SOUTHWESTERN CHILD DEVELOPMENT COMMISSION INC.
CHILDREN'S FILE CHECKLIST

Name of Child: __________________________ Date of Enrollment: __________________________

The following items must be present in each child’s file

<table>
<thead>
<tr>
<th>Item</th>
<th>Date Received/Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Child’s Application</td>
<td></td>
</tr>
<tr>
<td>□ Children’s Medical Report</td>
<td></td>
</tr>
<tr>
<td>□ Immunization History Record</td>
<td></td>
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<tr>
<td>□ Discipline Policy for Parents</td>
<td></td>
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<tr>
<td>□ Shaken Baby Policy</td>
<td></td>
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<tr>
<td>□ Emergency Medical Information</td>
<td></td>
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<tr>
<td>□ Child’s Release's and Emergency Information Form</td>
<td></td>
</tr>
<tr>
<td>□ Documentation of Child Receipt of Policies/Center Emergency Policy/Documentation of Receipt of Summary</td>
<td></td>
</tr>
<tr>
<td>□ (CACFP) Child Eligibility Application</td>
<td></td>
</tr>
<tr>
<td>□ (CACFP) Participant Enrollment Form</td>
<td></td>
</tr>
<tr>
<td>□ Building for the Future</td>
<td></td>
</tr>
<tr>
<td>□ (CACFP) Infant Formula and Provision of Baby Food</td>
<td></td>
</tr>
<tr>
<td>□ Infant Feeding Schedule (children less than 15 months of age)</td>
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</tr>
</tbody>
</table>
SOUTHWESTERN CHILD DEVELOPMENT COMMISSION INC.

Date Application Completed ____________________ Date of Enrollment ________________

CHILD’S APPLICATION FOR ENROLLMENT
To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually

CHILDF INFORMATION: Date of Birth: ________________
Full Name: ____________________________________________
Last               First               Middle               Nickname

Child's Physical
Address: ______________________________________________

FAMILY INFORMATION: Child lives with: ____________________________
Father/Guardian’s Name __________________ Home Phone __________
Address (if different from child’s) ____________________________ Zip Code __________
Work Phone __________ Cell Phone __________

Mother/Guardian’s Name __________________ Home Phone __________
Address (if different from child’s) ____________________________ Zip Code __________
Work Phone __________ Cell Phone __________

CONTACTS: Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Phone Number</th>
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HEALTH CARE NEEDS:
For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child’s parent or health care professional. Is there a medical action plan attached? Yes ___ No __

List any allergies and the symptoms and type of response required for allergic reactions. ____________________________________________

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns ____________________________________________

List any particular fears or unique behavior characteristics the child has ____________________________________________

List any types of medication taken for health care needs ____________________________________________

Share any other information that has a direct bearing on assuring safe medical treatment for your child ____________________________________________

EMERGENCY MEDICAL CARE INFORMATION:
Name of health care professional ____________________________ Office Phone __________
Hospital preference ____________________________ Phone __________

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency. Signature of Parent/Guardian __________ Date ________________

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child’s parent, guardian, or full-time custodian.

Signature of Administrator __________ Date __________

Sample Document

Revised 10/2016
Children’s Medical Report

Name of Child ____________________________ Birthdate ___________________
Name of Parent or Guardian ____________________________
Address of Parent of Guardian ____________________________

A. Medical History (May be completed by parent)
1. Is child allergic to anything? No ___ Yes ___ If yes, what?

2. Is child currently under a doctor’s care? No ___ Yes ___ If yes, for what reason?

3. Is the child on any continuous medication? No ___ Yes ___ If yes, what?

4. Any previous hospitalizations or operations? No ___ Yes ___ If yes, when and for what?

5. Any history of significant previous diseases or recurrent illness? No ___ Yes ___; diabetes No ___ Yes ___;
convulsions No ___ Yes ___; heart trouble No ___ Yes ___; asthma No ___ Yes ___.
If others, what/when?

6. Does the child have any physical disabilities: No ___ Yes ___ If yes, please describe:

Any mental disabilities? No ___ Yes ___ If yes, please describe:

Signature of Parent or Guardian ____________________________ Date __________________

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized
agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering
states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.
Height ________%  Weight ________%
Head ________  Eyes ________  Ears ________  Nose ________  Teeth ________  Throat ________
Neck ________  Heart ________  Chest ________  Abd/GU ________  Ext ________
Neurological System ________  Skin ________  Vision ________  Hearing ________
Results of Tuberculin Test, if given: Type ________  date ________  Normal ________  Abnormal ________  followup ________

Developmental Evaluation: delayed ________  age appropriate ________
If delay, note significance and special care needed:

Should activities be limited? No ___ Yes ___ If yes, explain:

Any other recommendations:

Date of Examination __________________

Signature of authorized examiner/title ____________________________  Phone # __________________
SOUTHWESTERN CHILD DEVELOPMENT COMMISSION INC.

IMMUNIZATION HISTORY

Name: ___________________________ Date of Birth: _______________________

Update as immunizations are received

Attach Immunization Record here
SOUTHWESTERN CHILD DEVELOPMENT COMMISSION, INC.
DISCIPLINE POLICY FOR PARENTS

The following is a statement of the discipline policy of Southwestern Child Development Commission. We ask that both parents read the statement. If you have read and understand the policy, please sign on the appropriate lines.

The goal of effective discipline is to teach the children self control. That is, to teach each child how to live usefully and happily with himself/herself and others. Good discipline results in a child who conducts himself/herself in an appropriate manner even when adults are not present. We, at Southwestern, believe the benefits of respect, consistency and positive reinforcement are more effective than corporal punishment. As such, no form of corporal punishment will be used in Southwestern centers. Southwestern's discipline policy is consistent with the policy of the North Carolina Division of Child Development.

When the need presents itself, the following methods of discipline will be used by classroom teachers:

1. Model appropriate behavior.
2. Redirect the child from an unacceptable activity to a more acceptable activity.
3. Provide alternative activities.
4. Give praise whenever possible for appropriate behavior.
5. Ignore behavior that would best be ignored when possible.
6. Distract children from inappropriate behavior.
7. Allow a child to get away from the situation briefly. This respects the fact that the child may be overly stimulated or upset and need an opportunity to be apart from the group.
8. Give the child time to consider his behavior. There will be a specified place (in full view of the caregiver) where the child will be allowed to sit for no more than 3 minutes of quiet time. This will be used as one of the last options for controlling a child's behavior. When a child's ability to understand that he/she is being asked to sit for quiet time, is impaired by disabilities or young age, his/her behavior will be dealt with by distraction or redirection.
9. If these methods of discipline fail to bring about the acceptable behavior necessary for safe and happy relationships with the other children in group care, a conference with parents will be requested.

Southwestern employees will follow these guidelines, at times, about the discipline of children:

1. No child shall be subjected to any form of corporal punishment by the owner, operator, director, or staff of any day care facility. For the purposes of this statement, "staff" shall mean any regular or substitute caregiver, any regular or substitute caregiver, any volunteer, and any auxiliary personnel, such as cooks, secretaries, janitors, maids, vehicle drivers, etc.
2. No child shall be handled roughly in any way, including shaking, pushing, shoving, pinching, slapping, biting, kicking, or spanking.
3. No child shall ever be placed in a locked room, closet, or box.
4. No discipline shall ever be delegated to another child.
5. Discipline shall in no way be related to food, rest, or toileting:
   a. No food shall be withheld, or given, as a means of discipline.
   b. No child shall ever be disciplined for lapses in toilet training.
   c. No a child shall ever be disciplined for not sleeping during rest period.
6. Children will be spoken to with a respectful tone of voice at all times.
7. Caregivers will not put hands on children for anything other than gentle and appropriate intentions.
8. A caregiver will never physically force a child to specified place for quiet time, raise her voice or place her hands on a child's face to force eye contact.

I attest that I received a copy of the Parent Handbook, which contains a copy of this Discipline Policy and it was discussed with me.

Child's Name __________________________ Date of Enrollment __________________________

Signature of Parent __________________________ Date __________________________

Signature of Director __________________________ Date __________________________
Prevention of Shaken Baby Syndrome and Abusive Head Trauma

Belief Statement
We, ________________ (name of facility), believe that preventing, recognizing, responding to, and reporting shaken baby syndrome and abusive head trauma (SBS/AHT) is an important function of keeping children safe, protecting their healthy development, providing quality child care, and educating families.

Background
SBS/AHT is the name given to a form of physical child abuse that occurs when an infant or small child is violently shaken and/or there is trauma to the head. Shaking may last only a few seconds but can result in severe injury or even death. According to North Carolina Child Care Rule (child care centers, 10A NCAC 09.0608, family child care homes, 10A NCAC 09.1726), each child care facility licensed to care for children up to five years of age shall develop and adopt a policy to prevent SBS/AHT.

Procedure/Practice
Recognizing:
- Children are observed for signs of abusive head trauma including irritability and/or high pitched crying, difficulty staying awake/lethargy or loss of consciousness, difficulty breathing, inability to lift the head, seizures, lack of appetite, vomiting, bruises, poor feeding/sucking, no smiling or vocalization, inability of the eyes to track and/or decreased muscle tone. Bruises may be found on the upper arms, rib cage, or head resulting from gripping or from hitting the head.

Responding to:
- If SBS/ABT is suspected, staff will:
  - Call 911 immediately upon suspecting SBS/AHT and inform the director.
  - Call the parents/guardians.
  - If the child has stopped breathing, trained staff will begin pediatric CPR.

Reporting:
- Instances of suspected child maltreatment in child care are reported to Division of Child Development and Early Education (DCDEE) by calling 1-800-859-0829 or by emailing webmasterdc@dhhs.nc.gov.
- Instances of suspected child maltreatment in the home are reported to the county Department of Social Services. Phone number: ________________

Prevention strategies to assist staff in coping with a crying, fussing, or distraught child
Staff first determine if the child has any physical needs such as being hungry, tired, sick, or in need of a diaper change. If no physical need is identified, staff will attempt one or more of the following strategies:
- Rock the child, hold the child close, or walk with the child.
- Stand up, hold the child close, and repeatedly bend knees.
- Sing or talk to the child in a soothing voice.
- Gently rub or stroke the child's back, chest, or tummy.
- Offer a pacifier or try to distract the child with a rattle or toy.
- Take the child for a ride in a stroller.
- Turn on music or white noise.
- Other ________________
- Other ________________

In addition, the facility:
- Allows for staff who feel they may lose control to have a short, but relatively immediate break away from the children.
- Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.
- Other ________________
## Prevention of Shaken Baby Syndrome and Abusive Head Trauma

**Parent or guardian acknowledgement form**

I, the parent or guardian of ____________________________

**Child’s name**

acknowledges that I have read and received a copy of the facility's Shaken Baby Syndrome/Abusive Head Trauma Policy.

<table>
<thead>
<tr>
<th>Date policy given/explained to parent/guardian</th>
<th>Date of child's enrollment</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Print name of parent/guardian</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of parent/guardian</th>
<th>Date</th>
</tr>
</thead>
</table>
SOUTHWESTERN CHILD DEVELOPMENT COMMISSION INC.

Emergency Medical Information

Child's name: ____________________________________________

Parent's name: __________________________________________

Parent's home phone: _____________________________________

Parent's work phone: _____________________________________

If parents cannot be reached call: ____________________________
@ this phone number: ______________________________________

Doctor: ___________________________ Phone: __________________

Hospital Preference: ____________________________

Please use the space below to indicate any allergies or special medical precautions.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Medical Release

"If emergency medical care becomes necessary, I give permission for my child to receive treatment as a physician deems necessary."

Signature of Parent or Guardian: ______________________________

Date: ______________________________
SOUTHWESTERN CHILD DEVELOPMENT COMMISSION INC.

Child’s Release’s and Emergency Information Form

Please Initial beside each Release

Transportation Information
1) I give my permission for my child to be transported to and from the child development center by the transportation system operated through the Southwestern Child Development Commission. I understand every precaution will be taken to ensure the safety of my child, I will not hold the driver responsible should an accident occur. I understand my child is covered by accident insurance carried by Southwestern Child Development Commission Inc.

2) If you are not home when we bring your child home, give the name and address of the person with whom we may leave you child.

Name of Person: ____________________________
Address: __________________________________
Directions to the House: _____________________

Phone Number: _____________________________

Field Trips and Activities Outside the Fenced Playground
I hereby give permission for my child to participate in a walking trip or transported in a vehicle for a field trip. I further give permission to the facility for my child to participate in developmentally appropriate supervised activities outside of the fenced playground.

Photographs
I consent to Southwestern Child Development Commission, Inc. or anyone authorized by the Commission to use or take photographs of my child, during his experiences with his child development center.

Emergency Information
If emergency medical care becomes necessary, I give my permission for my child to receive treatment as a physician deems necessary.

Parent or Guardian Signature __________________________ Date ________________
Child’s Receipt of Policies

I, __________________________, the parent of, __________________________, have received the following documents. (Please check all that apply)

___ Southwestern Child Development’s Parent Handbook, which includes Operational Policies and the Parent Participation Policy

___ Southwestern Child Development’s Discipline Policy

___ Summary of NC Child Care Laws and Rules

___ Centers Safe Sleep Policy

___ Shaken Baby Policy

_________________________________________  __________________________________
Signature of Parent                             Date

Center Emergency Policy

Our center Emergency Preparedness Plan includes shelter in place, Fire Evacuation and lock down Procedure. The director will go over these evacuation plans at time of enrollment. Centers will develop a long term evacuation plan that will have a central evacuation location.

This center, ___________________________________ will evacuate to ________________________________

I give permission for my child, _______________________, to be evacuated from the _____________ center to ___________________________________ in the case of an emergency evacuation.

_________________________________________  __________________________________
Signature of Parent                             Date
<table>
<thead>
<tr>
<th>Age</th>
<th>Place</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>10:00</td>
<td>Morning</td>
<td>Cooking class</td>
</tr>
<tr>
<td>0-1</td>
<td>11:00</td>
<td>Midday</td>
<td>Art and craft class</td>
</tr>
<tr>
<td>0-1</td>
<td>12:00</td>
<td>Afternoon</td>
<td>Science experiments</td>
</tr>
<tr>
<td>1-2</td>
<td>10:00</td>
<td>Morning</td>
<td>Math class</td>
</tr>
<tr>
<td>1-2</td>
<td>11:00</td>
<td>Midday</td>
<td>English class</td>
</tr>
<tr>
<td>1-2</td>
<td>12:00</td>
<td>Afternoon</td>
<td>Dance class</td>
</tr>
</tbody>
</table>

**Rules:**
- Children must arrive on time.
- No food or drinks allowed in the classroom.
- Children must be supervised by their teacher at all times.
- No running or shouting in the classroom.
- Children must clean up after themselves.

**Safety Measures:**
- Fire exits are clearly marked and accessible.
- First aid kit is available in each classroom.
- Emergency contact information is displayed in each classroom.

**Behavior:**
- Children must be respectful to their classmates and teachers.
- Children must follow the teacher's instructions.
- Children must participate in all activities.

**Table:**

<table>
<thead>
<tr>
<th>Size</th>
<th>Teacher: Chinese Education Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>5 years old</td>
</tr>
<tr>
<td>12</td>
<td>7 years old</td>
</tr>
<tr>
<td>20</td>
<td>9 years old</td>
</tr>
<tr>
<td>25</td>
<td>11 years old</td>
</tr>
<tr>
<td>30</td>
<td>13 years old</td>
</tr>
</tbody>
</table>

**Schedule:**
- Monday: Chinese Education Group (5 years old)
- Tuesday: Chinese Education Group (7 years old)
- Wednesday: Chinese Education Group (9 years old)
- Thursday: Chinese Education Group (11 years old)
- Friday: Chinese Education Group (13 years old)
North Carolina Department of Health and Human Services
Women's and Children's Health
CHILD AND ADULT CARE FOOD PROGRAM
CHILD ELIGIBILITY APPLICATION

1. PRINT PARTICIPANT'S NAME & DATE OF BIRTH:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

INSTITUTION NAME: __________________________

AGREEMENT#: __________________________

FACILITY NAME: __________________________

2. SNAP, TANF or FDPIR: If a child is a member of a SNAP or FDPIR household or TANF recipient, the child is automatically eligible to receive free Program meal benefits, subject to the completion of the application. If the household currently receives SNAP, TANF or FDPIR benefits give the case number.

Case number is: SNAP # __________ TANF#: __________ FDPIR # __________

If you have provided the case number; DO NOT complete #3 and #4. Complete #5 and #6.

3. A foster child is automatically eligible to receive free Program meal benefits, and a Head Start participant is automatically eligible to receive free Program meal benefits, subject to submission by Head Start officials of a Head Start statement of income eligibility or income eligibility documentation.

Is this a Foster Child? ☐ Yes ☐ No

Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children.

Is this a homeless child or a child evacuated from Japan or Bahrain? ☐ Yes ☐ No

Certification from the agency that assisted with the evacuation or is providing shelter is required.

4. HOUSEHOLD MEMBERS MONTHLY INCOME: List all others living in your household, DO NOT include participant listed above. List all gross income (before deductions) received last month. If you did not give a SNAP, TANF or FDPIR case number or if this is not a foster child, you must complete the income information.

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5. ETHNIC IDENTITY: (Check one).

☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: I certify that all of the above information is true and correct; that the application is being made in connection with the receipt of federal funds, that Program officials may verify the information on the application; and that deliberate misrepresentation of any of the information on the application may subject me to prosecution under applicable State and Federal criminal statutes.

Signature of Adult Household Member (Required) __________________________

Date __________________________

Last Four Digits of Social Security Number __________________________

(Required for households qualifying by income)

Printed Name __________________________

Address __________________________

City __________________________

State __________________________

Zip Code __________________________

Telephone # __________________________

Work Telephone # __________________________

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 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 for your child 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 your child is eligible for free or reduced price meals and for administration and enforcement of the Program.

For Institution to be classified and completed by institution/sponsor

TOTAL HOUSEHOLD SIZE __________________________

TOTAL HOUSEHOLD MONTHLY INCOME $ __________________________

Approved: ☐ Free ☐ Reduced ☐ Denied

Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other: __________________________

Withdrawn on (Date) __________________________

For state use only: __________________________

Verified by: __________________________

Date: __________________________

Verified classification: ☐ Free ☐ Reduced ☐ Denied

Reason for classification change: __________________________

Signature of Eligibility Official (Individual at the Institution Level) – REQUIRED __________________________

Date __________________________

NCDHIS-CACFP 11 – Child Income Eligibility Application (5/17)

This institution is an equal opportunity provider.
CACFP ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Eligibility Applications using the instructions below. Sign the certification statement and return it to your child care center.

PART 1-PARTICIPANT’S INFORMATION: Complete this part.
Print the name(s) of the child enrolled in the center.

PART 2-HOUSEHOLD GETTING SNAP, TANF, OR FDPIR BENEFITS: Complete this PART and PART 6.
(1) List your current SNAP, TANF, or FDPIR case identification number.
(2) An adult household member must sign the certification statement in PART 6.

PART 3-FOSTER or HOMELESS CHILD (Including children evacuated from Japan and Bahrain)
(1) Indicate if child is a Foster Child or is homeless. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Additionally, when a host family applies for free and reduced price meals for their own children, the host family may include the homeless family as household members if the host family provides financial support to the homeless family. In such cases, the host family must also include any income received by the homeless family.
(2) An Adult household Member must sign the certification statement in PART 6.

PART 4- HOUSEHOLD INCOME: Complete this PART and PART 6
(1) List the names of household members.
(2) Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received last month for each household member and where it came from, such as earnings, public assistance, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person’s usual income.
(3) An adult household member must sign this income eligibility statement and give the last four digits of his/her social security number in PART 6.

PART 5-RACIAL/ETHNIC IDENTITY: Complete the Ethnic/Racial identity question.

PART 6-SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: All households complete this PART.
(1) All eligibility applications must have this signature of an adult household member;
(2) The adult household member who signs the certification statement must include the last four digits of his/her social security number. If he/she does not have a social security number, write “none”. If you listed a SNAP, TANF, or FDPIR number a social security number is not needed.

### INCOME TO REPORT

<table>
<thead>
<tr>
<th><strong>Earnings from Employment</strong></th>
<th><strong>Pensions</strong></th>
<th><strong>Disability benefits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wage/salaries/tips</td>
<td>Pensions</td>
<td>Cash withdrawn from savings</td>
</tr>
<tr>
<td>Strike benefits</td>
<td>Supplemental security income</td>
<td>Interest/dividends</td>
</tr>
<tr>
<td>Unemployment compensation</td>
<td>Retirement income</td>
<td>Income from estates/trusts/investments</td>
</tr>
<tr>
<td>Net income from self-owned business or farm</td>
<td>Veteran’s payments</td>
<td>Regular contributions from persons not living in the household</td>
</tr>
<tr>
<td>Worker’s compensation</td>
<td>Social Security</td>
<td>Net royalties/annuities/net rental income</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Public Assistance/Child Support/Alimony</strong></th>
<th><strong>Military Households</strong></th>
<th><strong>Other Income</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public assistance payments</td>
<td>All cash income, including military housing/uniform allowances. Does not include “in-kind” benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)</td>
<td>Disability benefits</td>
</tr>
<tr>
<td>TANF payments</td>
<td></td>
<td>Cash withdrawn from savings</td>
</tr>
<tr>
<td>Alimony/Child support payments</td>
<td></td>
<td>Interest/dividends</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Income from estates/trusts/investments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regular contributions from persons not living in the household</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Net royalties/annuities/net rental income</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any other income</td>
</tr>
</tbody>
</table>
Dear Parent or Guardian,

Please help us comply with the federal requirement mandating the annual submission of program Income Eligibility Application (CAC 11). This application will be used only for eligibility determination, placed in our files and treated as confidential information. In order for participants and the day care center to be considered eligible for program benefits, an adult household member must complete the program Income Eligibility Application (IEA) for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory unless you wish to be considered for eligibility as a free or reduced price participant.

If you currently receive SNAP, Temporary Aid to Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR), you are not required to list household income. You may give your SNAP, TANF or FDPIR case number, sign, date and return the application. If a child is a member of a SNAP or FDPIR household or is a TANF recipient, the child is automatically eligible to receive free program meal benefits, subject to completion of the application.

You should also note that if you have a foster child the day care center is eligible for program benefits for the foster child regardless of the income of your household. Households with foster and non-foster children may choose to include the foster child as a household member, as well as any personal income earned by the foster child, on the same household application that includes their non-foster children. Please contact the institution for further instructions.

You should list the name of everyone who lives in your household, including all children, parents, grandparents and other relatives. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e. sharing living expenses).

The income which you report must be the total gross income, before deductions, received by all members of your household last month (i.e. wages, public assistance, TANF or retirement, etc.). Military benefits received in cash, such as housing allowance for military households living off base and food or clothing allowance must be considered as income. If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

### REDUCED GUIDELINES EFFECTIVE JULY 1, 2017 - JUNE 30, 2018*

<table>
<thead>
<tr>
<th>HOUSEHOLD SIZE</th>
<th>YEARLY</th>
<th>MONTHLY</th>
<th>TWICE PER MONTH</th>
<th>EVERY TWO WEEKS</th>
<th>WEEKLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$22,3118</td>
<td>$1,860</td>
<td>$930</td>
<td>$859</td>
<td>$430</td>
</tr>
<tr>
<td>2</td>
<td>$30,044</td>
<td>$2,504</td>
<td>$1,252</td>
<td>$1,156</td>
<td>$578</td>
</tr>
<tr>
<td>3</td>
<td>$37,777</td>
<td>$3,149</td>
<td>$1,575</td>
<td>$1,453</td>
<td>$727</td>
</tr>
<tr>
<td>4</td>
<td>$45,510</td>
<td>$3,793</td>
<td>$1,897</td>
<td>$1,751</td>
<td>$876</td>
</tr>
<tr>
<td>5</td>
<td>$53,243</td>
<td>$4,437</td>
<td>$2,219</td>
<td>$2,048</td>
<td>$1,024</td>
</tr>
<tr>
<td>6</td>
<td>$60,976</td>
<td>$5,082</td>
<td>$2,541</td>
<td>$2,346</td>
<td>$1,173</td>
</tr>
<tr>
<td>7</td>
<td>$68,709</td>
<td>$5,726</td>
<td>$2,863</td>
<td>$2,634</td>
<td>$1,322</td>
</tr>
<tr>
<td>8</td>
<td>$76,442</td>
<td>$6,371</td>
<td>$3,186</td>
<td>$2,941</td>
<td>$1,471</td>
</tr>
<tr>
<td>For each additional family member add:</td>
<td>$7,733</td>
<td>$645</td>
<td>$323</td>
<td>$298</td>
<td>$149</td>
</tr>
</tbody>
</table>

*Households with income less than or equal to these levels are eligible for free or reduced price meals.

You may submit a program Income Eligibility Application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, this institution is prohibited from discriminating based on race, color, national origin, sex, age, disability and reprisal or retaliation for prior civil rights activity. 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](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 U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 by fax (202) 690-7442 or email program.intake@usda.gov. This institution is an equal opportunity provider.
Child and Adult Care Food Program (CACFP)
Child Participant Enrollment Form

Institution Name: Southwestern Child Development
Agreement Number: 7272

Center Name: ___________________________

Dear Parent/Guardian,
This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all children. Please complete the table below for each child in your family that is enrolled at this center/program. Be sure to sign and date in the space below. Thank you.

The information below should be completed by the parent or guardian.

<table>
<thead>
<tr>
<th>Child's First Name</th>
<th>Child's Last Name</th>
<th>Date of Birth</th>
<th>Normal/Typical Hours of Care</th>
<th>Normal/Typical Days of Care (Circle all that apply)</th>
<th>Meals Normally Eaten (Circle all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M T W Th F Sat Sun</td>
<td>B AM L PM S LPM</td>
</tr>
</tbody>
</table>

Normal/Typical Hours of Care: Please write in each child’s usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Please circle the days of the week each child is usually in attendance at the facility.
(M- Monday; T- Tuesday; W- Wednesday; Th- Thursday; F- Friday; Sat- Saturday; Sun- Sunday)

Meals Normally Eaten – Please circle the meals each child usually eats at the facility.
(B- Breakfast; AM- AM Snack; L- Lunch; PM- PM Snack; S- Supper; LPM- Late PM/Evening Snack)

Parent/Guardian Signature: ________________________________ Date: ____________

Print Name: ________________________________________________

Address: ________________________________________________

City: ______________________________________ State: _____ Zip Code: ________

Home Telephone Number: ( ) __________________ Work Telephone Number: ( ) __________________

For Facility/Provider Use Only:
Signature of Facility Representative/Provider: __________________________ Date: ____________

Date each child withdrew: ______________________________________

For State Use Only: Complete: ______ Incomplete _______ Reason: _____________________________ Verified by: _______ Date: ________

This institution is an equal opportunity provider.

CAC-Enrollment Child (06/17)
Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

**Meals**
CACFP homes and centers follow meal requirements established by USDA.

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Lunch or Supper</th>
<th>Snacks (Two of the four groups: )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk</td>
<td>Milk</td>
<td>Milk</td>
</tr>
<tr>
<td>Fruit or Vegetable</td>
<td>Meat or meat alternate</td>
<td>Meat or meat alternate</td>
</tr>
<tr>
<td>Grains or Bread</td>
<td>Grains or bread</td>
<td>Grains or bread</td>
</tr>
<tr>
<td></td>
<td>Two different servings of fruits</td>
<td>Fruit or vegetable</td>
</tr>
<tr>
<td></td>
<td>or vegetables</td>
<td></td>
</tr>
</tbody>
</table>

**Participating Facilities**
Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes**: Licensed or approved private homes.
- **Afterschool Care Programs**: Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters**: Emergency shelters provide food services to homeless children.

**Eligibility**
State agencies reimburse facilities that offer non-residential day care to the following children:
- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool care programs in needy areas.

**Contact Information**
If you have questions about CACFP, please contact one of the following:

<table>
<thead>
<tr>
<th>Sponsoring Organization/Center</th>
<th>CACFP Unit Manager,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwestern Child Development Commission, Inc.</td>
<td>Department of Health and Human</td>
</tr>
<tr>
<td>Po Box 250</td>
<td>Services</td>
</tr>
<tr>
<td>Webster, NC 28788</td>
<td>Division of Public Health</td>
</tr>
<tr>
<td>Phone: 1-800-662-4158 or 828-586-5561</td>
<td>Nutrition Services Branch</td>
</tr>
<tr>
<td>Fax: 828-586-4039</td>
<td>1914 Mail Service Center</td>
</tr>
<tr>
<td></td>
<td>Raleigh, NC 27699</td>
</tr>
<tr>
<td></td>
<td>919-707-5799</td>
</tr>
</tbody>
</table>

USDA
USDA is an equal opportunity provider and employer
CHILD AND ADULT CARE FOOD PROGRAM
PROVISION OF BREASTMILK OR
INFANT FORMULA AND PROVISION OF BABY FOOD

Name of child care provider or center

This institution/facility offers Parents Choice with Iron formula for infants (Iron-Fortified Formula name must be filled in by institution/facility) through the Child and Adult Care Food Program. It is a parental choice whether or not to use this formula based on you and your infant’s needs.*

Please select from (✓) the following choice(s):

- I will provide breastmilk for my infant.
- I will use the iron-fortified formula offered by this facility. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility’s staff.
- I will not use the iron-fortified formula offered by this facility. If not, which formula will you send for your infant? If the formula you provide is a special formula, a medical statement will be requested.
- My infant is four (4) months old or older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which are allowed under 7CFR §226.20 (b) (2) (3) (4).

Allowable foods for infants are: iron-fortified infant cereal, fruit, vegetable, meats or meat alternates, enriched or whole grain bread and crackers. Foods shall be of appropriate texture and consistency to meet developmental needs. Baby foods provided by institution/facility must be in compliance with the infant meal pattern as required by 7CFR §226.20.

Infant’s Name

Infant’s Age

Parent’s Signature Date

*Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find that you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care institution/facility.

DHHS CACFP (01/09)
SNP Provision Infant Formula Form
Infant Feeding Plan

As your child's caregivers, an important part of our job is feeding your baby. The information you provide below will help us to do our very best to help your baby grow and thrive. Page two of this form must be completed and posted for quick reference for all children under 15 months of age.

Child's name: ____________________________________________________________

Birthday: __________ mm/dd/yyyy

Parent/Guardian's name(s): ________________________________________________

Did you receive a copy of our "Infant Feeding Guide"?

Yes     No

If you are breastfeeding, did you receive a copy of:

"Breastfeeding: Making It Work?"

Yes     No

"Breastfeeding and Child Care: What Moms Can Do?"

Yes     No

TO BE COMPLETED BY PARENT

At home, my baby drinks (check all that apply):

- Mother's milk from (circle)
  - Mother bottle cup other

- Formula from (circle)
  - bottle cup other

- Cow's milk from (circle)
  - bottle cup other

- Other: ____________________ from (circle)
  - bottle cup other

How does your child show you that s/he is hungry?

How often does your child usually feed?

How much milk/formula does your child usually drink in one feeding?

Has your child started eating solid foods?

If so, what foods is s/he eating?

How often does s/he eat solid food, and how much?

TO BE COMPLETED BY TEACHER

Clarifications/Additional Details:

At home, is baby fed in response to the baby's cues that s/he is hungry, rather than on a schedule?

Yes     No

If NO,

- I made sure that parents have a copy of the "Infant Feeding Guide" or "Breastfeeding: Making it Work"

- I showed parents the section on reading baby's cues

Is baby receiving solid food? Yes     No

Is baby under 6 months of age? Yes     No

If YES to both,

- I have asked: Did the child's health care provider recommend starting solids before six months?
  Yes     No

  If NO,

  - I have shared the recommendation that solids are started at about six months.

Handouts shared with parents;
Tell us about your baby’s feedings at our center.
I want my child to be fed the following foods while in your care:

<table>
<thead>
<tr>
<th>Frequency of feedings</th>
<th>Approximate amount per feeding</th>
<th>Will you bring from home? (must be labeled and dated)</th>
<th>Details about feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's Milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow's milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby Food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table Food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (describe)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I plan to come to the center to nurse/ feed my baby at the following time(s): ____________________________________________________________________________________

My usual pick-up time will be: ____________________________________________________________________________________

If my baby is crying or seems hungry shortly before I am going to arrive, you should do the following (choose as many as apply):

- hold my baby
- use the teething toy I provided
- use the pacifier I provided
- rock my baby
- give a bottle of milk
- other Specify: _______________________________________________________________________________________

I would like you to take this action ________ minutes before my arrival time.

At the end of the day, please do the following (choose one):

- _______ Return all thawed and frozen milk / formula to me.
- _______ Discard all thawed and frozen milk / formula.

We have discussed the above plan, and made any needed changes or clarifications.

Today's date: ____________________________________________

Teacher Signature: __________________________ Parent Signature ________________

Any changes must be noted below and initialed by both the teacher and the parent.

<table>
<thead>
<tr>
<th>Date</th>
<th>Change to Feeding Plan (must be recorded as feeding habits change)</th>
<th>Parent Initials</th>
<th>Teacher Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

In Collaboration With:
NC Department of Health and Human Services
NC Child Care Health and Safety Resource Center
NC Infant Toddler Enhancement Project

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http://breastfeeding.unc.edu/