GREATER CONNECTIONS
CHILDHOOD DEVELOPMENT CENTER

Child Enrollment Information

Child Information			
Child's Name:		Date of Birth:	
Address:	City:	State:	ZIP:
Allergies, special instructions, comforting items:			

Parent/Guardian Information (1)			
Name:		Relationship to child:	
Address: (if different than child)	City:	State:	ZIP:
Home #:	Cell #:	Work #:	
Email (personal):		Email (work):	
Place of work:		Address:	
Parent/Guardian Information (2)			
Name:		Relationship to child:	
Address: (if different than child)	City:	State:	ZIP:
Home #:	Cell #:	Work #:	
Email (personal):		Email (work):	
Place of work:		Address:	

Emergency Contact (1)			
Name:		Relationship to child:	
Address:	City:		State:
Home #:	Cell #:	Work #:	
Email (personal):		Email (work):	
Emergency Contact (2)			
Name:		Relationship to child:	
Address:	City:		State:
Home #:	Cell #:	Work #:	
Email (personal):		Email (work):	
Emergency Contact (3) – Out-of-Area/Out-of-State			
Name:		Relationship to child:	
Address:	City:		State:
Home #:	Cell #:	Work #:	
Email (personal):		Email (work):	

Medical Information			
Child's Doctor's Name:		Phone #:	
Address:	City:		State:
Preferred Hospital to Contact:		Phone #:	
Address:	City:		State:

Does your child have any special needs that I need to be aware of? _____

_____

_____

Persons allowed to pick up my child if I am unable to: **(Also list emergency contacts below if you want to allow them to pick up your child)**		
Name:	Phone #:	Relationship to child:
Name:	Phone #:	Relationship to child:
Name:	Phone #:	Relationship to child:
Name:	Phone #:	Relationship to child:
Name:	Phone #:	Relationship to child:
Name:	Phone #:	Relationship to child:

Any one NOT allowed to pick up my child (with copy of court order, if applicable):

I understand that if Greater Connections Childhood Development Center staff assess the person picking the child up to be impaired by drugs, alcohol, or other reasons will notify the authorities before the child is released into the care of that person. Staff will not authorize anyone who is not listed above to pick up the child unless arrangements have been made with the parent or guardian. Identification will be required of anyone picking up the child that is not recognized by staff, regardless of whether or not they are listed. I agree to review and update this information annually or whenever changes occur.

Parent's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

GREATER CONNECTIONS
CHILDHOOD DEVELOPMENT CENTER

Consent & Release

Name of Child: _____

The following persons are allowed to pick up my child from child care in the event that I am unable to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Anyone NOT permitted to pick up my child (with copy of court order, if applicable):

_____	_____	_____
_____	_____	_____

Consent is given for the items initialed below:

_____ Walking Trips

_____ Transportation by Trolley or Bus

_____ Swimming and/or Wadling

Location: Southern Prairie Family Fitness Center or Creston Community Pool

_____ Other Activities (e.g. homework supervision, trips to neighborhood playgrounds, special trips)

_____ Photo Release

My child may be photographed while in child care. Photos may be used in newspapers or other media for the purpose of publicity or shared with families whose children attend the childcare program.

_____ Decline Photo Release

_____ _____

Signature of Parent Date

GREATER CONNECTIONS
CHILDHOOD DEVELOPMENT CENTER

Emergency Medical Treatment Authorization

Permission for medical care in parental absence.

Child's Full Name: _____ Birth Date: _____

Name child answers to: _____

I, _____, parent or guardian of the child named above give my permission to, Greater Connections Childhood Development Center, to secure and authorize such emergency medical care and treatment as my child might require under the Provider's supervision. I also authorize the Provider to administer emergency care or treatment as required, until emergency medical assistance arrives. I also agree to pay all the costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent.

NOTE: Every effort will be made to notify parents immediately in case of emergency. In the event of an emergency, it would be necessary to have the following information:

Name of Parent or Legal Guardian: _____
Address: _____
Home Phone: _____ Work Phone: _____

Name of Parent or Legal Guardian: _____
Address: _____
Home Phone: _____ Work Phone: _____

Doctor: _____
Doctor's Address: _____
Doctor's Phone: _____

Preferred Hospital to Contact: _____
Address: _____ Phone: _____

Persons to be contacted in emergency if the parents are unavailable:

Name	Home Phone	Work Phone	Relationship

Present medication(s): _____
Known allergies: _____
Date of last tetanus: _____ Insurance Number: _____
Insurance: _____

Father's Signature: _____ Date: _____

Mother's Signature: _____ Date: _____

GREATER CONNECTIONS
CHILDHOOD DEVELOPMENT CENTER

Parent and Provider Contract

Date Enrolled: _____

Child's Name: _____

Please mark the days of the week you will need childcare.

Monday AM_____ PM_____

Tuesday AM_____ PM_____

Wednesday AM_____ PM_____

Thursday AM_____ PM_____

Friday AM_____ PM_____

Will your child attend:

Full time (26 to 48 hours) Part time (9 to 25 hours) Drop In (8 hours or less)

Will your child(ren) attend during winter break?

☐ Yes

☐ No

Will your child attend during spring break?

☐ Yes

☐ No

You can expect my child to be there in the following events:

Early Outs Late Starts Cancelled School

I _____, the parent of, _____, understand that the staffing of the center is based on the number of children within the classroom. I am providing a schedule of times my child will be in the center to ensure that my child's needs are adequately met on a daily basis. If I have a rotating schedule, I will communicate that need the week prior to my child attending. If my child's schedule should change or my child no longer needs care, I will notify the center immediately, as I understand my child's place is not guaranteed.

_____ I understand that my child will be required to lay down for a rest period between 12:00 p.m. – 2:00 p.m. If my child has a special stuffed animal or blanket that helps comfort them, I will be sure to provide these items. If a child arrives before 6:30 a.m., my child will be required to lay down for a rest period prior to a.m. snack being served at 6:45 a.m.

Signature of Parent/Guardian: _____ Date: _____

Greater Connections Childhood Development Center Tuition Rates

Effective July 17th, 2023

Age	6 weeks – 24 months	2 Years	3 Years	Four Years	Five Years – Twelve Years (Summer)	Five Years – Twelve Years (BASP)
Full Time (26 – 48 hours)	$180.00	$175.00	$165.00	$160.00	$160.00	$90.00
Part Time (9 – 25 hours)	$145.00	$140.00	$145.00	$130.00	$130.00	
Drop In Rate	$45.00	$40.00	$40.00	$35.00	$35.00	

Surcharge Rate over 49 hours - $4.00/hour
Late Charge - $1/minute after 6:30pm
Registration Fee - $30.00 per child (non-refundable)

I, _____, understand that Greater Connections Childhood Development Center must meet their monthly expenses for wages, rent, utilities, and program materials, in order to provide the best quality care for my child. It is important that income from fees be as stable and dependable as possible, so there will be no deductions for absences or holidays (except for vacation time that has accrued according to Greater Connections Childhood Development Center's policies.

_____ I understand that there is a registration fee of $30.00 and is due upon enrollment. I further understand that if I withdraw my child for any reason (including, but not limited to, unauthorized vacation, leave of absences, and lay off) there will be a $30.00 fee for re-registration.

_____ I understand tuition is due every Monday for the week of care. Failure to pay by Friday at 6:00 p.m. will result in a late fee of $25. Accounts that are 14 days past due, child care services will be terminated. Restatement of child care services will be evaluated once payment is paid in full. Drop in tuition is due on the day of service.

_____ I understand there is a supply fee of $30.00 and is due every September.

_____ I understand that there is a late fee for picking up a child after the center closes at 6:30 p.m. That rate is $1.00 per minute that I am late.

_____ I understand daycare payments can be made by cash or check payable to Greater Connections Childhood Development Center. Payments can also be made by credit card on the Brightwheel app.

_____ I understand that there is a daily drop in rate, which is paid at the time of drop in. I further understand that if my child is dropped off for the day, I will call prior to my child coming to ensure there is enough space available for care that day.

_____ I understand that after 6 months of full time status, my child will have accrued 5 consecutive days of vacation. If my child is absent due to illness, for more than half the normal attendance, please talk with the director.

_____ I understand I can appeal any of these policies through the board of directors during regular monthly meetings. Please request to be on the agenda prior to the meeting date by contacting the center director. I understand that Greater Connections Childhood Development Center reserves the right to change fees and schedules. We will provide a 30 day notice of any changes to fees and schedules. I have read the fee agreement and I agree to all the terms and conditions of this agreement.

Signature of Parent/Guardian: _____ Date:_____

PARENT/GUARDIAN COMPLETE THIS PAGE **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

Growth
☐ I am concerned about my child's growth.

Appetite
☐ I am concerned about my child's eating/ feeding habits or appetite.

Rest -
☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child
☐ had a serious illness, injury, or surgery.

Please describe:

Physical Activity - My child
☐ must restrict physical activity.

Please describe:

Development and Learning
☐ I am concerned about my child's behavior, development, or learning.

Please describe:

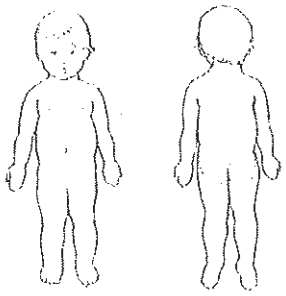
☐ **Allergies**-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** – My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

Body Health - My child has problems with
☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aids or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature Date:

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE –
OR PROVIDE COPY OF WELL CHILD PHYSICAL

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr.:_____

Hgb or Hct- @ 12 mo.: _____

Lead Risk Assessment: _____

Blood Lead Level: date_____ results _____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe
Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)
☐ IDPH Certificate of Immunization reviewed and signed

☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at the child care facility: (

Medication Name Dosage
☐ Diaper crème:
☐ Fever or Pain reliever:
☐ Sunscreen:
☐ Other

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Additional Referrals made:

☐ _____
☐ _____

Health Provider Assessment Statement:

☐The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(please complete and file a copy in child's file)

Comments:

Signature _____
Circle the Provider Type: **MD DO PA ARNP**

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Parent's/Guardian's Permission To Apply Sunscreen To Child

(Name of Child) _____

As the parent or guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at:

(Child Care Business) Greater Connections Childhood Development Center

to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- ❑ I do not know of any allergies my child has to sunscreen.
- ❑ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.
- ❑ I have provided the following brand/type of sunscreen for use on my child:

  _____

- ❑ My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

  _____

  _____

- ❑ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

  _____

Parent/Guardian full name (print): _____

Parent/Guardian signature: _____ Date: _____

Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 7/2022

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

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. See instructions on the back for more information.

If you do not qualify now to receive free or reduced-price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for SNAP or FIP, you may fill out an application at that time.

Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2022 to 6-30-2023

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$25,142	$2,096	$1,048	$967	$484
2	$33,874	$2,823	$1,412	$1,303	$652
3	$42,606	$3,551	$1,776	$1,639	$820
4	$51,338	$4,279	$2,140	$1,975	$988
5	$60,070	$5,006	$2,503	$2,311	$1,156
6	$68,802	$5,734	$2,867	$2,647	$1,324
7	$77,534	$6,462	$3,231	$2,983	$1,492
8	$86,266	$7,189	$3,595	$3,318	$1,659
For each additional family member add:	+ $8,732	+ $728	+ $364	+ $336	+ $168

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

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. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a SNAP number, or Family Investment Program number, 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 CACFP. 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.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

Iowa Eligibility Application

FFY 22-23

Complete one application per household. Fiscal Year 2022-2023

Part 1. Check all applicable boxes:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home (HP) Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or SNAP Eligible: Enter the FIP or SNAP Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.
Name of household member with Case Number _____ **List Case Number** _ _ _ _ _ _ _ _ _ _

Part 4. Children enrolled: REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino
Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White
Completing ethnicity & race is voluntary

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income: DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR SNAP NUMBER IN PART 3.
Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	Gross Income: Report income by how often the household member is paid. Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: **X XX - X X -** ___ ___ ___ ___ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form_____

Signature of Adult Completing Form | Printed Name of Adult Completing Form | Date Signed

Address of Adult Completing Form | Town | ZIP Code | Work Phone | Home Phone | Cell Phone

Part 7. TO BE COMPLTED BY CENTER STAFF.
Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $ _____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _____

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/SNAP
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk
Application Denied: ☐ Incomplete ☐ Over income limits

☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature | **Effective Date**

CHILD & ADULT CARE FOOD PROGRAM

Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

June 2022

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Birthdate	Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it.

Infants only (0 to 12 months): ☐ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

☐ I will provide breastmilk for my infant. ☐ Yes ☐ No ***If infant is still hungry and no breastmilk is available, list what to feed*** _____

☐ I would like to breastfeed on site, if this option is available[1]. ☐ Yes ☐ No If yes, time(s) _____

☐ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____

☐ I accept the center's formula for my infant. Name of iron-fortified formula: _____

☐ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____

☐ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

☐ I will provide solid foods for my infant[2]. The center may supplement with additional solid foods when my infant needs them: ☐ Yes ☐ No

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

[1]Ask your center if you can breastfeed on-site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.