DayStar

CHILDCARE CENTER

Enrollment Packet

Daystar Childcare Center is licensed Christian Childcare Facility caring for children ages 6 weeks to 12 years

Phone (810) 743-3898 Fax (810) 743-9616

New Enrollment Checklist

Date Completed	Item
	Child Information Record
	Financial Agreement
	Family & Social History
	Child Disciplinary Action
	Permission Form-topical medication
	Licensing Notebook Notification
	CACFP Enrollment Form
	CACFP Income Eligibility Form
	Infant Formula Sign Off (*if applicable*)
	Immunization Record
	Health Appraisal
	Copy of Parent's/Legal Guardian's ID
	Copy of Child's Birth Certificate OR Social Security Card
	Registration Fee Paid
	First Week Tuition Paid in Advance

Child Information

For Provider Use Only: Date of Admission:	Date of Discharge:

Child's Name (Last, First, Middle Initial)	Date of Birth
Address (Number and Street, Building/Apartment Number)	City, State, ZIP

Parent Guardian Information

Parent/ Legal Guardian (relationship to child)	Date of Birth	Other Parent/ Legal Guardian (relationship to child)	Date of Birth
Address (if not child's address)	Primary Phone	Address (if not child's address)	Primary Phone
City, State, ZIP	Alt. Phone	City, State, ZIP	Alt. Phone
Employer	Work Phone	Employer	Work Phone
Preferred Email		**Preferred Email**	
Cell Phone Carrier (to receive text messages from Daystar, this information is needed)		Cell Phone Carrier (to receive text messages from Daystar, this information is needed)	

Authorized Pick-Ups *Other than Parent/Guardian listed above.*

List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released.

***Must list legal name that will match ID/Driver's License at Pickup.**

1. Legal Name*	Relationship	Home	Cell
2. Legal Name*	Relationship	Home	Cell
3. Legal Name*	Relationship	Home	Cell
4. Legal Name*	Relationship	Home	Cell
5. Legal Name*	Relationship	Home	Cell
6. Legal Name*	Relationship	Home	Cell

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian: Date Signed:

For Future Use:

I acknowledge that I have reviewed and made necessary updates to the Emergency Contact/Child Information Sheet				
Signature:	Date:	Parent Updated Online	Date:	Office Initial:
Signature:	Date:	Parent Updated Online	Date:	Office Initial:
Signature:	Date:	Parent Updated Online	Date:	Office Initial:
Signature:	Date:	Parent Updated Online	Date:	Office Initial::

Medical Information

All allergies, special dietary needs and instructions must be accompanied by a letter from your physician.

Child's Name	Physician's Name	Physician's Phone	Allergies, Special Dietary needs & Instructions*
Child's Name	Physician's Name	Physician's Phone	Allergies, Special Dietary needs & Instructions*
Child's Name	Physician's Name	Physician's Phone	Allergies, Special Dietary needs & Instructions*
Child's Name	Physician's Name	Physician's Phone	Allergies, Special Dietary needs & Instructions*

Please check one:

☐ My child(ren) is/are in good health and able to participate in all activities without restrictions.
☐ My child(ren) is/are NOT in good health and able to participate in all activities without restrictions.
☐ See restrictions in attached physician's letter.

Disabilities

In order for us to best meet the individual needs of your child(ren) and assist them in their development, please check any and all boxes that apply to your child(ren).

Medical:

☐ Hearing impairment ☐ Vision Impairment
☐ Mobility impairment ☐ Head injury
☐ Chronic illness ☐ Other

Please specify: _____

Developmental:

☐ ADD/ADHD ☐ Asperger Syndrome
☐ Autism ☐ Down Syndrome
☐ Dyslexia ☐ Other _____

Behavioral:

☐ Opposition Defiance Disorder
☐ Reactive Attachment Disorder
☐ Other _____

Cognitive:

☐ Bipolar Disorder
☐ Other _____

I understand Daystar Childcare Center will make reasonable accommodations, as needed, to support my child(ren)'s disability. However, since they are not a special needs facility, they are limited in the scope of support they can offer and may need to recommend another facility and/or services for my child(ren). The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Authorizations

Emergency Authorization

I give permission to Daystar Childcare Center, licensed by the Department of Human Services, to secure emergency medical and/or emergency surgical treatment for the above named child(ren) while in care.	
Preferred Hospital	Major Crossroads for Preferred Hospital

School Age Children

My school age child(ren) attend school at:
My child(ren)'s health appraisal and immunization records, or appropriate waiver are on file and current at the above named school. I acknowledge that my child(ren) is/are in good health and assume responsibility for their state of health while at the center.

Additional Authorizations

Authorization for topical, non-prescription medication: I authorize Daystar Childcare Center to apply topical, nonprescription medication on my child(ren) on an as needed basis. Such medications include, but are not limited to: sunscreen, insect repellent, diaper rash cream or ointment (infant/toddler).
Photo & Video Release: I give authorization to Daystar Childcare Center to take photographs and video clips of my child(ren). I understand that these may be used for ongoing child assessments, classroom displays, or sent through electronic communications. I understand these photos and/or video clips may be used on print or electronically to promote Daycare services.
Licensing Notebook Notification: Licensing Notebook Notification: I understand that Daystar Childcare Center keeps a licensing notebook that contains all the licensing inspection and special investigation reports and related corrective action plans. Licensing inspection and special investigation reports from at least the past three years are available here onsite through the child care licensing website at www.michigan.gov/michildcare.
Acknowledgement of Parent Handbook: I acknowledge that a copy of the Parent Handbook is available at www.daystarchildcarecenter.org. I understand that I am being presented with the opportunity to ask questions for clarification. I agree to abide by the policies in the handbook.

By placing my signature below, I am giving my acknowledgement and authorization of the sections listed above.

Parent Signature _____ Date _____

For Future Use:

I acknowledge that I have reviewed the above authorizations and sign my agreement to them				
Signature:	Date:	Parent Updated Online	Date:	Office Initial:
Signature:	Date:	Parent Updated Online	Date:	Office Initial:
Signature:	Date:	Parent Updated Online	Date:	Office Initial:

Financial Agreement

Child's Name: _____

Please List Below the fees that apply:

Registration Fee (non-refundable)	$ 50.00	
Approximate DHHS weekly co-payment	$ 25.00	
Full or Part Time childcare Rates	$	$
Discounts	$	
Total Owed (1st week)	$	
Weekly Payment	$	

I will be responsible for all daycare fee payments according to those deemed appropriate by Daystar Childcare Center Board and Administration. I affirm that fees will be paid on time and in full.	Date	Initials
I understand that field trips are optional and the cost of the field trip is not included in tuition. If my child attends a field trip, I must give my written consent and I must pay the extra fee.	Date	Initials
Rates and all family discounts are valid only if paid by Monday of the current week.	Date	Initials
I agree to be fully responsible to pay for any amount of DHHS does not cover.	Date	Initials
I agree to pay a $25.00 fee if my check is returned or re-deposited.	Date	Initials
I agree to abide by the guidelines listed in the parent handbook. I understand that the parent handbook is available to read at www.daystarchildcare.org	Date	Initials
I agree that there will be a $5.00 late fee added to each bill which is not paid by Monday.	Date	Initials
I understand that if my bill is not paid on the date of my child's disenrollment, that my account will be sent to collections and a collection fee of %20 of my total bill will be added to my account balance that will I will be responsible to pay.	Date	Initials

Family and Social History

Name of Child	Date of Birth
Mother / Guardian	Father / Guardian

Marital status of parents: (check one)				
Married	Single	Divorced	Separated	Living Together

Is the child adopted?	Yes	No	Age at adoption (if yes)	
Does the child know (if yes)?				
Remarks				

Siblings of child:		
Name:	Age:	School Grade:
Name:	Age:	School Grade:
Name:	Age:	School Grade:

Other Members of household:	
Name:	Relationship
Name:	Relationship
Does the child have a room alone?	If not, with whom?
Previous group play experience?	Where?

Developmental history of child: (Write age at which the child performed action)		
Sat alone:	Crawled:	Walked alone:
Began Toilet Training:	Dressing Self:	Undressing Self:
Is the child right or left handed?		
Do they have any eating problems?		
Do they have any dietary restrictions?		
Does the child have any special fears that you are aware of? (If yes, please explain)		

Child Disciplinary Action

Each child's concern is a matter of concern to the Director and Teacher. We would appreciate if you, the parent/guardian, would go over these guidelines with your child regarding his/her appropriate behavior while at the center.

1. Everyone is a valued person and should be treated respectfully. Ask the question how you would want to be treated.
2. There is to be no physical acts of aggression perpetrated on any child for any reason.
3. There is to be no use of profane language one toward the other or toward any teacher or parent.
4. All children's bodies belong to themselves and absolutely no one else. **NO ONE ELSE!**
5. No child shall be ridiculed for any differences in his/her physical makeup.
6. We are admonished in the Word of God to love one another and that we will do at Daystar Childcare Center.

Parents, we would like to state that should any violations of the above occur, we will take the following measures:

1. Your child will be called aside and spoken to in a soft and private voice. Your child will be reminded, in a way appropriate to their age, of the rules concerning respecting one another. This will be acknowledged as the first warning and your child will either be redirected to a different activity or area of play.
2. If your child repeat the offense, we will again call your child aside and speak to him/her in a soft and private voice. The second warning will be written down.
3. A third offense committed by your child will also be written down and a phone call will be made to you at an appropriate time by the Director.
4. A fourth offense committed by your child will require a parent conference to ascertain what the nature of the problem may be and what can be done to resolve it.

It is the priority of our staff to lovingly care for, and kindly treat, your child, but repeated offenses by any child only upsets the center's environment. In our mission statement, we stated that it is our goal to provide a safe, wholesome, and warm environment. That can be enhanced by you, the parent/guardian, by giving your total support to the guidelines established by this facility and reinforcing them at home to your child.

Yours in Christian Service,

Daystar Childcare Center Teachers and Director

_____ _____

Parent Signature **Date**

Individual Care Plan

Family Information Form
Infants & Toddlers

Child:
Child's DOB:
Teacher:
Family Member(s):
Date:

Arrival

What time will you usually arrive at the center_____

What will help you and your child say good-bye to each other in the morning?

Diapering and Toileting

What type of diapers do you use?

How often do you change your child's diaper? When does your child usually need a diaper change?

Are there any special instructions for a diaper change?

Is your child beginning to use the toilet? If so, are there any special instructions for toileting?

Sleeping

How will we know that your child is tired and needs to sleep?

When does your child usually fall asleep? For how long does he/she usually sleep?

What helps your child fall asleep?

Eating Plan-Infants

Are you breast-feeding or bottle-feeding your baby?

If breast-feeding, will you come to the center to breast-feed? Y/N

If so, at what time?

If not, will you send expressed breast milk?

If bottle-feeding, what kind of formula do you use?

How do you prepare the bottles?

How much do you prepare at one time?

How much does your baby drink at one time?

Does your baby drink bottles of water during the day? Y/N

If so, which ones?

When?

How do you prepare your baby's solid foods?

How much does your baby eat at one time?

How is your baby used to being fed (in what position)?

Does your baby eat any finger foods? If so, which ones?

Eating Plan-All Children

What are some of your child's favorite foods?

What foods does your child dislike?

Is your child sensitive or allergic to any foods? If so, please list them.

Are there any foods that you don't want your child to eat?

Dressing:

Is there anything special that we should know about dressing and undressing your child?

Awake Time:

How does your baby like to be held? What position does your baby prefer when awake?

In what language do you speak with your child at home?

What language does your child use when talking and singing with family members?

How do you play with your child?

Departure:

What time will you usually come to pick up your child?

What will help you and your child greet each other at the end of the day?

Daystar Childcare Center

Child and Adult Care Food Program (CACFP)
Formula/Food Sign-Off Statement

MICHIGAN Department of Education

As a participant in the CACFP, we must offer to supply all infant meal food components, as developmentally appropriate, to all infants in our care.

We will supply the following items to your infant:

- Iron-fortified infant formula
- Iron-fortified infant cereal
- Infant foods and/or table foods in the appropriate texture for the age of your infant.

Parents/Guardians may choose to accept our supplied infant formula and/or foods or provide their own. Mothers are always welcome to breast feed on-site and/or provide expressed breastmilk.

Parents/Guardians may provide one food component towards a reimbursable meal. Our center must supply all other meal components, as developmentally ready, to receive reimbursement.

Please check your preferences below for each meal pattern requirement.

Our center will supply the following formula and infant food:

Formula offered by our center: _____
(Specific brand/type identified by center)

Parent/Guardian check your breast milk/formula preference:

- ☐ I want the center to provide formula to my infant
- ☐ I will come to the center to breast feed my infant
- ☑ I will bring iron-fortified formula for my infant
- ☑ I will bring expressed breast milk for my infant

Iron-Fortified Infant Cereal offered by our center:

☐ Rice ☐ Barley ☐ Wheat ☐ Oat ☐ Multi-grain

Parent/Guardian check your infant cereal preference:

- ☐ I want the center to provide iron fortified infant cereal for my infant
- ☐ I will bring iron fortified infant cereal for my infant

Food offered by our center:

- ☐ Store-bought infant foods
- ☑ Table foods at the appropriate consistency for the development of your infant

Parent/Guardian check your infant food preference:

- ☐ I want the center to provide developmentally appropriate foods for my infant
- ☐ I will bring foods for my infant

If parent/guardian is supplying any breast milk, formula, or infant foods: Specify what we may feed your infant if they are still hungry after they are fed what has been supplied for the day:

Infant Name:_____ Birth Date:_____

Parent/Guardian Signature:_____ Date Signed:_____

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**.)

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

_____ / / Was the health history reviewed by a health professional?

Parent/Guardian Signature Date ☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ _____ ___/___/___

Health Professional's Signature Title Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature Date ***Examiner's Name (Print or Type)*** Degree or License

_____ _____ MI _____ (___) _____

Number & Street City ZIP Code Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

Return this completed form to: ***(Insert institution's name, address & telephone number)***

Household Income Eligibility Statement – Child Care Institutions

Part 1 – Households Receiving Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR)

If any member of your household receives FAP, FIP, or FDPIR, provide the name and case number for the person who receives the benefits.

Name:_____ **Case Number:** _____

Part 2 – Household Information

First and Last Names of All Household Members, Related and Unrelated	Enrolled for Child Care (x)	Age	Birth Date	Foster Child (x)	Amount of Earnings from Work (before deductions)	How Often? (x) Annually	Monthly	2xMonth	BiWeekly	Weekly	Amount of Welfare, Child Support, or Alimony	How Often? (x) Annually	Monthly	2xMonth	BiWeekly	Weekly	Amount of All Other Income (Indicate source and amount)	How Often? (x) Annually	Monthly	2xMonth	BiWeekly	Weekly	Mark if No Income (x)

Part 3 – All Households: Signature and Last Four (4) Digits of Adult Social Security Number (Adult household member MUST sign and date)

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 receive 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.

Signature:_____ Print Name:_____ Date:_____

Last four digits of Social Security Number: XXX-XX-_ _ _ _ ____I do not have a Social Security Number

For Institution Use Only:

For Institution Use Only		
Total Household Members:	Total Income: $ ___ Annually ___ Monthly ___ 2x Month ___ Bi-Weekly ___ Weekly	APPROVED CATEGORY Categorical Eligibility (A/Free): Foster FIP FAP FDPIR Other Household Children: A (Free) B (Reduced) C (Paid)
Institution Official Signature: _____ Approval Date: _____		

This form is valid for 12 months from the date of institution signature. Approval date and institution signature are required.

Privacy Act Statement
The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Family Independence Program (FIP), 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.

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: USDA Program Discrimination Complaint Form, 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: **mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf

Rev 7/2023

MICHIGAN Department of Education

Return this completed form to: (*insert institution's name, address & telephone number)*

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

_____ Adult/Parent/Guardian's Address

_____ Adult/Parent/Guardian's Phone Number

_____ Signature of Adult/Parent/Guardian

_____ Date Signed

USDA Nondiscrimination Statement

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This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:
https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf

MICHIGAN Department of Education