ACADEMY OF ART & LEARNING
Parent/Provider Contract

Child's Name: _____

Parent's Name: _____

Parent's scheduled work hours: Mother: _____
Father: _____

REGISTRATION

Enrollment at the Academy of Art & Learning requires a $50 registration fee with your completed enrollment forms including your child's health record. These requirements must be met prior to providing care for your child.

TUITION

Tuition is billed on weekly basis for a MAXIMUM of 10 hours a day. Tuition payments must be received on Fridays for the following week. Due dates apply regardless of attendance. If your child is absent or not scheduled on Friday, the due date still applies. Penalty fees are as follows:

- $15 late fee if payment is not received by next payment due date
- $15 fee for returned checks

For pick-ups after 5:30pm, there will be a charge of $1 for each minute you are late. You are expected to pay for the following holidays: Christmas Eve, Christmas Day, New Year's Eve, New Year's Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving Days (Thurs and Fri) and President's Day.

Fee: Your tuition fee for childcare is _____weekly.

WITHDRAWAL

Parents who wish to discontinue service with the Academy of Art and Learning Center must give two weeks advanced notice of withdrawal.

TERMINATION

Failure to honor the obligations listed in this contract, the Parent Handbook, or any other written policies provided by daycare can result in termination of care. As a private corporation, we reserve the right to discontinue care at any time and for any reason with or without advance notice.

ACADEMY OF ART AND LEARNING will provide childcare service in accordance with the terms of the handbook, the registration form and this contract. By signing this contract, the Parent or Guardian agree to cooperating with the general policies of the school and to perform their obligations as set forth in this contract, the registration form and the Parent Handbook.

SIGNATURES OF AGREEMENT

Parent/Guardian (1) _____ Date _____

Parent/Guardian (1) _____ Date _____

Owner/Director of the Academy _____ Date _____

Academy of Art and Learning – Enrollment Form Enrollment Date _____

MOTHER'S INFORMATION

Name _____ SSN _____

Home Address _____

Home Phone (i.e. Land Line)_____ Cell Phone _____

E-mail Address _____

Employer _____Work Phone _____

FATHER'S INFORMATION

Name _____ SSN _____

Home Address _____

Home Phone (i.e. Land Line)_____ Cell Phone _____

E-mail Address _____

Employer _____Work Phone _____

EMERGENCY CONTACTS (People we can call if parents cannot be reached)

Name_____Relationship to Child_____

Home Phone (i.e. Land Line) _____ Cell Phone _____

Name_____Relationship to Child_____

Home Phone (i.e. Land Line) _____ Cell Phone _____

CHILDREN

1. Name _____ DOB _____ Schedule: M T W Th F / Drop-in
   If School Age: School _____ Grade _____ Hours Care is Needed: _____
   Physician Name _____ Phone _____Food Allergies_____
2. Name _____ DOB _____ Schedule: M T W Th F / Drop-in
   If School Age: School _____ Grade _____ Hours Care is Needed: _____
   Physician Name _____ Phone _____Food Allergies_____
3. Name _____ DOB _____ Schedule: M T W Th F / Drop-in
   If School Age: School _____ Grade _____ Hours Care is Needed: _____
   Physician Name _____ Phone _____Food Allergies_____

Office Use Only	Start Date_____	Daycare/Classroom	ICP (circle one)	CACFP (circle one)
		1. ____/_____	Y or N	F R O
Weekly Fee_____	Care 4 Kids: Y or N	2. ____/_____	Y or N	F R O
	DCF: Y or N	3. ____/_____	Y or N	F R O

CHILD ENROLLMENT & EMERGENCY MEDICAL CARE FORM

Date of Application: _____ **Date of Enrollment:** _____ **Last Day of Enrollment:** _____
Child's Name: _____ Child's Date of Birth: _____
Child's Address: _____ City: _____ Zip Code _____
Mother's Name: _____ Address: _____
City: _____ Zip Code: _____ e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Mother's Employer: _____ Work #: (_____) _____
Mother's Employer Address: _____ City: _____ Zip Code _____
Father's Name: _____ Address: _____
City: _____ Zip Code: _____ e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Father's Employer: _____ Work #: (_____) _____
Father's Employer Address: _____ City: _____ Zip Code _____

****

Weekly Care Schedule: (please include the child's hours in care for each day)
Sunday: _____
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____

Persons permitted to remove the child from the child care home on behalf of parent. (Use back for additional names.)
Name: _____
Phone #: _____ Relationship _____

****

In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.
(Use back for additional names.)
Name: _____
Phone #: _____ Relationship _____

Known Allergies: _____ Last Tetanus: _____
Insurance Carrier: _____ Insurance ID: _____
Medical Facility: _____ Phone #: (_____) _____

Child's Physician: Name: _____ Phone #: (_____) _____
Address _____ City: _____ Zip Code: _____
Child's Dentist: Name: _____ Phone #: (_____) _____
Address _____ City: _____ Zip Code: _____

I give my consent for **(provider's name)** _____, and (**if applicable, approved substitute's name**) _____to contact the above named physician or dentist if my child has a medical emergency. I understand that if my child's physician or dentist is not available, another physician or dentist may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____. I will be responsible for all medical charges.
(hospital or walk-in clinic)

(Provider's name) _____ and (**if applicable, approved substitute's name**) _____ have my permission to transport my child away from the home as part of the child care program.

Is your child related to the person providing his/her child care? ☐No ☐Yes, if yes, what is the relationship? _____

The provisions outlined on this form have been worked out in consultation with me and have my approval.
Signature of Parent or Guardian: _____ **Date**: _____

Signature of Parent or Guardian: _____ **Date**: _____

Attention Provider: This information must be kept current at all times. Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable. This form must be kept on file for one year after the child is no longer enrolled in the child care home.

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑Male ❑Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months?	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168.

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT** ____in/cm_____% ***Weight** ____lbs._____oz /_____% **BMI**____/_____% ***HC**____in/cm_____% (Birth–24 months) ***Blood Pressure**____/ ____ (Annually at 3–5 years)

Screenings

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
❑ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑Unable to assess
❑Referral made to: _____

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
❑ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑Pass
	❑ Fail	❑Fail

❑Unable to assess
❑Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level
≥ 5µg/dL ❑nNo ❑nYes

***TB:** High-risk group? ❑No ❑Yes
Test done: ❑No ❑Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ❑No ❑Yes
❑Referral made to: _____
Has this child received dental care in the last 6 months? ❑No ❑Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth–5 years) ❑No ❑Yes **Type:**

Results:

*IMMUNIZATIONS ❑Up to Date or ❑Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑No ❑Yes: ❑Intermittent ❑Mild Persistent ❑Moderate Persistent ❑Severe Persistent ❑Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑Rescue medication required in child care setting: ❑No ❑Yes

Allergies ❑No ❑Yes: _____
Epi Pen required: ❑No ❑Yes
History/risk of Anaphylaxis: ❑No ❑Yes: ❑Food ❑Insects ❑Latex ❑Medication ❑Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑No ❑Yes: ❑Type I ❑Type II **Other Chronic Disease:** _____
Seizures ❑No ❑Yes: Type: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑Vision ❑Auditory ❑Speech/Language ❑Physical ❑Emotional/Social ❑Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑No ❑Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑No ❑Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑No ❑Yes This child may fully participate in the program.
❑No ❑Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑No ❑Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):
State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑Male ❑Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	Normal	**Referral Made:**
Completed by: ❑Dentist	Completed by: ❑MD/DO ❑APRN ❑PA ❑Dental Hygienist	❑Yes ❑Abnormal (Describe) _____ _____ _____ _____ _____	❑Yes ❑No

Risk Assessment	**Describe Risk Factors**	
❑Low	❑Dental or orthodontic appliance	❑Carious lesions
❑Moderate	❑Saliva	❑Restorations
❑High	❑Gingival condition	❑Pain
	❑Visible plaque	❑Swelling
	❑Tooth demineralization	❑Trauma
	❑Other_____	❑Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA/ RDH	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

Child's Name:_____ **Birth Date:**_____ REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____
Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

Initial/Signature of health care provider MD / DO / APRN /PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

****

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

ACADEMY OF ART AND LEARNING
Permission Forms

CHILD RELEASE FORM #18 9C

I _____, give my permission to the Academy of Art and Learning to have my child _____ released to _____ or _____ or _____ only.

There will be NO exceptions unless I authorize it by phone or through written permission.

Signature _____Date _____

FIELD TRIP PERMISSION SLIP #17 9C

I _____, give my permission to the Academy of Art and Learning to take my child on field trips and off site activities. I understand that my child will be transported by the center. The staff will give parents a 24-hour notification of the field trip and activity, except for the following: local library, local park, local stores and local schools that my be part of the normal curriculum. Field trip on licensed property to areas that are not inspected or approved by OEC.

Signature _____Date _____

SCHOOL TRANSPORTATION PERMISSION SLIP

I give my permission to the Academy of Art and Learning to transport my child _____ I to and from school and other activities.

Signature _____Date _____

FOOD PERMISSION

I give my permission for my child(ren) _____ to participate in the Academy's food program. I understand that the Academy serves breakfast, lunch and snacks.

My child(ren) is allergic to the following foods: _____

_____

Signature _____Date _____

Academy of Art & Learning Discipline Policy (8A)

The goal of discipline is to help the child develop self-control and move toward appropriate social behavior. Examples of developmentally appropriate methods utilized for resolving conflict are:

- ✓ **Positive guidance**

  When disputes arise among children or between a child and staff, the staff will encourage a "talking out" process where the goal is to acknowledge feelings and find solutions using the children's ideas wherever possible.
- ✓ **Setting clear limits**

  Staff will encourage and model positive behavior, positive reinforcement, the use of peer support and clearly defined rules.
- ✓ **Redirection**

  A child who may be aggressive or who is disruptive or destructive of other children's work may be asked to make an activity choice in another area. Staff will continuously supervise children during disciplinary actions.
- ✓ **Time-Out**

  One minute per year of the age of the child

Staff shall not be abusive, neglectful, or use corporal, humiliating or frightening punishment under any circumstances. No child will be physically restrained unless it is necessary to protect the safety or health of the child or others, using least restrictive methods, as appropriate.

<u>Working with parents</u>

For ongoing behavior issues, we will work with parents to correct a child's behavior prior to possible termination of care.

- ✓ We will send home behavior sheets
- ✓ We will start the child on a specific behavior reward program
- ✓ We will work with the parents if behavior warrants termination
- ✓ We will give notice to parents if behavior warrants termination
- ✓ We will not allow any child to cause an unsafe environment for the rest of our children

Our discipline policy will be discussed with each child's parent prior to enrollment to ensure mutual understanding and reviewed as needed during the period of enrollment. Each parent will sign the acknowledgement of our discipline policy and it will be maintained in the child's files. There will be a copy of the discipline policy on the parent bulletin board.

Parental Acknowledgement

of Academy of Art & Learning's Discipline Policy

I, _____ , have read and understood the discipline policy of the Academy of Art & learning. I have discussed these policies with Pauline. I understand that I can speak to Pauline at any time regarding my child's discipline or any other policy that affects my child's care and development.

_____

Signature

_____

Date

Child and Adult Care Food Program (CACFP)

Dear Parent/Guardian,

The Academy of Art and Learning Daycare Center is planning to seek assistance for nutritious meals served under the Child and Adult Care Food Program (CACFP). The CACFP is funded by the U.S. Department of Agriculture (USDA) and administered by the Connecticut State Department of Education.

Our program may receive reimbursement for meals served to children meeting the eligibility criteria for free or reduced-price meals. We must document the eligibility of these children by obtaining family size and income data. Households with incomes at or below the level in "Income Guidelines for Child Nutrition Programs" are eligible for free meals. Please complete, sign, date and return the attached application. **The information you provide will be treated confidentially and will be used only for eligibility determination.**

Please provide the information requested on the enclosed Income Eligibility Application and return as soon as possible. We will use this information to decide the level of CACFP benefit your provider will receive. We may also inform officials of other child nutrition, health and education programs of the information on your form to determine benefits for those programs.

PARTICIPANTS CATEGORICALLY ELIGIBLE AS FREE FOR CACFP BENEFITS: Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits and households with foster children are eligible for free CACFP meals.

- **SNAP OR TFA:** If you currently receive SNAP or TFA benefits for your child, you only need to list your child's name, SNAP or TFA case number and **sign and date** the application.
- **Foster Children:** If your household includes a foster child, you only need to list your child's name, check the foster child box, and **sign and date** the application. In accordance with the Healthy, Hunger-Free Kids Act of 2010, foster children who are the responsibility of the state or are formally placed by a state child welfare agency or court are categorically eligible for free CACFP benefits. *This provision does not apply to informal arrangements or placements that may exist outside of state or court-based systems.* Eligibility for formally placed foster children is no longer determined based on their personal use income and a family size of one. The child care institution must obtain documentation from an appropriate state or local agency documenting the child's foster status. Households with both foster and non-foster children may choose to include all children on the same application. However, the presence of a foster child in the household does not convey eligibility for free meals to all children in the household.

ALL OTHER HOUSEHOLDS: If your household income is at or below the level shown in the table "Income Guidelines for Child Nutrition Programs," you must provide the following information for your application to be processed.

- **Household Members**: List the names of everyone who lives in your household. Include parents, grandparents, all children, other relatives and unrelated people who live in your household.
- **Social Security Number**: List the last four digits of the social security number of the adult household member who signs the application. If the adult does not have a social security number, check the box next to the statement, "I do not have a SSN."
- **Current Income**: List the amount of income each person earned **last** month (before deductions for taxes, social security, etc), and where it is from, such as wages, retirement or welfare. If any household member's income last month was higher or lower than usual, list that person's usual average monthly income.

SIGNATURE and DATE: An adult household member must **sign and date** the application.

REPORTING CHANGES: In accordance with the Child Nutrition and WIC Reauthorization Act of 2004, households are no longer required to report changes in circumstances, e.g. increase in income, decrease in household size, or when the household is no longer certified eligible for SNAP or TFA benefits. Once properly approved for free or reduced-price benefits, a household will remain eligible for those benefits for a period not to exceed 12 months.

Child and Adult Care Food Program (CACFP)

INCOME ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS AND HEAD START

For instructions, see *Instructions for Income Eligibility Application for Child Care Centers and Head Start*.

PART 1 — CHILD'S INFORMATION

Child's Name: _____ Age: _____ Birth Date (*month, day, year*): _____

Child's Normal Child Care Schedule (*Check all days that apply):*

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Child's Normal Hours of Care *(Include time and circle AM or PM):*

_____ AM/PM to _____ AM/PM and _____ AM/PM to _____ AM/PM

Normal Meal Services Provided to Child *(Check all meals/snacks that apply):*

☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper

PART 2A — PARTICIPANTS CATEGORICALLY ELIGIBLE AS FREE FOR CACFP BENEFITS

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) or Temporary Family Assistance (TFA) benefits, and households with foster children: Complete this part and part 3. Do **not** complete part 2B.

SNAP Case Number: _____ TFA Case Number: _____ Check if foster child: ☐

PART 2B — ALL OTHER HOUSEHOLDS

If you did not complete part 2A, complete this part and part 3.

Names of all household members *List **everyone** in the household, including the child listed in part 1 above*	**Gross income and how often it was received:** Indicate if income was received monthly, two times a month, every two weeks or weekly by placing the **amount of income** in the appropriate frequency box. *You **must** place the income in the appropriate frequency box.*											
	Earnings from Work (before deductions) – Job 1				**Public Assistance/ Alimony/Child Support**				**Pensions/Retirement/Social Security/All Other Income**			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	$200					$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

PART 3 — CONTACT INFORMATION, SIGNATURE AND SOCIAL SECURITY NUMBER

*An adult household member must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed Name of Adult: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX- _____ ☐ I do not have a SSN

Home Telephone: _____ Work Telephone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

PART 4 — RACIAL AND ETHNIC IDENTITY (OPTIONAL) *You are not required to complete this part.*

Ethnicity ***(Check one):***

☐ Hispanic/ Latino
☐ Not Hispanic/Latino

Race ***(Check one or more):***

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

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number 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 if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. 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:

(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.

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Annual Income Conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a Month X 24 • Monthly X 12

Total family income: $_____ Family size: _____ **OR** ☐ SNAP/TFA household ☐ Foster Child

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Sponsor Eligibility Official: _____ Date: _____
Signature

CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

For information on the CACFP, visit the CSDE's CACFP website or contact the CACFP staff in the Connecticut State Department of Education, Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103.

This form is available at
http://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/IncElig/IEAppCenter.pdf.

Connecticut State Department of Education

Income Guidelines for Determining Eligibility for Free and Reduced-Price Meals JULY 1, 2018, TO JUNE 30, 2019

Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP)

Instructions:

1. Income guidelines to be used by all persons reviewing applications.
2. Distribute to all schools/sites for use by determining officials.

The following income guidelines will be used in Connecticut from **July 1, 2018**, to **June 30, 2019**, for determining eligibility of participants for free and reduced-price meals in the Child Nutrition Programs. These guidelines are taken from the United States Department of Agriculture's annual adjustments to the Income Guidelines.

INCOME * GUIDELINES FOR CHILD NUTRITION PROGRAMS

FREE MEALS/MILK						REDUCED-PRICE MEALS					
Number in Family	Annual Gross Income	Monthly Gross Income	Twice Per Month	Every Two Weeks Gross Income	Weekly Gross Income	Number in Family	Annual Gross Income	Monthly Gross Income	Twice Per Month	Every Two Weeks Gross Income	Weekly Gross Income
1	15,782	1,316	658	607	304	**1**	22,459	1,872	936	864	432
2	21,398	1,784	892	823	412	**2**	30,451	2,538	1,269	1,172	586
3	27,014	2,252	1,126	1,039	520	**3**	38,443	3,204	1,602	1,479	740
4	32,630	2,720	1,360	1,255	628	**4**	46,435	3,870	1,935	1,786	893
5	38,246	3,188	1,594	1,471	736	**5**	54,427	4,536	2,268	2,094	1,047
6	43,862	3,656	1,828	1,687	844	**6**	62,419	5,202	2,601	2,401	1,201
7	49,478	4,124	2,062	1,903	952	**7**	70,411	5,868	2,934	2,709	1,355
8	55,094	4,592	2,296	2,119	1,060	**8**	78,403	6,534	3,267	3,016	1,508
Each Additional Family Member	+ 5,616	+ 468	+ 234	+ 216	+ 108	**Each Additional Family Member**	+ 7,992	+ 666	+ 333	+ 308	+ 154

* Income means income before deductions such as income taxes, Social Security taxes, insurance premiums, charitable contributions and bonds. It includes the following: 1) Monetary compensation for services, including wages, salary, commissions or fees; 2) net income from non-farm self-employment; 3) net income from farm self-employment; 4) Social Security; 5) dividends or interest on savings or bonds or income from estates or trusts; 6) net rental income; 7) public assistance or welfare payments; 8) unemployment compensation; 9) government civilian employee or military retirement, or pensions or veterans' payments; 10) private pension or annuities; 11) alimony or child support payments; 12) regular contributions from persons not living in the household; 13) net royalties; and 14) other cash income. Other cash income would include cash amounts received or withdrawn from any source including savings, investments, trust accounts and other resources.

"Income" as used here does not include any income or benefits received under any Federal programs, which are excluded from consideration as income by any legislative prohibition, for example, the value of benefits received under the Supplemental Nutrition Assistance Program or SNAP (formerly known as Food Stamps).

If a household has only one source of income, or if all sources of income are the same frequency, do **not** use conversion factors. Compare the income or sum of the incomes to the chart above for the appropriate frequency and household size to make the eligibility determination.

CACFP and SFSP Income Guidelines, continued

Many households have different sources of income coming into the home at different frequencies, such as weekly or bi-weekly wages and monthly social security benefits. In these situations, all sources of income must be converted to an annual amount using the calculations below.

- Multiply **weekly** income by 52
- Multiply income received **every two weeks** by 26
- Multiply income received **twice a month** by 24
- Multiply **monthly** income by 12

In applying guidelines, a school food authority/institution **must** compare the household's size and total household income to the income guidelines to determine eligibility for free or reduced-price meals. Children of parents or guardians who become unemployed may be eligible for free or reduced-price meals during the period of unemployment.

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.

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(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.

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For information on the CACFP and SFSP, visit the CSDE's CACFP and SFSP webpages or contact the Connecticut State Department of Education, Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103-1841.

This document is available at https://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/IncElig/IncomeGuidelinesCACFPSFSP2.pdf.