Woodland
Child Development Center

Child/Family Enrollment Application

Date of Admission_____

Today's date_____

Full Name of Child_____

Address:_____

Date of Birth_____

City/State/Zip Code_____

Mother's Name_____
SSN_____
Cell Phone #_____
Employer_____
Occupation_____
Work Phone #_____
Email_____

Father's Name_____
SSN_____
Cell Phone #_____
Employer_____
Occupation_____
Work Phone #_____
Email_____

Family Household Section (circle one) Married Single Separated Divorced

Initial please
Legal Custody_____Visiting Privileges to_____Contact Allowed_____Non-Custodial Parent_____

Is the person that is legally responsible for the family n the military? **Yes_____No_____**

If yes, are there occasions when the family member/s is stationed away from the home that could have an affect on the social/emotional stability of the family?

How/Who disciplines your child?_____

	Brothers/Sisters	Birth Date
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Emergency Information: (**Other than Parents), (Must Give Two)**

Name_____
Address_____
_____

Name_____
Address_____
_____

Family_____

Date of Admission_____

Home Phone_____
Cellular Phone_____
Relationship_____

Home Phone_____
Cellular Phone_____
Relationship_____

Entry Date_____

Weekly Schedule_____
Hours Daily from_____to_____

Child's Health History

1. Has your child have any serious health problems?
   _____
   _____
2. Was your child ☐full-term ☐premature
   If so, how many weeks?_____
3. Does your child have any allergies? If so, what are they?
   _____
   _____
4. Has your child had
   Mumps_____
   Chicken Pox_____
   Whooping Cough_____
5. Does your child have any condition now requiring regular medication?
   _____
   _____
   _____
6. Does your child have any **I**ndividual **E**ducation **P**lan (**IEP**) or **I**ndividual **F**amily **S**ervice Plan (**IFSP**) that can help us better meet the needs of you and your child/children needs? **Please provide a copy if applicable**

Has your child/children been exposed to any communicable disease prior to admission to Woodland Child Development Center such as COVID-19, chicken pox, measles, etc.

Name of Child's **Physician/Dentist**

Physician_____

Address_____

Phone_____

Dentist_____

Address_____

Phone_____

Family_____

Date of Admission_____

Optional

What is the primary language spoken in the home?_____

What special days do you celebrate?_____

Are there any days that you do not celebrate?_____

What ethnicity do you and your family identify with?

Hispanic/Latino_____ Not Hispanic/Latino_____ African American/Black_____

Caucasian/White____ Pacific Islander_____ Native American/Alaska Native____

Asian_____ Native Hawaiian/Pacific Islander_____ Other_____

What if any religious beliefs do you and your family share?_____

Does the person legally responsible for the care of the children and family work outside of the home?
Yes_____or No_____

Are other relative living in the home that help care for your child/children, such as grandparents?
Yes_____or No_____

What is your preferred method of contact? Home_____

Home_____ Email_____

Please list any special skills you have that you would be willing to share with the program as a family volunteer that will aid in the growth and development of all children and families in the Center_____

_____

_____

_____

Parent/Guardian Signature:_____

Date:_____

It is the policy of the Woodland Child Development Center to accept children twelve weeks through twelve years of age without discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil right activity in any program or activity conducted or funded by USDA.

Family_____

Child/Family Enrollment Application

Date of Admission_____

Today's date_____

Full Name of Child_____

Address:_____

Date of Birth_____

City/State/Zip Code_____

Mother's Name_____
SSN_____
Cell Phone #_____
Employer_____
Occupation_____
Work Phone #_____
Email_____

Father's Name_____
SSN_____
Cell Phone #_____
Employer_____
Occupation_____
Work Phone #_____
Email_____

Family Household Section (circle one) Married Single Separated Divorced

Initial please

Legal Custody_____Visiting Privileges to_____Contact Allowed_____Non-Custodial Parent_____

Is the person that is legally responsible for the family n the military? **Yes_____No_____**

If yes, are there occasions when the family member/s is stationed away from the home that could have an affect on the social/emotional stability of the family?

How/Who disciplines your child?_____

	Brothers/Sisters	Birth Date
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Emergency Information: (**Other than Parents), (Must Give Two)**

Name_____
Address_____
_____

Name_____
Address_____
_____

Family_____

Date of Admission_____

Home Phone_____
Cellular Phone_____
Relationship_____

Home Phone_____
Cellular Phone_____
Relationship_____

Entry Date_____

Weekly Schedule_____
Hours Daily from_____to_____

Child's Health History

1. Has your child have any serious health problems?
   _____
   _____
2. Was your child ☐full-term ☐premature
   If so, how many weeks?_____
3. Does your child have any allergies? If so, what are they?
   _____
   _____
4. Has your child had
   Mumps_____
   Chicken Pox_____
   Whooping Cough_____
5. Does your child have any condition now requiring regular medication?
   _____
   _____
   _____
6. Does your child have any **I**ndividual **E**ducation **P**lan (**IEP**) or **I**ndividual **F**amily **S**ervice Plan (**IFSP**) that can help us better meet the needs of you and your child/children needs? **Please provide a copy if applicable**

Has your child/children been exposed to any communicable disease prior to admission to Woodland Child Development Center such as COVID-19, chicken pox, measles, etc.

Name of Child's **Physician/Dentist**

Physician_____

Address_____

Phone_____

Dentist_____

Address_____

Phone_____

Family_____

Date of Admission_____

Optional

What is the primary language spoken in the home?_____

What special days do you celebrate?_____

Are there any days that you do not celebrate?_____

What ethnicity do you and your family identify with?

Hispanic/Latino_____ Not Hispanic/Latino_____ African American/Black_____

Caucasian/White____ Pacific Islander_____ Native American/Alaska Native_____

Asian_____ Native Hawaiian/Pacific Islander_____ Other_____

What if any religious beliefs do you and your family share?_____

Does the person legally responsible for the care of the children and family work outside of the home?
Yes_____or No_____

Are other relative living in the home that help care for your child/children, such as grandparents?
Yes_____or No_____

What is your preferred method of contact? Home_____

Home_____ Email_____

Please list any special skills you have that you would be willing to share with the program as a family volunteer that will aid in the growth and development of all children and families in the Center_____

_____

_____

_____

Parent/Guardian Signature:_____

Date:_____

It is the policy of the Woodland Child Development Center to accept children twelve weeks through twelve years of age without discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil right activity in any program or activity conducted or funded by USDA.

Family_____

Child Pickup List

Child's Name: _____

My child(ren) may be picked up by:

Name	Phone	Relationship to Child

I have the legal right to designate these people because:
(Do **NOT** check but **initial** one)

_____ I, alone, have legal and physical custody of the children

_____ My spouse and I share legal and physical custody of the children

_____ My ex-spouse and I share legal and physical custody of the children

_____ My child's father and I share legal and physical custody of the children

_____ My parent(s)/legal guardian share legal and physical custody of the children

My children may NOT have contact with these persons:

Name	Address	Relationship to Child

_____
Signature

_____
Relationship to child

_____
Date

Handling of Animals

I, _____, parent /legal guardian of _____ am fully aware that some WCDC classrooms have animal pets and that animal dander can potentially be a problem for young children with asthma and/or allergies. I have been informed and assured that in those classrooms that have animals, the animal cages and litter boxes are cleaned no less than twice a week and are out of the reach of the children. All animals that need to be seen by a veterinarian have proper documentation on file.

To help protect the children, carpets are vacuumed daily with the state of the art hepafilter vacuum and an allergy filter has been installed in the furnace, which helps to reduce 98% of airborne allergens. Most importantly, hands of the children are thoroughly washed after the handling of animals.

I have fully read the above information and have discussed it with my child's physician. We feel this is not a concern for my child and give permission for _____ to play with and handle animals.

_____

Parent/Legal Guardian

_____

Date

Emergency Care Agreement

I am the parent/legal guardian of _____. In the event of a medical emergency and/or any incident that requires emergency care/admission, I hereby give permission for my child to be taken to:

Community Hospital
901 MacArthur Blvd.
Munster, IN 46321

This also includes incidents where my child should become ill or injured while in the charge of Woodland Child Development Center staff.

_____ _____
Signature of Parent/Legal Guardian Relationship to Child

_____
Date

_____
Woodland Child Development Center Representative

_____
Date

CACFP Meal Benefit Income Eligibility

Complete one application per household. Please use a pen (not a pencil).

Sponsor Name:

Center Name:

APPLY ONLINE: Insert URL Here

STEP 1 List ALL children or adults in day care (if more spaces are required for additional names, attach another sheet of paper)

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Children in **Head Start** are eligible for free meals if an approved head start application or statement of enrollment is attached.

Check all that apply

Participant's First Name	MI	Participant's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

STEP 2 List the following assistance programs any household member participates in - for child care: SNAP, TANF, or FDPIR, or for adult daycare: SNAP, FDPIR, SSI, or Medicaid

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

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

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

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

Child Income	How often? Weekly	Bi-Weekly	Monthly	Annually
$	○	○	○	○

B. All Other Household Members (Including yourself)
List all adult Household Members (including yourself) as well as any children not listed in STEP 1 even if they do not receive income. For each person listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars. If they do not receive income from any source, you must write '0' - do not leave blank. If you enter '0', you are certifying that there is no income.

Name of Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	Annually	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	Annually	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	Annually
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - ☐☐☐☐

Check if no SSN ☐

STEP 4 Contact information and adult signature. SUBMIT COMPLETED FORM TO THE DAY CARE AT:

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

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Participant's Ethnic and Racial Identities (Optional)

We are required to ask for information about the participant's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT Sponsor use only - The Determining Official's dated signature is required

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Monthly x 12 (*required if earnings are in more than one frequency type)*

Use this space for income calculations:

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ Annually ○

Household size

Categorial Eligibility ☐

Eligibility: Free ☐ Reduced ☐ Paid ☐ Tier I ☐ Tier II ☐

Determining Official's Signature (required) | Date (required) | 2nd Official's Signature | Date | 3rd Official's Signature | Date

CHILD ENROLLMENT FORM

IDOE/CACFP
July 2017

Name of Institution: Woodland Child Development Center Sponsor ID Number: 1450074

Name of Facility: Woodland CDC

Child's Name: **Birthdate:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (☐) the meals your child normally receives while in care.	Breakfast___ Lunch_____ PM snack___	Breakfast___ Lunch_____ PM snack___	Breakfast___ Lunch_____ PM snack___	Breakfast___ PM snack___ Lunch_____	Breakfast___ Lunch_____ PM snack___	Breakfast___ Lunch_____ PM snack___	Breakfast___ Lunch_____ PM snack___
If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc.) Please check (☐) here _____							

FOR INFANTS ONLY: All facilities must offer infant formula and meals/snacks to infants in care during meal service times

Infant Formula

This facility will provide the following iron-fortified infant formula:

Check here to accept: ☐ Check here to decline: ☐ Provide name of parent-provided formula:

Infant Meals and Snacks

Check here to accept: ☐ Check here to decline: ☐

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant and must be updated annually.

Printed name of parent/guardian: Phone Number:

Signature of parent/guardian: Date:

Consent for Child Care Programs Activities

Woodland Child Development Center
3027 JF Mahoney Dr. Hammond IN 46323

Name of Child_____

Parental/Legal Guardian Consent is given for the following: (**Please Initial)**

Walking Trip

_____ Walking trip to the following location:

The children will go on a **daily** walking trip (weather permitting) on the Dowling Park Neighborhood Walking Trail.

_____ Monday –Friday the children will be going to the Dowling Park playground during their classroom outside time.

Infants Only

Buggy Ride Ride

_____ Buggy ride toe following location:

The infants will go on a Daly buggy ride (weather permitting) on the Dowling Park Neighborhood Walking Trail.

Printed Legal Guardian Name_____

Signature Legal Guardian Name_____

Date_____

Infants First Day Attendance

On your child's first day of attendance, please bring the following items:

1. Completed medical form: physical, shot record, feeding schedule, and record of medicine signed by your child's physician or nurse practitioner. If your infant drinks concentrated or powder formula, you must have a food substitution form and a health care plan signed by the physician or a nurse practitioner.
2. Unopened diapers and wipes
3. **Four** (4) new bottles with caps and nipples to stay at the school. If you would like to start introducing a sippy cup, you would have to supply the item.
4. Formula/Breast milk
5. Pacifier (optional)
6. Family picture for classroom (optional)
7. Any medication
8. A change of clothing (Two complete outfits)
9. Five (5) new bibs
10. Two (2) packages of washcloths
11. Two (2) packages of burp cloths
12. Nursery water

_____

Room assignment

_____

Teacher

_____

Entry date (Please call the office if this date has changed for any reason)

Pre-school First Day Attendance

On your child's first day of attendance, please bring the following items:

1. Completed medical form
2. A change of clothing in a clear plastic box (shoe box size)
3. Copy of any legal custody paperwork
4. Standard crib sheet for sleeping cot, small size blanket and pillow
5. Parent's picture ID
6. Child's insurance card
7. Tuition
8. Coupon or registration fee

_____
Room assignment

_____
Teacher

_____
Entry date (Please call the office if this date has changed for any reason)

Toddler First Day Attendance

On your child's first day of attendance, please bring the following items:

1. Completed physical signed by physician, medication, and consent form (if needed)
2. Any medication (turned in to the office)
3. Unopened diapers and wipes
4. Two (2) crib sheets and two (2) blankets. If your child needs a pillow, a travel pillow can be brought in with two (2) pillowcases.
5. Family pictures for classroom
6. Change of clothes in a small plastic tote (2 complete outfits)

_____
Room assignment

_____
Teacher

_____
Entry date (Please call the office if this date has changed for any reason)

WHAT MY CHILD NEEDS

Child's Name _____ Age _____ Date _____

Parent(s) Name(s) _____

In each of the boxes write some notes about "what it takes" for your child to do the activity listed. Include words you and your child use, equipment needed, special ways for doing things, positioning, etc. This form should be updated and given to providers to help them understand your child.

	My Child's Strengths	My Child's Challenges	What it Takes to Help My Child	
			Equipment	Other
Communicating Talking/Listening				
Thinking and Understanding				
Eating and Drinking				
Toileting				
Resting/Sleeping				
Traveling and Moving Around				

The Indiana Association for Child Care Resource & Referral, Indianapolis, IN

Adapted from: Chicago Metropolitan A.E.Y.C. Special Needs Commission Booklet

	My Child's Strengths	My Child's Challenges	What it Takes to Help My Child Equipment	 Other
Inside Play Time: ~Floor ~Table ~Getting toys				
Transition (Moving from one activity to the next)				
Playing with others				
Outside Play Time: ~Getting to the playground ~Using the equipment				
Fine Motor Activities (cutting, coloring, etc.)				
Large Motor Activities (running, jumping, riding a bike, etc.)				

NOTES: