarily dis-enroll your child until the biting diminishes.

_____ (Initials)

SMILES & GIGGLES DAY CARE and LEARNING CENTER

GENERAL CHILD CARE POLICY
ACKNOWLEDGEMENT

Confidentiality

Smiles & Giggles Day Care and Learning Center respects the right to privacy and confidentiality of each family in regards to all health, behavioral and development records and information concerning their child. Various federal and state statutes, local ordinances, and regulatory rules protect these rights to privacy and confidentiality. If your child is involved in an altercation or a biting incident with another child, Smiles & Giggles Day Care and Learning Center will not reveal your child's identity to the parents of the other child without your prior written consent, except as required by law.

_____ (Initials)

Immunization of Children

Smiles & Giggles Day Care and Learning Center maintains compliance with the Standards for Licensed Child Day Centers as mandated by the Department of Social Services of the Commonwealth of Virginia. As such we are required to obtain documentation that each child has received the immunizations required by the State Board of Health before the child can attend the center. The required immunizations can be found on the COMMONWEALTH OF VIRGINIA SCHOOL ENTRANCE HEALTH FORM - Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization document as included in the New Child Registration Package. If your child's immunizations are not completed following the recommended schedule, with the proper documentation thereof provided to the center, Smiles & Giggles Day Care and Learning Center may exclude your child for the protection of the other children until such immunizations are current and proper documentation provided to the center.

_____ (Initials)

Conduct Notices

If three (3) notices of improper conduct are provided to a parent in one thirty (30) day period the parent will be asked to make other child care arrangements for the two (2) scheduled care days following the issuance of the third improper conduct notice. If the disruptive behavior continues we will request a parent conference to discuss concerns and further actions as necessary.

_____ (Initials)

SMILES & GIGGLES DAY CARE and LEARNING CENTER

GENERAL CHILD CARE POLICY
ACKNOWLEDGEMENT

Holidays
I understand that the center is closed for the following holidays:

- Martin Luther King Jr.'s Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day and the following Friday
- Christmas Eve and Christmas Day

I agree that I am not entitled to any refund, credit, make-up day or any other allowance for holidays. If a holiday fails on a weekend, it will be observed on either the preceding Friday or the following Monday, or in accordance with the at-work/management contract holiday schedule. On New Year's Eve the the center will close promptly at noon.

_____ (Initials)

Absences/Tardiness
I understand that no allowance shall be made for occasional absences. Refund's credit or make-up days cannot be granted. If your child arrives late a parent must escort the child to their classroom and they will be integrated into whatever activities the class is doing.

_____ (Initials)

Withdrawal from the Program
I understand that I must provide two (2) weeks written notice of withdrawal from the program. If proper notification is not provided I agree to pay all fees for the program in which my child was scheduled to attend for two (2) weeks from the last week of actual attendance. I understand that my child will then be automatically withdrawn and can be readmitted only if space is available. If I wish to re-enroll my child, an additional registration fee will be required.

_____ (Initials)

Medication
Smiles & Giggles Day Care and Learning Center does not administer medications.

_____ (Initials)

SMILES & GIGGLES DAY CARE and LEARNING CENTER

GENERAL CHILD CARE POLICY
ACKNOWLEDGEMENT

Daily Sign-In
I agree to complete the Sign-In/Sign-Out form, including complete signatures, on a daily basis. All parents are required to escort their children to and from their designated classroom.

_____ (Initials)

Special instructions
I understand that field trips and optional programs, such as swimming, gymnastics, and special summer programs may be offered. Most of these programs require fees in addition to regular tuition and these fees are payable by the first day of the program. In instances of agency reimbursement, fees for these programs are my responsibility.

_____ (Initials)

Release of a child
I understand that my child will be released only to those persons whose names I have listed on the Child Enrollment Card and the Information Card. I understand that I must advise the director or the other designated person in charge, in writing, if any other person other than those listed is to pick up my child. Smiles and giggles employees will require proof of identification and knowledge of my password from a caller or any person arriving to pick up my child. A telephone authorization will be confirmed with the custodial parent at a previously designated telephone number.

_____ (Initials)

Model release
Smiles and Giggles Childcare, inc., its licensees and signees may not use photographs, reproductions, and/or sound recordings of my child. Such use may include advertising and publicity purposes.

_____ (Initials)

Immunization
I have shown proof that my child's immunizations are up to date.

_____ (Initials)

Default

In the event it becomes necessary to refer a delinquent account for collection to an authorized agent and/or attorney, PARENT agrees to pay all costs of collection, including, but not limited to: collection costs, finder's fees, and investigation costs, court costs, and attorney's fees at the rate of thirty-three (33%). Delinquent accounts are assessed a yearly interest rate of twenty percent (20%), for every year the account remains delinquent. In the event the CENTER must institute legal proceedings to enforce any provisions of the AGREEMENT, PARENTS agree that the venue will be in Hampton or Newport News, VA per the CENTER's choice.

_____ (Initials)

Illness/good health

I understand that I will be notified should my child becomes ill during the day, and that it will be necessary to make arrangements to have my child picked up within 30 minutes after notification. If my child is exposed or contracts a contagious disease, I agree to notify the Director and keep my child out until he or she is symptom free and has a doctor's note. I understand that if my child is sent home with a fever, that my child may not return until he or she has been fever free for 24 hours from the time of pick up.

_____ (Initials)

Field trips

Supervised field trips may be scheduled to local settings of interest. I understand that I must complete and sign a permission slip for each event in which I wish my child to participate.

_____ (Initials)

Interviewing children/inspecting records

The director will report suspected abuse/neglect to Social Services and the Child Protective Services Agency. The Department of Social Services or Licensing agency shall have the authority to interview children or staff, and to inspect and audit child or faculty records without prior consent. The liscensee shall make provision for private interviews with any child (ren) or any staff member, and for the examination of all records relating to the operation of the facility. The department or licensing agency shall have the authority to observe the physical condition of the child (ren), including condition which could indicate abuse, neglect, or inappropriate placement, and to have a licensed medical professional physically examine the child (ren).

_____ (Initials)

SMILES & GIGGLES DAY CARE and LEARNING CENTER

GENERAL CHILD CARE POLICY
ACKNOWLEDGEMENT

Inclement weather
In an effort to service our parents and families, it is our intent to remain open every day (except designated holidays). If inclement weather occurs, please call the center to ensure that we are open.

_____ (Initials)

Transportation
Smiles & Giggles Day Care and Learning Center may transport children to and from public schools. A signed Transportation Agreement must be on file for transportation services to be used.

_____ (Initials)

Personal items
Smiles & Giggles Day Care and Learning Center is not responsible for personal items brought to the center such as toys, jewelry etc. Personal items such as coats and backpacks should be labeled with the child's full name.

_____ (Initials)

Parents guide
I have received a copy of Smiles & Giggles Day Care and Learning Center Parent's Guide. I have read and understand the content and agree to abide by it.

I have read, I understand, and will comply with the policies included in Smiles & Giggles Day Care and Learning Center Agreement and Parents Guide.

_____ (Initials)

SMILES & GIGGLES DAY CARE and LEARNING CENTER

GENERAL CHILD CARE POLICY
ACKNOWLEDGEMENT

I have read, understand and will comply with the statements of this General Child Care Policy as set forth by this document.

_____ _____

Signature of Parent Date

_____ _____

Center Director or designated representative Date