Waverly's Hope Child Care LLC
5956 Colerain Ave
Cincinnati, Ohio 45239
513-923-4673
Enrollment Packet
(EHS)

Waverly's Hope Child Care LLC
EHS Enrollment Required Materials

Waverly's Hope Child Care is in partnership with Community Action Agency Early Head Start Program. This partnership enables us to provide your child diapers, wipes, lower student teacher ratios, quality staff, and additional supports for your child and our staff. Although you have enrolled with us as an Early Head Start family you will need to complete your enrollment Community Action Agency. ***Information shared with CAA is solely for their program purposes and will not be reported or shared with other agencies.***

Contact Ms. Brenda Ellis at (513)569-1850 ext 4344 to schedule an appointment to finalize your enrollment. Please provide the documents below to the Center Administrator prior to meeting with Ms. Brenda. We will send the required information to Ms. Brenda on your behalf. Should she determine you need any additional information it must be provided to Waverly's Administration within a week.

If you fail to complete your enrollment with our partner Community Action Agency we will terminate your care.

Child's Immunizations (shot records same as provided to center)
Child's Birth Certificate
Pay stubs showing 12 months of activity or 2019 W-2 **** talk to Waverly Adm to determine other options if unavailable
Parent Identification
Child's Insurance Card

Please direct any questions that you may have in regard to this partnership to our Center Administrator.

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State / Zip Code	Home Telephone Number	
Parent/Guardian Name		Relationship to Child
Home Address		Home Telephone Number
City	State / Zip	
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name		Relationship to Child
Home Address		Home Telephone Number
City	State / Zip	
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**_Do Not Give Permission_ to Transport**	
Program or Home Name			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**OR** **Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No
(check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.
What might you and/or your child be anxious about as he/she starts in this program?
What are you and/or your child excited about as he/she starts in this program?
What are your expectations of this program?
What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date

Ohio Department of Job and Family Services

BASIC INFANT INFORMATION FOR CHILD CARE

This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.

Child's Name	Nickname
Child's Date of Birth	Siblings

What are you feeding your infant? *(Check all that apply)*

☐ Formula (include brand) ☐ Breast milk

Formula preparation *(if center/provider is to prepare.)*

Amount for each feeding	Frequency of feedings

My infant likes a bottle warmed: *(Check one)* ☐ Room temp ☐ Warm ☐ Very warm/NOT HOT

Juice *(type, amount, when?)*

Does child use a cup yet? ☐ No ☐ Yes

Solid foods *(baby food, brand, types, amounts, frequency)*
**you must have written permission from your child's physician if your child is under 4 months and given solid foods.*

Are foods served room temperature or warmed?

Table food *(types, amounts, frequency, special instructions)*

Security items *(pacifier, blankies, etc.)*

Nap schedule

Hints for getting baby to sleep

Sleeping Position ☐ Back ☐ Side* ☐ Tummy*
**You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.*

Special Precautions

Any additional information about your child that would be helpful or you would like staff to know.

Parent Signature	Date
Primary Caregiver Signature	Date

Date form last updated					

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional
Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*
If yes, what medications?

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

CACFP
INFANT MEALS – PARENT PREFERENCE LETTER

TO: **Parents and Guardians of Infants under one year of age**

FROM:

Name of Center or Provider	

TOPIC: **Who will provide food for your infant's meals?**

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a child nutrition program of the United States Department of Agriculture. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

Center or provider to insert the NAME OF FORMULA that they will provide	

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section.

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

☐ I want the center or FCC home provider to provide formula for my infant

☐ I will bring iron fortified infant formula for my infant

Parent/Guardian: List Name of Formula You Will Provide

☐ I will bring expressed breast milk for my infant

☐ I will come to the center or FCC home to breast feed my infant

Solid Food: (check one)

☐ I want the center or FCC home to provide solid food for my infant when he/she is developmentally ready for it

☐ I will bring solid food for my infant when he/she is developmentally ready for it

***Note: If your feeding preferences change, the center or provider will ask you to complete a new form.**

INFANT'S NAME:	INFANT'S BIRTHDATE:
PARENT/GUARDIAN SIGNATURE:	DATE:

Ohio Department of Education - Office of Integrated Student Supports

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME		
CHILD'S NAME (please print)	**AGE**	**BIRTHDATE** / / month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List hours child normally in care				Check (✓) meals child normally receives while in care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ **Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.**

SIGNATURE OF PARENT/GUARDIAN	DATE	DAY PHONE NUMBER
MAILING ADDRESS: **STREET /APT.**	**CITY**	**ZIP CODE**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email:program.intake@usda.gov.

This institution is an equal opportunity provider. Revised 10/2019

OHIO CHILD AND ADULT CARE FOOD PROGRAM: ADULT DAY CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS: Fiscal Year 2020-2021

Instructions: For the center to receive free or reduced-price meal reimbursement for meals served, please complete this application and return to the center. Follow the directions below and in the Household Letter on the backside of form. Asterisks (*) indicate information that must be completed. **Form must be completed annually and is valid for only 12 months.**

PART 1: PARTICIPANT INFORMATION - Enter name, age, and birth date of the adult participant(s).

*NAME	AGE	BIRTH DATE
*NAME	AGE	BIRTH DATE

PART 2: BENEFITS - Complete this section if you currently receive benefits from Medicaid, Supplemental Security Income (SSI), or if household receives Food Assistance (SNAP, formerly Food Stamps). Only one number is required. If you complete this part, skip Part 3. Continue to Part 4

Medicaid Number	SSI Number	Food Assistance Case Number

PART 3: TOTAL HOUSEHOLD GROSS INCOME - Complete this section if Part 2 did not apply to you. In the Name column, list the name of the adult participant, spouse and dependent(s) living in the household who share income and expenses. If you need more space, use a separate sheet of paper. Refer to the information below and the backside of form for descriptions of various types of income.

For participants NOT receiving Medicaid, Supplemental Security Income (SSI) or Food Assistance (SNAP), complete the chart below according to these instructions: **List all income received last month on the same line with the person who received it and how often it was received: weekly, every 2 weeks, twice per month, monthly or annually.**

Line 1: List the name and gross income during the last month of the adult day care participant and how often it was received.
Line 2: List the name and gross income during the last month of the participant's spouse and how often it was received.
Line 3 & 4: List the name and gross income during the last month of all dependents who live with the participant and how often it was received.
If no or zero income, check box in column b. Households with no or zero income have year-long eligibility as Free.

a.NAME: List only the adult participant(s), spouse and dependents of participant(s)		c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, every two weeks, twice per month, monthly, annually			
	b. CHECK IF NO / ZERO INCOME	1. Earnings from work before deductions/how often	2. Welfare payments, child support, alimony/how often	3. Pensions, retirement, Social Security, SSI, VA /how often	4. All Other Income/ how often
1.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
2.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
3.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____
4.	☐	$_____/_____	$_____/_____	$_____/_____	$_____/_____

PART 4: SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER - Adult household member must sign/date form (participant, guardian or household member). The SSN is not required if you provided a Medicaid, SSI or Food Assistance number. If Part 3 is completed, the adult signing the form must also list the last 4 digits of his or her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF PERSON COMPLETING FORM	* DATE	If Part 3 is completed, insert last 4 digits of Social Security Number ☐☐☐☐
		☐ (Check if applicable) I do not have a Social Security Number

Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled adult participant.

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

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

State Distribution: 7/1/2020

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying participant by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following annual income conversion:
weekly x 52, every two weeks (bi-weekly) x 26, twice per month (semi-monthly) x 24, monthly x 12

Application Certified/Categorized as:

☐ **FREE,** based on ☐ Medicaid
☐ Supplemental Security Income (SSI)
☐ Food Assistance
☐ Household Size & Income

☐ **REDUCED,** based on **household** size and income

Total Household Size: _____

Total Household Income: $_____

Per: ☐ Week ☐ Every two weeks ☐ Twice Per Month ☐ Month ☐ Year

☐ **PAID,** based on ☐ Income too high
☐ Incomplete
☐ Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized	Form Effective Date	Expiration Date
		(From the first of month of date signed)	(Valid until last day of month in which form was signed one year earlier)

Note: Effective date is determined by participant/guardian/adult household or sponsor signature date as selected on CRRS application. If date of participant/guardian/adult household member signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

ETHNIC and RACIAL DATA FORM

Agency/Daycare Center_____

Agency/Daycare Address _____

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. **We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. If you choose not to Self Identify, then please be aware that the agency/daycare will need to make a judgment of your child's race and ethnicity because Civil Rights law require them to do so.** This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

Child's name _____

Ethnic Category: Choose one

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
Non-Hispanic or Latino:	

Racial Categories: Check all that apply

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: A person having origins in any of the black racial groups of Africa.	
Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
Other	

Parent/Guardian Signature_____ **Date**_____

PARENT/GUARDIAN REQUEST FOR FLUID MILK SUBSTITUTION

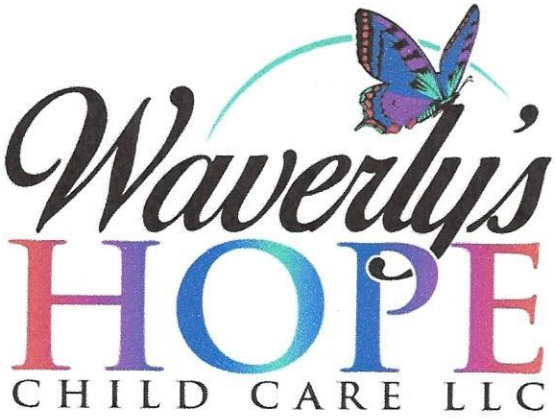
Parents or guardians may now request in writing that non-dairy beverages be substituted for fluid milk for their children with special dietary needs without providing statement from a recognized medical authority. However, fluid milk substitutions requested are at the **option** and expense of the facility/center.

The non-dairy beverage provided must be nutritionally equivalent to fluid milk and meet the nutritional standards set by the U.S. Department of Agriculture (USDA) for Child Nutrition Programs in order for the facility/center to claim reimbursement for the meal through the Child and Adult Care Food Program (CACFP).

A non-dairy beverage product must at a minimum contain the following nutrient levels per cup to qualify as an acceptable milk substitution:		
a. Calcium 276 mg	d. Vitamin D 100 IU	g. Potassium 349 mg
b. Protein 8 g	e. Magnesium 24 mg	h. Riboflavin .44 mg
c. Vitamin A 500 IU	f. Phosphorus 222 mg	i. Vitamin B-12 1.1 mcg

To be completed by Child Care Center/Provider prior to distribution of form	
Name of Child Care Center/Provider:	
	This child care center/provider will provide the following non-dairy beverage which meets the USDA-approved nutrient standards for a milk substitute: (list substitute(s))
	This child care center/provider has chosen not to provide non-dairy beverages for the substitution of fluid milk.

To be completed by Parent/Guardian		
Child's Full Name:		
Identify the medical or other special dietary need that restricts the diet of your child (why your child needs a non-dairy beverage as a milk substitute):		
	I request that my child is served the non-dairy beverage which meets the USDA-approved nutrient standards for a milk substitute that is provided by the center/provider as indicated above.	
	I am aware that the center is not providing a non-dairy beverage for the substitution of fluid milk. I will provide a non-dairy beverage for my child that meets the USDA-approved nutrient standards for a milk substitute as stated above.	
	I will provide a non-dairy beverage for my child that does **not** meet the USDA-approved nutrient standards for the substitution of fluid milk. I understand that the center cannot claim meals that require milk unless I get written statement from a recognized medical authority.	
Signature of Parent/Guardian:		**Date:**



Waverly's Hope Child Care LLC
Child Pick Up/ Release Form

To ensure the safety of your child we require all enrolling parents/ guardians to complete the Child Pick Up/ Release Form. All individuals must show their identification the first time that they pick up. We will only release your child to individuals that you list on this form. We will not take verbal communication as authorization to release your child to someone not on this list. Should you need to amend this form at any time, please speak with the center Administrator.

Please list all people including yourself that you authorize to pick up your child.

Legal Name	Relationship to Child

Enrolled Child's Name:_____
Enrolling Parent/ Guardian Name:_____
Parent Signature:_____
Date Completed:_____

Waverly's HOPE
CHILD CARE LLC

Waverly's Hope Child Care LLC
Enrollment Daily Schedule

In effort to provide children in our care with quality care, we are requesting your child's schedule. Please fill in the information below regarding the times that your child will be in our care. We provide all full-time children with a maximum of ten (10) hours per day. Once this schedule is set your child will not be permitted to arrive earlier that the agreed upon time. Your child will also not be permitted to be picked up after the agreed upon time. Parents that arrive after the agreed upon time will receive a late fee of $5 per minute per child. The late fee must be paid upon drop off the next day.

Enrolled Child's Name:
Parents Name:
Drop Off Time:
Pick Up Time:
Parent Signature:
Date:

Waverly's HOPE
CHILD CARE LLC

Waverly's Hope Child Care LLC
Permission to Photograph/ Video

I _____ parent/ guardian of _____ grant to Waverly's Hope Child Care LLC, its representatives and employees the right to take photographs/ videos of me and or my child in connection with Waverly's Hope Child Care LLC. I authorize its assigns and transferees to copyright, use and publish the same in print and electronically.

I agree to allow Waverly's Hope Child Care LLC to use such photographs of me with or without my name and for any lawful purpose, including publicity, illustration, advertising, and web content.

I have read, understand and agree with the above statements regarding permission to photograph/ video.

Printed Name of Minor Enrolled in Center _____

Printed Parent Name _____

Parent Signature _____

Date_____

Waverly's HOPE
CHILD CARE LLC

Waverly's Hope Child Care
Cot Permission Form

I, _____ parent of _____ grant Waverly's Hope Child Care LLC and its staff permission to allow my child_____ to use a cot at or after 12 months of age.

Parent Signature:_____ Date:_____

Waverly's Hope Child Care LLC
Quick Center Facts

Welcome to the Waverly's Family! Please find highlighted below some guidelines that are included in your parent handbook.

Schedule:
We provide a ten (10) hour daily schedule to full time children. This allows our center to maintain lower staff to student ratios per requirement of Step Up to Quality.
i.e. if your schedule is 9 am-4pm, you cannot drop off before 9:00 am and cannot pick up after 4:00 pm

Fulltime enrollment requires at least 25 hours a week of attendance.

Absence:
Please call the center if your child will not be in attendance. After 3 consecutive absences with no communication we reserve the right to remove your child from care.

Center Drop Off Cut Off:
Our Center drop off cut off is 9:00 am. Children will not be accepted after 9:00 am. In the event that you have a previously scheduled appointment please speak with the Center Administrator in advance.
In the event you are running late contact the center 30 mins in advance, admission is at the discretion of the Center Administrator.

Late Pick Up Charges:
Late charges are accrued after picking up after your scheduled pick up time. Our late fee **is $5 per minute per child**. We use the JFS sign in clock to determine time. We stop counting after you walk through the door. Late fees must be paid in cash before your child is able to return to care.

Child Care Payment/ Co-Payments:
Payments and Co-Payments are due every Monday or the first day that your child is in care. If your child/ children are not in care full payment/ co-payment is due to reserve your child's spot. All past due accounts are subject to a $15 late fee.

Holidays:
Full tuition is due for all periods including holidays and inclement weather closures.

Registration:
All families are required to pay a $50 registration fee per child. Children with vouchers JFS cover the registration fee. Private pay families must pay to reserve their spot.

Sick Policy:
A parent will be required to pick up their child immediately if they develop any of the following symptoms below:

- Diarrhea (3 loose stools within a 24-hr. period)
- Severe coughing, causing the child to become red or blue in the face or to make a whooping sound
- Difficult or rapid breathing
- Yellowish skin or eyes
- Redness of the eye or eyelid, thick and purulent (pus) discharge, matted eyelashes, burning, itching or eye pain
- Untreated infected skin patches, unusual spots or rashes
- Unusually dark urine and/ or gray or white stool
- Stiff neck with and elevated temperature
- Evidence of untreated lice, scabies, or other parasitic infestations
- Sore throat or difficulty swallowing
- Vomiting more than one time or when accompanied by any other sign or symptom of illness

We reserve the right to remove your child from care if you do not pick your child up within the hour.

All sick symptoms require a 24-hour removal from the center. Please ensure that your child is symptom free before they return for care. If staff indicate the need for a doctor's note, please provide one upon return to the center.

Student Behavior:

Children will be required to be picked up

1. If your child displays behaviors that are continuously disruptive to the center
2. If the behavior is deemed unsafe to the child and/or other children and/or staff

Outside Food/ toys:
No outside food or toys may be brought into the center. We are a nut free facility.

What Does a Safe Sleep Environment Look Like?

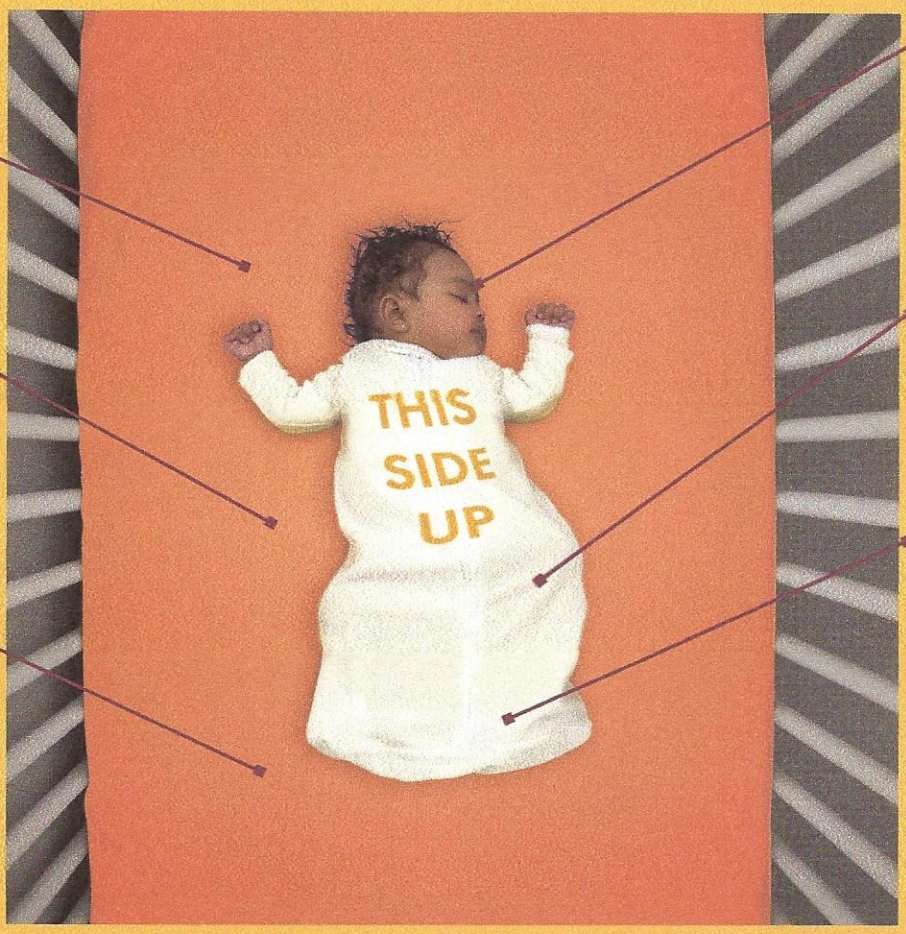
Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

Use a firm sleep surface, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

Do not use pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area.

Do not smoke or let anyone smoke around your baby.



Make sure nothing covers the baby's head.

Always place your baby on his or her back to sleep, for naps and at night.

Dress your baby in light sleep clothing, such as a one-piece sleeper, and do not use a blanket.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

*For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or www.cpsc.gov.

www.SafeSleep.Ohio.gov

Alone.

Always put me in my crib alone. I shouldn't sleep in your bed or have anyone else in mine.

Back.

Always put me on my back to sleep – at night or even when I'm just napping.

Crib.

Always make sure the only thing on my firm mattress is a fitted sheet. No blankets. No stuffed animals.

Ohio Department of Health

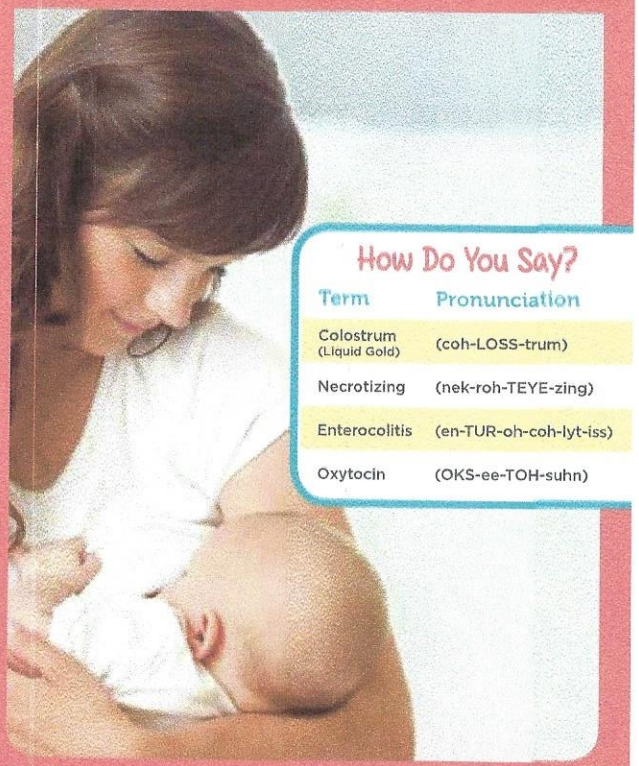
Why Breastfeed?

Newborns Need Colostrum

The first milk made just after birth is known as colostrum. It's thick, yellow/orange in color and helps newborn digestive systems grow and function. Rich in nutrients and antibodies, colostrum protects baby from infections.

Mother's Milk Works Wonders

Colostrum changes to mature milk 3-4 days after birth. This thinner milk contains the same nutrients and antibodies. It also has fat, sugar, water and protein to nourish baby. The protection in mother's milk is unique and changes to meet baby's needs.



How Do You Say?

Term	Pronunciation
Colostrum (Liquid Gold)	(coh-LOSS-trum)
Necrotizing	(nek-roh-TEYE-zing)
Enterocolitis	(en-TUR-oh-coh-lyt-iss)
Oxytocin	(OKS-ee-TOH-suhn)

Did You Know This About Breastfeeding?

Saves Babies' Lives

Research shows that if 90% of families breastfed exclusively for six months, nearly 1,000 infant deaths could be prevented nationally.

Cuts Medical Expenses

The U.S. would save $2 billion a year as fully breastfed infants usually need fewer sick care visits, prescriptions, and hospitalizations.

Keeps Moms on the Job

Mothers who breastfeed miss less work to care for sick infants than mothers who feed their infants formula. Employer medical costs are also lower.

Helps the Environment

Formula cans and bottles create trash and plastic waste. Your milk is a renewable resource that comes packaged and warmed.

Helps During Emergencies

Protects your baby from the risks of an unclean water supply and is available without any other supplies.

Ohio Department of Health
Help me grow
www.helpmegrow.ohio.gov

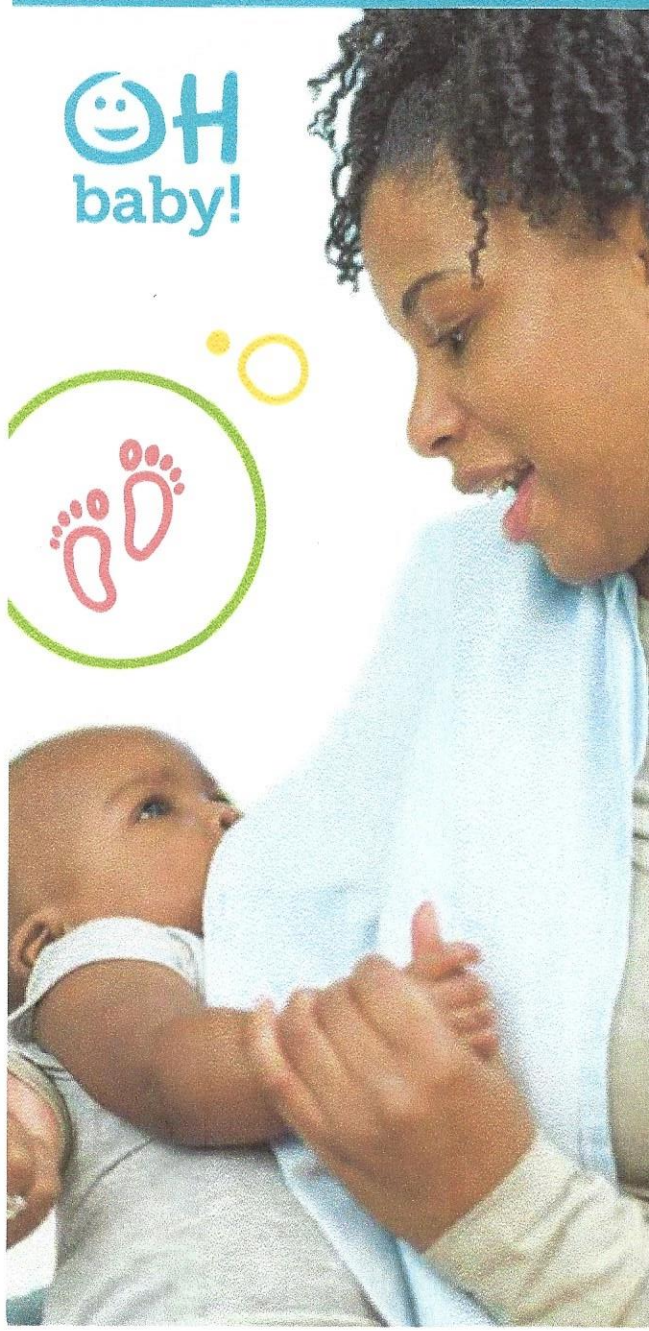
OHIO WIC
Women, Infants, and Children Program
bit.ly/WICProgram

Source: U.S. Department of Health and Human Services, Office on Women's Health

Breastfeeding

Gives Baby a Healthy Start in Life

OH baby!



Breastfeeding Lowers Health Risks

For Baby

- Asthma
- Childhood leukemia & obesity
- Ear infections
- Eczema (atopic dermatitis)
- Diarrhea and vomiting
- Lower respiratory infections
- Necrotizing enterocolitis, a disease that affects the digestive system in premature infants
- Sudden Infant Death Syndrome (SIDS)
- Type 2 diabetes

For Mom

- Type 2 diabetes
- Certain types of breast cancer
- Ovarian cancer
- Not healing following childbirth

Breastfeeding Offers Many Benefits

Saves Time

Breastfeeding may take a little more effort at first. But then there's nothing to buy, sterilize, fix or mix. Best of all, you can satisfy baby's hunger right away.

Is Free

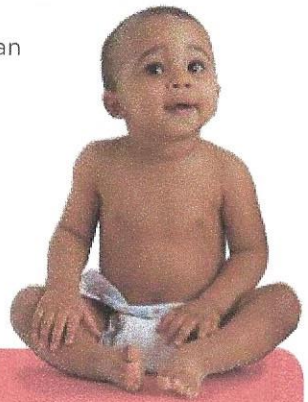
Formula, bottles and nipples can cost $1,500+ a year. Breastfed babies may also be sick less often, saving on doctor bills.

Can Be Easier on Baby's Tummy

Formula is made from cow's milk or soybeans, and it often takes time for tiny stomachs to adjust to it — especially premature babies.

Keeps Mom and Baby Close

Physical connection helps newborns feel more secure. The skin-to-skin contact also boosts moms' oxytocin levels. This hormone helps breastmilk flow and can calm the mother.



Learn More
bit.ly/breastfeeding_benefits

Commonly Asked Questions

Q Does my breastfed baby need more vitamin D?

A Sunlight provides vitamin D which builds strong bones. But it's hard to measure how much your baby gets and sun exposure can be bad. Your doctor may recommend vitamin D daily.

Q Don't some babies need formula?

A Very rarely babies can't tolerate milk of any kind. Or you may have a health condition that prevents breastfeeding and you don't have access to donor breast milk. Soy, lactose-free, dairy-free, hypoallergenic and hydrolyzed formula are available. *(Hydrolyzed means partially broken down to reduce risk of reactions like baby eczema.)*

Q Can breastfeeding help me lose weight?

A Many women said it helped them get back to their pre-pregnancy weight more quickly, but experts are still uncertain.

Q Does breastfeeding prevent pregnancy?

A Breastfeeding can delay normal ovulation and periods. But it's not a sure way to prevent pregnancy. Talk to your doctor about birth control that's okay to use while breastfeeding.

Talk to your doctor before feeding baby anything but breast milk.

What Do I Bring to My First Visit?

- Proof of income (current pay stubs, approval letter for Healthy Start, Ohio Works First, Food Stamps or current Medicaid card)
- Proof of address (utility or credit bill, or Ohio driver's license)

- Proof of identity for you and any other applicants (birth certificate, driver's license, Medicaid card, crib card or shot record)
- All family members applying for WIC services
- If pregnant, a doctor's statement showing due date
- Children's shot records

Healthy Ohio
The State of Living Well.

The mission of the WIC program is to improve the health status and prevent health problems among Ohio's at-risk women, infants and children.

Visit our Web site: http://www.odh.ohio.gov

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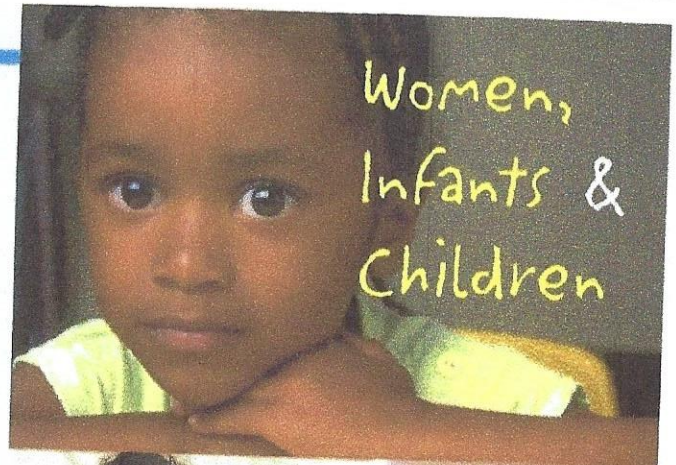
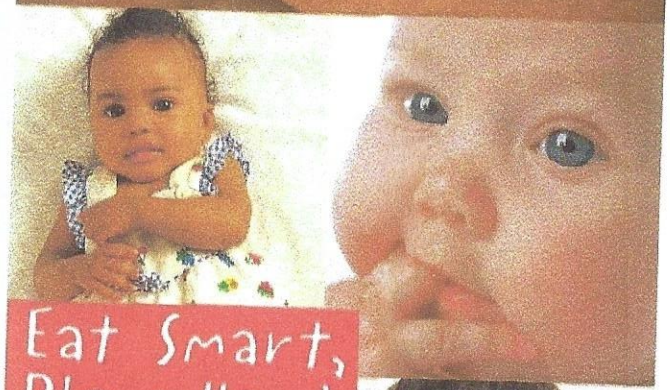
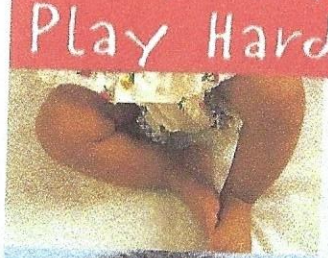
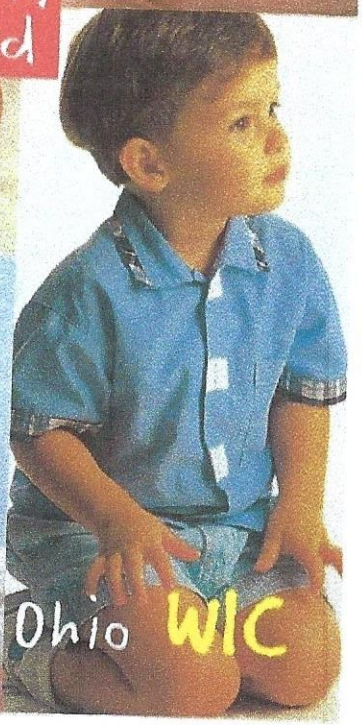


Women, Infants & Children





Eat Smart, Play Hard



Ohio WIC

What is WIC?

WIC is a nutrition education program. WIC provides nutritious foods that promote good health for pregnant women, women who just had a baby, breastfeeding moms, infants and children up to age 5.

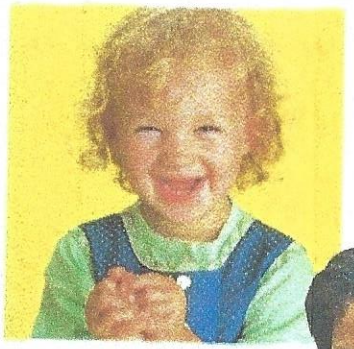
What Does WIC Provide?

- Nutrition education and support
- Breastfeeding education and support
- Referral for health care
- Immunization screening and referral
- Supplemental foods such as:
  - Cereal
  - Eggs
  - Milk
  - Whole-grain foods
  - Fruits and Vegetables
  - Infant formula

How Do I Apply?

Make an appointment
Call your local clinic to schedule an appointment to meet with a WIC staff member or call **1-800-755-GROW (4769)** for locations and more information.

See if you qualify
All it takes is a visit to your local WIC clinic to see if you qualify for services.

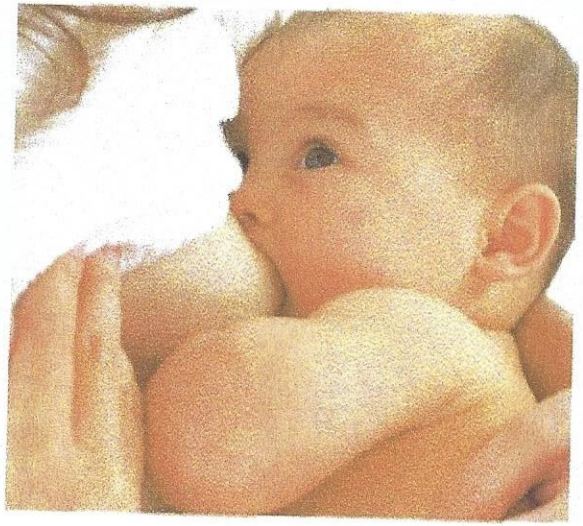


Who is Eligible for WIC?

Women who are pregnant, breastfeeding or have a baby less than 6 months old, and infants and children up to 5 years old are eligible to apply for WIC. Fathers are welcome to apply for WIC for their children up to age 5.

To qualify for services you must:

- Live in Ohio
- Meet WIC income guidelines
- Have certain nutritional or health risks



Receive WIC coupons
If you are eligible, you will receive coupons to buy healthy foods at local WIC-approved grocery stores.

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

[Here is space for the State agency and sponsoring organization to add contact information]

Learn more about CACFP at USDA's website:

https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

¡Buena nutrición hoy significa un mañana más saludable!

Construyendo para el Futuro con CACFP

Esta guardería infantil recibe ayuda del Child and Adult Care Food Program para servir comidas nutritivas a sus niños.

Comidas servidas aquí deben de seguir los requisitos nutricionales establecidos por USDA.

¿Preguntas? ¿Inquietudes?

[Here is space for the State agency and sponsoring organization to add contact information]

Aprenda más información sobre CACFP en el sitio web del USDA: https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
Noviembre 2019