Operation Name & Number: Small Steps Granbury 1713809

Director Name: Christina Castillo Center Phone No.: 817-219-2803

Child Information:

Child's Full Name: _____ Child's Date of Birth: _____

Child's Home Address: _____

Date of Admission: _____ Date of Withdrawal: _____

Parent/Guardian Information:

Mother's Name/Guardian's Name: _____

Mother's Home Address (if different than child's): _____

Mother's Telephone: _____ Mother's Work Phone: _____

Father's Name/Guardian's Name: _____

Father's Home Address (if different than child's): _____

Father's Telephone: _____ Father's Work Phone: _____

Would you like to be added to our email list? If so, please list email address here. More than one is fine: _____

Emergency Contact Information:

Name: _____ Relationship to child: _____

Address: _____ Telephone #: _____

Does your child have custody documents that we need to have a copy of on file? _____

If so, please include a copy with admissions paperwork.

Pick up Information:

I authorize Small Steps Granbury to release my child from care ONLY to the following people. Please be aware that we will require verification of identity with a Drivers License or another form of official ID.

Name: _____ Phone No. _____

Name: _____ Phone No. _____

Name: _____ Phone No. _____

Authorization for Emergency Medical Attention

In the event that I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Child's Physician: _____ Phone No. _____

Address: _____

Emergency Care Facility: _____ Phone No. _____

Address: _____

I give consent for Small Steps Granbury to secure any and all necessary emergency medical care for my child.

Parent/Legal Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

Child's Additional Information

Please list any special needs that your child may have such as environmental allergies, food intolerances, any existing illnesses, hospitalizations, and injuries during the past 12 months, any medications prescribed for continuous use, and any other information which caregivers should be aware of.

_____

_____

Does your child have any diagnosed food allergies? Yes No

If yes, you must submit an emergency food plan with your admissions paperwork that is completed by a Health Care Provider before your child starts care.

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination, in violations of Title III, you may call the ADA information line at (800) 514-0301 (voice), or (800) 514-0383 (TTY).

Permissions

I give consent for my child to participate in the following water activities:

_____Water Table Play _____Sprinkler Play

I give permission for my child's picture to be taken at Small Steps Granbury. I give permission for any photos taken to be used by Small Steps Granbury in presentations and publications.

_____Yes _____No

Small Steps Granbury does provide transportation from Emma Roberson Elementary for children in our school age program as well as occasional field trips. I understand that in order for my child to participate in transportation I will need to have a transportation form on file. _____Please Initial

I understand that the following meals will be served to my child while in care if they are present for the posted meal times: Breakfast Morning Snack Lunch Afternoon Snack _____Please Initial

I acknowledge that I have received a copy of the facilities operational policies and procedures including those for: _____Please Initial

Discipline & Guidance	Release of Children	Suspension and Expulsion
Emergency Plans	Dispensing Medication	Safe Sleep
Health Checks	Immunization Requirements	Parent/Director Communication
Meals & Food Service	Visitation Procedures	Parent Participation
Contact Information for Childcare Licensing, DFPS, Child Abuse Hotline, DFPS Website		

Days & Times in Care (check all that apply)

My child will typically be in care __Monday___Tuesday___Wednesday___Thurday___Friday between the hours of _____ & _____.

Gang Free Zone

Under the Texas Penal Code, any area within 1000 feet of a child care center is a gang free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Signature of Parent: _____Date: _____

Signature of Director: _____Date: _____

Admission Health Requirement:

If your child attends school away from the childcare operation, please skip this section. Otherwise, please complete the following information for your child. This must be on file within one week of admission.

Child Name: _____ DOB: _____

Please check and complete ONLY one option:

_____Healthcare Professional Statement: I have examined the above named child within the past year and find that he/she is able to participate in daycare.

Healthcare Professional's Signature: _____ Date: _____

_____A signed and dated copy of the Healthcare Professional's Statement is attached.

_____A medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

_____My child has been examined within the past year by a health care professional and is able to participate in the daycare program. Within 12 months of admission, I will obtain a health care professional's statement and submit to the child care operation.

Name of Health Care Professional: _____

Address: _____

Signature of Parent: _____ Date: _____

Immunizations

_____I give permission for Small Steps Granbury to access my child's immunization records through Immtrac. I also understand that if they are unable to access the immunization records, I am responsible for providing my child's current records to them BEFORE my child can attend the center.

OR

_____I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief on the form described by section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

Vision & Hearing Screening

I understand that once my child turns 4 year sold a hearing and vision screening must be on file. Please choose ONLY one option.

_____ I have attached a copy of this with my child's enrollment paperwork from our Healthcare Provider.

_____I will obtain and submit within 14 days of my child being enrolled in the center.

_____I have attached a signed and dated affidavit stating that the hearing and vision screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Signature of Parent: _____ Date: _____

CACFP STUDENT ENROLLMENT

CM-1500

_____ **participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to annually review and make changes to enrollment data.**

CHILD INFORMATION

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check One)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: ___/___/___
Re-Enroll Date ___/___/___

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check One)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: ___/___/___
Re-Enroll Date ___/___/___

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M T W TH F SA SU

Normal Hours in Care
Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: BRK AMS LUN PMS SUP EVS

Ethnic Identity (Check One)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
- ☐ White
- ☐ Black / African American
- ☐ Am. Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander

Gender
- ☐ Male
- ☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: ___/___/___
Re-Enroll Date ___/___/___

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature _____ **Date** _____

Parent First Name

Parent Last Name

Cell Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

SITE / SPONSOR USE ONLY

Non – Discrimination Statement

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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660),* provide the name of the program and eligibility number: NAME: _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

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

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

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

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

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) eligibility 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.

Non-discrimination Statement:

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;

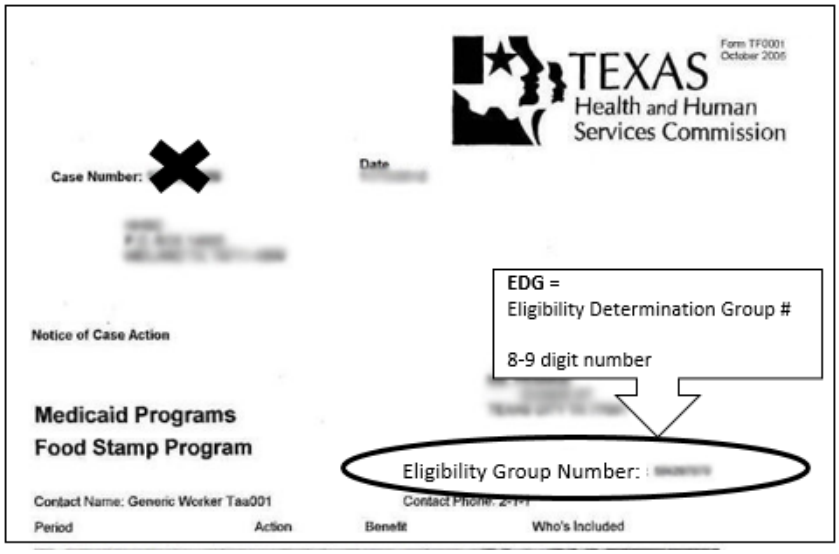
(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC (see illustration).
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.



If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children**.** Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have an eligibility number, skip this part.
Part 3: **Applies only to parents/guardians of children in Tier II Day Care Homes**. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly. See next.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

Infant's Name_____Infant's Date of Birth_____

Breast milk and/or Formula preference

Please mark your preference (choose all that apply)	**Today's Date _____ Birth through 5 months**	**Today's Date _____ 6 – 11 months**
I will bring expressed breast milk for my infant.		
I want the child care provider to provide the infant formula it offers for my infant.		
I will bring the infant formula for my infant. Please list the kind of infant formula you will bring:		

Preference regarding infant cereal and other foods

Please mark your preference	**Today's Date _____ 6 – 11 months**
My child is developmentally ready for solid foods. I want the child care provider to provide the infant cereal and other foods for my infant.	
My child is developmentally ready for solids. I will bring the infant cereal and/or other foods for my infant.	
My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.	

Parent's (or guardian's) Signature_____Date of Signature_____

1. This form must be kept on file for each infant enrolled for child care.
2. This form must be kept current and accurate for each infant enrolled for child care until the infant reaches one year of age.
3. If the parent (or guardian) provides expressed breast milk and the child care provider feeds it to the child, and/or if the mother breast feeds her child on site, the meal may be claimed for reimbursement.
4. If the parent (or guardian) declines the formula and the child care provider provides meal and/or snack components, the meal may be claimed for reimbursement.
5. If the parent (or guardian) declines infant meals/snack, meals and snacks may NOT be claimed for reimbursement.

2021

January

	M	T	W	T	F	S
					1	2
	4	5	6	7	8	9
	11	12	13	14	15	16
	18	19	20	21	22	23
	25	26	27	28	29	30

February

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	**15**	16	17	18	19	20
21	22	23	24	25	26	27
28						

March

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Notes:

Jan 1	New Year's Day
Apr 2	Good Friday
Apr 5	Easter Monday
May 31	Memorial Day
July 2	Independence D
July 5	Independence D
Sep 6	Labor Day
Nov 25	Thanksgiving
Nov 26	Thanksgiving
Dec 24	Christmas Eve
Dec 27	Christmas
Dec 31	New Years Eve

April

	M	T	W	T	F	S
				1	2	3
	5	6	7	8	9	10
	12	13	14	15	16	17
	19	20	21	22	23	24
	26	27	28	29	30	

May

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	**31**					

June

S	M	T	W	T	F	S
		1	2	3	**4**	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
2	21	22	23	24	25	26
27	28	29	30			

July

	M	T	W	T	F	S
				1	2	3
	5	6	7	8	9	10
	12	13	14	15	16	17
	19	20	21	22	23	24
	26	27	28	29	30	31

August

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

September

S	M	T	W	T	F	S
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

October

	M	T	W	T	F	S
					1	2
	4	5	6	7	8	9
	11	12	13	14	15	16
	18	19	20	21	22	23
	25	26	27	28	29	30

November

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	**11**	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

December

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	**25**
26	27	28	29	30	31	

Form J-800-2550
New January 2017

OPERATIONAL POLICY ON INFANT SAFE SLEEP

Purpose: This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at _____, and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

SAFE SLEEP POLICY

All staff, substitute staff, and volunteers at _____ will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415 and §747.2315]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415 and §747.2315].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing _____ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415 and §747.2315].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must *not be attached* to a stuffed animal or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2415 and §747.2315].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide an Infant Sleep Exception form 2710 signed by the infant's health care professional [§746.2428 and §747.2328].

PRIVACY STATEMENT
DFPS values your privacy. For more information, read our privacy policy at: http://www.dfps.state.tx.us/policies/privacy.asp.

SIGNATURES	
This policy is effective on: _____ (date) Child's name:	
Signed by: X Director/Owner	Date signed:
Signed by: X Staff member	Date signed:
Signed by: X Parent	Date signed:

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INFANT FEEDING INSTRUCTIONS

Child's name:	Date of birth:

Feeding

Breastmilk, Type of Milk, or Formula:	Bottle: Yes ☐ No ☐

If child is receiving breastmilk and supply of pumped milk runs out, what do you want staff to do?

Allergies

☐ No	☐ Yes – Explain:

Does child have any problems with feedings, such as choking or spitting up?	☐ No

☐ Yes – Explain:

Foods

Introduced: See Attached List on page 2.

Consistency: ☐ Puree ☐ Junior ☐ Table

Food Likes:	Food Dislikes:

Method of Feeding:

Utensils used: ☐ Cup ☐ Fork ☐ Spoon ☐ Other:

Explain:

Feeding Schedules and Updates:

Date	Time	Foods	Amount	Time	Foods	Amount

Comments:	
Date:	Parent's signature:

Update as new foods are introduced or changes occur.
Post in kitchen and activity area.
All feeding instructions must be retained for 12 months (centers).

FOODS LIST

Child's Name:

Foods and dates introduced at home:

VEGETABLES					
FOOD	DATE	FOOD	DATE	FOOD	DATE
Carrots		Squash			
Creamed Corn		Potatoes			
Creamed Spinach		Sweet Potatoes			
Green Beans					
Peas					

FRUITS					
FOOD	DATE	FOOD	DATE	FOOD	DATE
Apple Sauce		Prunes			
Bananas		Plums			
Peaches		Apple Strawberry			
Pears		Banana Strawberry			
Bananas w/Apples		Apricots			
Prunes w/Apples					

MEATS					
FOOD	DATE	FOOD	DATE	FOOD	DATE
Beef		Lamb			
Chicken		Ham			
Turkey		Veal			

MIXED FOODS					
FOOD	DATE	FOOD	DATE	FOOD	DATE
Veg/Ham		Mixed Turkey			
Veg/Bacon		Chicken Noodle			
Veg/Turkey		Lasagna			
Apples/Turkey		Spaghetti			
Apples/Chicken		Veg/Pasta			
Pears/Chicken					

CEREALS					
FOOD	DATE	FOOD	DATE	FOOD	DATE
Rice					
Oatmeal					
Mixed					

COMMENTS and Additional Information:

DATE:	SIGNATURE:

All feeding instructions must be retained for 12 months (centers).