Child's Name_________________________ Site: ___________

2023-2024 ENROLLMENT APPLICATION CHECK LIST

Please submit the following documents for your child's enrollment. Please only include the information for the parents and or guardians living in the household.

You must use blue or black ink only and your child's legal name, when completing documents.

- ☐ ______ WACD Application and Signature Page
- ☐ ______ USDA Food Program Eligibility Forms
- ☐ ______ Current Immunization Record or Proof of Appointment
- ☐ ______ Health Insurance Card
- ☐ ______ Child Information Form
- ☐ ______ Vision Screening form for Advanced Family Eye Care
- ☐ ______ Well Child Check Up (including testing for lead & hemoglobin signed by a Doctor)
- ☐ _____ DHS Child Care Partnership Application (when applicable)
- ☐ _____ Medical care plans (if child has a chronic medical condition)
- ☐ ______Any relevant legal documentation (custody, visitation, etc.) on behalf of the child.

I give permission for a WACD, Inc. designated staff member to clock my child named above in and out of the site, each day my child attends.

Parent/Guardian:_____________________________ Date: ____________

For Site Use Only

Site Staff:____________________ Date:___________

Qualified as: ____________________ Entered in ProCare:___________

Notes:____

____

P.O. Box 1514 Alma, AR 72921
Phone 479-312-7416
email: wacd@wacd.net
website: www.wacd.net

Site Name: ____________________

Application Date: _____/_______/20____

Start Date: _____/_____/20____

Child Enrolling

Child's Name: ______________________________ Date of Birth: _____/________/________

Gender:(circle one) Male or Female Social Security Number: ______/______/_______

Ethnicity: ______________ Primary Language: ____________ Is the child a US citizen? Yes or No

Hours when care is needed: ______________________ Days of care needed: ________________

Physical Address: ________________________ City: ___________ State: _____ Zip: ______

Mailing Address: ________________________ City: ___________ State: _____ Zip: ______

Dentist: ________________ Phone: __________________ Date of last visit: ____/____/_____

Doctor: _________________ Phone: ______________ Address: _______________________

Are there any medical problems we should be aware of: _________________________________

Does the child enrolling have medical insurance? If yes, what type: ___________________________

List any known allergies: ____

Is this child currently receiving therapy services? Yes or No If so, what type and where? ____________

____

Funding Information

I would like to enroll my child (check all that apply):

- ❑ as a Private Pay student
- ❑ as a DHS Voucher funded student
- ❑ as an Early Head Start Student (AEL)
- ❑ as Indian Tribe Funding Student
- ❑ for extended day (Before/After school)
- ❑ other ____________________

Caregiver Information

Caregiver 1:

Name (first, mi, last): ________________________________ Relationship to child: __________________

Gender: Male or Female Date of birth: _____/______/______ Social Security number: ______/_____/_______

Cell Phone: (______)________________________ May we send text messages to your cell phone? Yes or No

Marital Status: ________________ Email address: ____

Do you receive Food Stamp/SNAP or WIC: ___ Yes ___No SNAP Case # ____________________________

Employer:____________________________ Employer's Phone:______________________ (ext) ________

Hours worked:_________________________ Days worked:____________________________________

Caregiver 2:

Name (first, mi, last): ________________________________ Relationship to child: __________________

Gender: Male or Female Date of birth: _____/______/______ Social Security number: ______/_____/_______

Cell Phone: (______)________________________ May we send text messages to your cell phone? Yes or No

Marital Status: ________________ Email address: ____

Do you receive Food Stamp/SNAP or WIC: ___ Yes ___No SNAP Case # ____________________________

Employer: ____________________________ Employer's Phone: ______________________ (ext) _______

Hours worked: _________________________ Days worked:____________________________________

Emergency Contact Information

(Person to contact if caregivers are **not** available must have at least 2 other contacts)

Name: __________________________________Relationship to child: _________________________

Mailing Address: __________________________________State:______________Zip: ____________

Home Phone:_________________ Work phone:______________Cell phone:______________________

List other people (**excluding** emergency contact & caregivers) that may pick up your child:

Name: _______________________Relationship:_________________ Phone:______________________

Name: _______________________Relationship:_________________ Phone:______________________

WACD Signature Page

Consent for Medical Treatment

I do hereby state that I have legal custody of the aforementioned child. I grant my authorization and consent for Western Arkansas Child Development, Inc., or its duly appointed representative(s) to administer general first aid treatment for any minor injuries or illnesses experienced by the Child. If the injury or illness is life threatening or in need of emergency treatment, I authorize Western Arkansas Child Development, Inc. or its duly appointed representative(s) to summon any and all professional emergency personnel to attend, transport, and treat the minor, and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment but is given to provide authority and power on the part of Western Arkansas Child Development, Inc. or its duly appointed representatives in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Signed this _____day of________, 20______.

Parent / Guardian Signature: ___________________________________ Printed Name: ______________________________

Witness Signature: ____ Printed Name: ______________________________

Photo and Video Release

WACD, Inc. has my permission to take pictures or video record my child for educational or marketing purposes. I understand that my child may have his/her picture included on educational or training videotapes, audiotapes, scrapbooks, yearbooks, bulletin boards, etc. My child's photo may also be included in WACD, Inc.'s online marketing tools, included but not limited to social networks and websites.

Parent/Guardian____ Date_________________________

Interviewing Children and Licensing Compliance

I understand that upon enrollment, my child may be subject to interviews by licensing staff, child maltreatment investigators and/or law enforcement officials for the purpose of determining licensing compliance or for investigative purposes. Child interviews do not require parental notice or consent. I also understand that licensing compliance forms are maintained at a facility for three years and are available for review upon request.

Parent/Guardian____ Date_________________________

Permission for Field Trips

I/We, ____, parent(s)/guardian(s) of ______________________________________
give permission for my/our child to go on field trips away from the premises of the WACD, Inc. facility, in the company of and under supervision by authorized WACD staff. During such trips, all required staff-child ratios shall be maintained.

Parent/Guardian____ Date_________________________

Consent for Developmental Screening

It is our policy and practice at WACD, Inc. to regularly screen each child in our care. We do this to see where your child is developmentally, so we can then individualize his or her classroom experience. We also use screening practices to identify any developmental concern early to allow for timely access to supports and services to help your child to develop optimally.

I give consent for my child, _________________________________ *(name)*, to participate in developmental screening at Western Arkansas Child Development, Inc. If asked to do so, I agree to complete a screening questionnaire at home and return it to the center within one week for further discussion with my child's classroom teacher. I understand I will be meeting with my child's teacher to discuss the results of the screening and will participate in developing any special plans based on the screening.

Parent/Guardian____ Date_________________________

- ☐ My child is currently receiving the following supports and services through:
  ______________________________ (name of therapist or agency).
  List services: ____

Special Nutrition Programs
Child and Adult Care Food Program

Letter to Parents

Dear Parent/Guardian:

The Western Arkansas Child Development, Inc. participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary so that we may receive CACFP reimbursement for the meals served to children in our program. This form will be placed in our files and treated as confidential information. All children in our program receive their meals free of charge, but the determination of eligibility category affects the amount of Federal funding received by us.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. Please contact us for additional information if you have a foster child enrolled in our program.

If you receive food stamps, then you need to only list your food stamp case number. In addition, you must complete Section 5 of the form including all required information with signature, Social Security Number of an adult household member, and date form was completed.

If a food stamp case number is not reported, you must complete Section 4 and Section 5 on the eligibility statement. Section 4 should include the names of all household members and the total current household income by source. Section 5 must include all required information with signature, Social Security Number of an adult household member, and date form was completed.

USDA defines a household as a group of related or unrelated individuals (not residents of an institution or boarding house) who are living as one economic unit (i.e., sharing living expenses). The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide a projection of your annual income, and you may use lasts year's income as a basis for making this projection if no significant changes have occurred. If your household's income is equal to or less than the amounts indicated for your household's size on the chart below, the center will receive a higher level of reimbursement.

You are required to notify us if there is a change in household size or an increase in income that exceeds $50 per month or $600 per year. If you list a food stamp case number, you must notify us when you no longer receive food stamps. Similarly, you should notify us if you become unemployed and the loss of income during the period of unemployment causes your family to be within the eligibility standards.

All meals served to children under the Child and Adult Care Food Program are served free regardless of race, color, sex, age, disability, or national origin.

There is to be no discrimination in admissions policy, meal service, or the use of facilities. Any complaints of discrimination should be submitted in writing to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

USDA CHILD NUTRITION PROGRAM
INCOME GUIDELINES

July 1, 2023 - June 30, 2024

Household Size	Annual	Monthly	Weekly
1	18,954	1,580	365
2	25,636	2,137	493
3	32,318	2,694	622
4	39,000	3,250	750
5	45,682	3,807	879
6	52,364	4,364	1,007
7	59,046	4,921	1,136
8	65,728	5,478	1,264
Each additional Household member add	+6,682	+557	+129

Thank you for your cooperation.

Institution Representative
(NPC-4 Rev. 07/18)

CHILD CARE FOOD PROGRAM
ENROLLEMENT FORM

Provider's Initials: ________

Date: ________

To be completed by Parent or Guardian

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information must be verified. The mealtime patterns and the daily menus should always be posted and available for parents. If you have questions, comments, or would like to learn more about the Child and Adult Care Food Program, contact our office at (505) 682-8869.

Western Arkansas Child Development, Inc. — 479-312-7416

Name of Day Care Facility — Telephone #

P.O. Box 1514 — Alma — AR — 72921

Address — City — State — Zip Code

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are specified below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious and well-balanced meals/snacks to day care children.

My Child(ren) will be served the following meals:

Breakfast: ☑ AM Snack: ☐ Lunch: ☑ PM Snack: ☑ Supper: ☐ Late Snack: ☐

Please Print Child(ren)'s Information						
First Name	Last Name	Age	Birthdate	Hours of Care	Days of Week	Gender
				From: To:	Sat. ☐ Tue. ☑ Fri. ☑ Sun. ☐ Wed. ☑ Mon. ☑ Thur. ☑	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	
				From: To:	Sat. ☐ Tue. ☐ Fri. ☐ Sun. ☐ Wed. ☐ Mon. ☐ Thur. ☐	

Please identify any fool allergies or special needs your child(ren) require:

Doctor's Name: ________________ Doctor's Telephone: ________________

Revised 07/2022

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program as administered in a nondiscriminatory manner.

***OPTIONAL* Participant's ethnic and racial identities**							**Please select all that apply**	
Name of Enrolled Child(ren)	Age	Foster Child?	Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex (including gender identity or sexual orientation), or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

EMERGENCY CONTACT INFORMATION:

Home Telephone #: ______________________ Work Telephone #: ______________________

____

Parent's Address City State Zip Code

Parent's Signature: ______________________ Date: ______________________

*Form expires one (1) year from this date

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name Western Arkansas Child Development, Inc.

PART 1. NAME OF ENROLLED CHILDREN ***OPTIONAL – Participant's ethnic and racial data**

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

NAME OF ENROLLED CHILDREN	AGE	DATE OF BIRTH	FOSTER CHILD?	HISPANIC OR LATINO Yes	No	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
				☐	☐					
				☐	☐					
				☐	☐					
				☐	☐					

ADDITIONAL HOUSEHOLD CHILDREN ______ TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD: _______

PART 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

Name:	Case Number	
1. ____________________	____________	**NOTE: A Case number is not the number found on the EBT card or an individual's Social Security number.**
2. ____________________	____________	
3. ____________________	____________	

PART 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Your School, Homeless Liaison, or Migrant Coordinator

☐ Homeless ☐ Migrant ☐ Runaway

PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income.

*** Weekly / Every 2 Weeks / Twice a Month / Monthly / Annual ***

Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$__________	$__________	$__________	$__________	
	$__________	$__________	$__________	$__________	
	$__________	$__________	$__________	$__________	
	$__________	$__________	$__________	$__________	

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name Western Arkansas Child Development, Inc

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

An adult household member must sign this form. **If Part 3 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 Statement on the back of this 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: ____________________ (form valid for one (1) year from this date)

Address: ______________________________ Phone Number: ____________________

City: ______________________________ State: ____________ Zip Code: ____________

Last four digits of Social Security Number: _*_*_*- _*_*- ____ (required) ☐ **I do not have a Social Security Number**

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__________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year Household Size: ________

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

Reason: ____

Temporary: Free_____ Reduced_____ Time Period: ______________________(expires after _____ days)

Determining Official's Signature: ______________________________ Date: ____________

If applicable, Sponsor Signature: ______________________________ Date: ____________

Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid".

HNP Representative Initials/Date (for use during CACFP Reviews)

____

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

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity or sexual orientation), age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired 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."

Child Information Form

Please help your child's teacher get to know your child by filling out this form. All information provided is confidential and will only be used by the WACD to plan for your child's development and to help with consistency between your home and our center. Thank you for your cooperation.

Child's Name:		Nickname:	
Date of Birth:		Place of Birth:	
Child Lives With:	☐ Mother ☐ Father ☐ Both ☐ Other	If other, list:	
Names/ages of any siblings			

Has your child had previous child care, babysitter or preschool experiences? ☐ Yes ☐ No
If yes, list any pertinent details (location, quality of experience):______________________

____

Does your child have any allergies or chronic medical conditions? ☐ Yes ☐ No
If yes, please give details:

____

What are some details about your child's developmental history you would like his/her teacher to be aware of? ______________________

Please list any pets you have at home: ______________________

List any preferences we should know about your child's naptime: ______________________

What are some of your child's strengths? ______________________

What are some of your child's likes?______________________

What are some of your child's dislikes? ______________________

How does your child get along with other children? Adults? ______________________

What is the discipline policy in your home? ______________________

Is your child currently receiving therapy? ☐ Yes ☐ No If yes, please give details:

____

Are there any religious/cultural preferences we need to be aware of? ______________________

Parent/Guardian Signature: ______________________ Date: __________

Advanced Family Eye Care

1127 S. Gutensohn Rd. Suite 101
Springdale, AR 72762
(479)750-3937
www.springdaleeyedoctor.com

Springdale Early Learning Academy West and Advanced Family Eye Care are partnering to provide your child with quality and convenient vision examination services at the school campus in a mobile exam unit. **This exam will check your child's refraction, eye health, and visual efficiency.** This form authorizes Dr. Micah Thomason and the staff of Advanced Family Eye Care to perform these services and bill them to your insurance provider if applicable. If you do not want your child to participate in this program, please check "no" at the bottom of this form.

Child's Information:

Last Name:______________________ MI:________ First Name:______________________________

DOB:_____/_____/________ Sex: M☐ F☐ Phone #:__________________ Cell:______________

Address:__________________________ City/State/Zip:______________________________________

Medical Insurance:____________________ Policy #:______________ Insured Name & DOB:____________

Vision Insurance: ____________________ Policy #:______________ Insured Name & DOB:____________

Parent/Guardian Name:_____________________ Address:___________________________________

Emergency Contact:______________________ Relationship:_______________ Phone #:______________

Child's Primary Care Physician:____

Current Medications:__________________________ Allergies:______________________________

Medical History: If there are any current problems, please provide additional information. Are there problems with:

Eyes: Yes☐ No☐ Cardiovascular: Yes☐ No☐ Respiratory: Yes☐ No☐ Psychiatric: Yes☐ No☐

Ear/Nose/Throat: Yes☐ No☐ Gastrointestinal: Yes☐ No☐ Kidney/Bladder: Yes☐ No☐ Diabetes/Thyroid: Yes☐ No☐

Muscles/Bones/Joints: Yes☐ No☐ Skin: Yes☐ No☐ Neurological: Yes☐ No☐ Headaches: Yes☐ No☐

Please provide a brief explanation if the answer was yes to any of the above:

____

____

Any Family History of: (circle all that apply) Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis. Are there any other heritable diseases that we should know about?

Please list:____

Parent's Signature:__________________________ Date: ____/____/______ Permission to Proceed: Yes ☐ No ☐

*****PLEASE note that this information will be used for insurance purposes only and will not be given out to anyone.*****

Arkansas Early Learning
Early Head Start

Physical/Well Child Check Report

(This form only needs to be completed if you are applying for Early Head Start)

Physicians Name: ____________________________________ ______Date of Exam:_____________

Child's Name: ____________________________________ ______D.O.B. _________________

Please **check** which physical/well child check/EPSDT is being performed.

___ **Newborn (2-4 days)** ___ **1 month** ___ **2 months** ___ **4 months** ___ **6 months**

___ **9 months** ___ **12 months** ___ **15 months** ___ **18 months** ___ **24 months** ___**3 years**

Height: ______ **Weight:** ______ **Head Circumference** (0-24 months) ______ **Blood pressure** (ages 3-5)______

Screenings	**Normal**	**Abnormal**	**Comments**
Growth/Physical			
Development			
Vision			
Eyes			
Teeth (mouth)			
Hearing			
Ears			
Hemoglobin/ Hematocrit **(12 months)**			**Results:**
Lead level **(12 & 24 months)**			**Results:**

Is this child **up to date** on all immunizations? Yes No Is child on catch up plan? Yes No

Special Instructions/Comments from PCP: ____

____

____

Allergies? ____

Next Appointment Date/Time (if applicable):___________________

I verify this child *is* up-to-date with the EPSDT schedule at this time.

Physicians Signature: _______________________________ **Date:**________________

Please attach a copy of the physical/EPSDT form and immunization record for our records to prevent duplication. (if applicable)