Enrollment Forms

The following forms and items must be completed and turned in to the Ballard Center prior to the first start date of your child.

Parent & Child Information Form

Emergency Contact & Pick-Up Authorization

Code of Conduct

Authorization for Emergency Medical Care (EMR)

Medical Records

History of Immunizations

Child Health Assessment

Off-Premise Permission Form

Photo Consent

Child & Adult Care Food Program Forms (CACFP)

Date Application Received:

_____/_____/_____

Date of Tour:

_____/_____/_____

Staff: _____

The Ballard Center
Early Childhood Education
Enrollment Application

I have read, understand, and agree to the policies and procedures as outlined in the Ballard Center's Parent Handbook.

Parent/Guardian Signature _____ **Date** _____

Parent/Child Information

Child Name: _____
(first) (last)

In-Home Visit scheduled on:

_____/_____/_____

at _____am/pm

Gender: [ ] Male [ ] Female

Birth Date: _____/_____/_____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Ethnicity:

[ ] Asian
[ ] Hispanic/Latino
[ ] Multi-Racial
[ ] White/Caucasian
[ ] Not Listed
[ ] Black/African American
[ ] Middle Eastern
[ ] Native American/Indigenous
[ ] Pacific Islander
[ ] Unknown

Does your child live with: (Check one)

[ ] One Parent Only
[ ] Both Parents
[ ] Grandparents
[ ] Foster Parents
[ ] Shared Custody
[ ] Other _____

Total number of people living in child's home: _____ # of Children _____ # of Adults_____

Number of brothers: _____ Name of brothers: _____

Number of sisters: _____ Name of sisters: _____

Contact Info & Pick-Up Authorization

We will not release your child to any person not listed on this form. Please give names and working phone numbers.

1. Parent/Guardian: _____ Home Phone ( ) _____-_____

   Email address: _____ Cell phone ( ) _____ - _____

   Employer: _____ Work phone ( ) _____-_____

2. Parent/Guardian: _____ Home Phone ( ) _____-_____

   Email address: _____ Cell phone ( ) _____ - _____

   Employer: _____ Work phone ( ) _____-_____

3. Emergency contact: _____ Relationship to child: _____

   Phone # ( ) _____--_____ [ ] Cell [ ] Home [ ] Work [ ] Other

4. Emergency contact: _____ Relationship to child: _____

   Phone # ( ) _____--_____ [ ] Cell [ ] Home [ ] Work [ ] Other

5. Emergency contact: _____ Relationship to child: _____

   Phone # ( ) _____--_____ [ ] Cell [ ] Home [ ] Work [ ] Other

6. Emergency contact: _____ Relationship to child: _____

   Phone # ( ) _____--_____ [ ] Cell [ ] Home [ ] Work [ ] Other

Late Pick Up Policy & Procedures

The Ballard Center's late pick up policy is as follows:

- Efforts should be made by parents or guardians to communicate a late pick up. This does not release responsibility for a late fee.
- Late pick up fees are as follows:
  - $1/per minute/per child
  - Late fees MUST be paid either upon pick-up or at drop-off the following morning
    - Late fees must be paid before children can return
  - Late fee must be paid in cash only
  - If a child has not been picked up by 30 minutes after closing (by 6:00pm) without communication from a parent/guardian, then the Lawrence Police Department will be contacted to report a child in need of care.

I understand and agree to the Ballard Center's late pick-up policies and procedures.

Parent/Guardian Signature: _____ Date: _____

CODE OF CONDUCT POLICY

The purpose of this policy is to provide a reminder to all parents, guardians, and visitors to our school about expected behavior. This is so we can continue to flourish, progress and achieve a safe, loving learning environment.

We expect parents, legal guardians, and visitors to:

- Respect the values and policies of our school.
- Understand that both teachers and parents need to work together for the benefit of their child/children.
- Demonstrate that all staff, children and families should be treated with respect and therefore set a good example in their own speech and behavior.
- Seek to clarify a child's version of events with the school's view to bring about a peaceful solution to any issue.
- Correct their own child's behavior, where it could otherwise lead to conflict, aggressive or unsafe behavior.
- Approach the school to help resolve any issue or concern.

To support a safe loving learning environment, the school cannot tolerate parents, guardians, or visitors exhibiting disruptive behavior which interferes or threatens to interfere with the operation of Ballard Center's classrooms. The school may feel it is necessary to contact the appropriate authorities to protect the safety of Ballard Center students and staff.

Any concerns you may have about the school, staff or children, must be made through the appropriate channels by speaking to the Education Director, Family Connections Coordinator or our Executive Director, so they can be dealt with fairly, appropriately and effectively for all involved.

We trust that the parents, guardians and visitors will assist our school with the implementation of this policy, and we thank you for your continued support of the school.

X_____ _____

Parent/Guardian Signature Date

_____ _____

Printed Name Ballard Rep

CCL 010
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	**License #**
Elizabeth B Ballard Community Center	0000160-014

I authorize Carolyn Krehbiel ________ (*caregiver/staff*) who

is (are) representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or

youth____ (*child's first and last name)* while child or youth is in the facility's custody

between ______________________ and _________________________.

MM/DD/YYYY MM/DD/YYYY

Is child covered by health insurance? ☐ Yes ☐ No

If yes, complete the following:

Health Insurance Policy Name ____ Policy Number ________________________

Medical Assistance Program ____ Card Number_________________________

Military Medical Care I.D. Number ____

If known, date of last Tetanus inoculation: __________________________________

MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

____

____

____

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of __________________________

Signed or attested before me on _____________________ by____.

MM/DD/YYYY Name of Person

(Seal, if any.)

____
Signature of notarial officer

____
Title (and Rank)

My appointment expires: ____________________________

- -

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is transported by the facility.

CCL. 029
Rev. 5/2019

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care_____ Name of Child Care Facility_____

Child's Name_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Work Address_____
Street City Zip Code

Work Phone Number_____

Cell Phone Number_____

E-mail Address _____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Work Address_____
Street City Zip Code

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

Best way to contact_____

Names and ages of children in family_____

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary._____

_____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows:

_____

Does your child have any of the following conditions (yes or no)? <u>If yes, provide information on Authorization for Emergency Medical Care form CCL. 010</u>.

_____Allergies _____Frequent sore throats/colds _____Ear Aches
_____Asthma _____Speech, Visual, Hearing _____Diabetes
_____Epilepsy/Seizures _____Other_____

If yes answered to any above, please provide additional information_____

Have there been major changes at home that might affect your child in care? ___ No ___Yes, as follows:

_____

Please provide additional information or special instructions that will help the person caring for your child.

_____

Parent/Guardian Signature:_____ **Date:**_____

KANSAS CERTIFICATE OF IMMUNIZATIONS (KCI)

This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-6262 (d) of the Kansas School Immunization Law (amended 1994.)

Student Name: _____

Birthdate (MM/DD/YYYY): _____ SEX: [ ] MALE [ ] FEMALE Race: _____ Ethnicity: _____ County: _____

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED ⊘ = Dose determined invalid by provider ! = Invalid Dose. KSWebIZ minimum age/interval not met						
	1st	2nd	3rd	4th	5th	6th	7th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis) Required for school entry. Single Tdap required for entry to 7th grade. State Type							
Polio Required for school entry.						If additional doses are added, please initial the dose and sign below:	
HEP B (Hepatitis B) Required for school entry.						_____	
Varicella (Chickenpox) Required for school entry.			Hx of Disease:__Y __N Date of Illness: _____ HCP Signature:			_____	
MMR (Measles, Mumps, and Rubella combined) Required for school entry.						_____	
Influenza (Flu) Recommended annually for ages 6 months of age and older. Not required for school entry.							
HIB (Haemophilus Influenzae Type B) Required < 5 years of age for preschool or child care operated by a school.							
PCV (Pneumococcal Conjugate) Required < 5 years of age for preschool or child care operated by a school.							
HEP A (Hepatitis A) Required for school entry.							
MCV4 (Meningococcal -Serogroup ACWY) Required for school entry. Doses required for entry into 7th grade and 11th grade.							
HPV (Human Papillomavirus) Recommended at 11-12 years of age. Not required for school entry.							
Rotavirus Recommended < 8 months of age. Not required for school entry.							

DOCUMENTATION

KCI MAY ONLY BE SIGNED BY A PHYSICIAN (MD/DO), HEALTH DEPT, OR SCHOOL.

❑ I certify I reviewed this student's vaccination record and transcribed it accurately

Agency Name:

Authorized Representative:

Address:

The record presented was: Date _____

❑ Kansas Immunization Record

❑ Other Immunization Record (Specify) _____

LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS "KSA 72-6262"

1. "Annual written statement signed by a licensed physician (Medical Doctor/M.D. or Doctor of Osteopathy/D.O.) stating the physical condition of the child to be such that the tests or inoculations would seriously endanger the life or health of the child." Medical exemption shall be validated annually by physician completion of KCI Form B and attachment to the KCI.
2. "Written statement signed by one parent or guardian that the child is an adherent of a religious denomination whose religious teachings are opposed to such tests or inoculations."

The Ballard Center requires that all students be immunized to be enrolled in our early childhood education program.

KANSAS IMMUNIZATION PROGRAM
1000 SW Jackson, Suite 210, Topeka, KS 66612-1274
PHONE 877-296-0464 FAX 785-559-4227

I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

_____ _____

Parent/Legal Guardian's Signature Date

CCL. 029a
Rev. 3/2017

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: _____IN/CM %ILE_____		**Weight: _____LB/KG %ILE_____**
Physical Examination	**✓ If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) ☐ None	
Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

CCL. 034
Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			**License #**
Elizabeth B. Ballard Community Center			0000160-012
Street Address of the Facility	**City**	**Zip Code**	**County**
708 Elm Street	Lawrence	66044	Douglas

_____may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
John Taylor Park	200 N 7th Street	Lawrence		X
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Watkins Museum of History	1047 Massachusetts	Lawrence	X	
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
McDonald's	4911 W 6th Street	Lawrence	X	
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Walmart Supercenter	550 Congressional Drive	Lawrence	X	
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Signature of Parent or Guardian			**Date Signed**	

PARENTAL PHOTO CONSENT FORM FOR CHILDREN/MINORS

We recognize the need to ensure the welfare and safety of all young people taking part in any activity associated with our organization. In accordance with our child protection policy, the Ballard Center will not permit photographs, video or other images of young people to be taken without the consent of the parents/guardians.

I hereby grant and authorize the Ballard Center the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures or video taken of my child to be used in and/or for legally promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits and submissions to journalists, websites, social networking sites and other print and digital communications, without payment or any other consideration. This authorization extends to all languages, media, formats and markets now known or hereafter devised. This authorization shall continue indefinitely, unless I otherwise revoke said authorization in writing.

I understand and agree that these materials shall become the property of the Ballard Center and will not be returned.

I hereby hold harmless, and release the Ballard Center from all liability, petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

This release must be signed by a parent or guardian, as follows:

CHECK ONE

◯ I hereby certify that I am the parent or guardian of student named below and do hereby give my consent without reservation to the foregoing on behalf of this individual.

◯ I hereby certify that I am the parent or guardian of student named below, and DO NOT give my consent to the foregoing on behalf of this individual.

Signature of Parent/Guardian	Printed Name of Parent/Guardian
Student's Name	Date

Child Care Center Enrollment and Income Eligibility Form (E/IEF) Instructions

This organization offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). We receive support from CACFP to serve those meals. The CACFP makes healthy food a regular part of your child's day care!

Please fill out the *CACFP Enrollment and Income Eligibility Form (E/IEF)*. This lets us know how much money CACFP will give to support your day care home or center. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2023 - June 30, 2024		
Household size	Yearly Income	Monthly Income
1	$26,973	$2,248
2	$36,482	$3,041
3	$45,991	$3,833
4	$55,500	$4,625
5	$65,009	$5,418
6	$74,518	$6,210
7	$84,027	$7,003

As you fill out the *CACFP Enrollment and Income Eligibility Form (E/IEF)*, please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms.

Points to Remember:

If:	Then:
Your income isn't always the same	List the amount of money that you normally get. For example, do not include overtime pay, if you do not normally get it. If your income is normally higher or lower, you can report annual income instead.
Your household includes members who aren't citizens	You or your children do not have to be U.S. citizens to qualify for meal benefits.
You are in the military	Do not include your Family Subsistence Supplemental Allowance (FSSA), combat pay, or the money you receive for privatized housing. If deployed, count the amount of pay that is made available to your household as income.

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

This institution is an equal opportunity provider.

USDA Nondiscrimination Statement (Continued)

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination 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: How to File a Complaint, 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.

Child and Adult Care Food Program
ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.				
Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.	

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

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

Signature of Adult	Today's Date	Print Name of Adult Signing
X____	___________________	Social Security Number (SSN) (last four digits) XXX-XX- ☐ Check if no SSN

Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

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

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

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

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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

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

FAX: 202-690-7442
EMAIL: program.intake@usda.gov

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

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced Price ☐ Paid

Household Size: _____

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Determining Official **Today's Date**

X_____ _____
Signature of Confirming Official **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.

BALLARD CENTER MEAL SUBSTITUTIONS
For Allergies or Intolerances

CHILD'S NAME: _____

1. Is the child's diet restricted by medical or other dietary needs? __ yes __ no

   Please state reason: _____

2. What food(s) are to be omitted from the child's diet?

   _____

   _____

   _____

3. What foods may be substituted to meet the child's dietary needs?

   _____

   _____

   _____

_____ _____

Parent Signature Date