



DOWNTOWN HAMPTON CHILD DEVELOPMENT CENTER

60 Battle Road, Hampton, Virginia 23666 (757) 825-6200

Child	Nickname	Sex	Birth date
Address			Home Phone
Chronic physical Problems/Pertinent Development Information/Special Accommodations needed			
Primary language spoken in home		Ethnic Background	

PARENTS/GUARDIAN

Father	Place Employed	Business Phone
Home Address		Home Phone Cell Phone
Mother	Place Employed	Business Phone
Home Address		Home Phone Cell Phone
Person(s) or Agency Having Legal Custody of Child*		
Home Address		Home Phone
Business Address		Business phone

EMERGENCY INFORMATION

Allergies or Intolerance to Food, Medication etc. and Action to Take in an Emergency		
Two People To Contact if Parents Cannot be Reached	Address	Home Phone Cell Phone Work Phone
1.		
2.	Address	Home Phone Cell Phone Work Phone
Person(s) Authorized to Pick up Child		
Person(s) NOT Authorized to Pick Up Child*		

***A copy of appropriate legal paperwork such as custody papers shall be attached if a parent is not allowed to pick up the child**

Previous Child Day Care Programs Attended: _____

Religious Restrictions: _____

Tuition Statement (Not Applicable to "VA Preschool Initiative" Children)

The policy concerning tuition is that your child will be automatically dropped from the Center if your bill gets more than **two (2) weeks behind**. If this does occur, you are held responsible for paying all due fees. I fully understand the policy set forth concerning tuition payments to Downtown Hampton Child Development Center, and hereby agree to meet the above requirements.

I understand tuition is due on Friday for the following week.

Weekly Tuition: \$ _____

Agreements

1. The child care center agrees to notify the parent/guardian whenever the child becomes ill and the parent/guardian will arrange to have the child picked up as soon as possible.
2. The parent/guardian authorizes the child care center to obtain immediate medical care if an emergency occurs when the parent cannot be located immediately.
3. The parent/guardian gives authorization for the child to participate in the center's transportation and field trips: _____yes_____no
4. I give my permission to photograph my child and reproduce my child's picture in connection with any Public Relations on behalf of our Center:_____yes_____no
5. The parents/guardian agree to inform the child day center within 24 hours or the next business day after a child or any member of immediate family has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases, which must be reported immediately.
6. I will receive a copy of the "Parent Policy Handbook" at orientation and understand the policies as stated. **It is my responsibility to read it completely.**

Signatures

Parent or Guardian Date

Administrator of Center Date

For Office Use only

Date Received:	Program:	Date Entered:	Left:
Orientation Date:	Site: Teacher:	Transportation:	
Birth Certificate No.:	Place of Birth:	Verified By:	Date:
Other Form of Proof:		Date Issued:	

Date of Notification of Local Law-Enforcement Agency (when proof of identity is **not** provided): _____

Date

Child and Adult Care Food Program Income Eligibility Form

PART 1

Participant's Name: _____ **DOB:** _____
 Last First Middle Initial

White Black Hispanic/Latino Am. Indian/Alaskan Native Hawaiian/Alaskan Asian/Pacific Islander
 (Circle one – needed for statistical reporting)

Participant's Name: _____ **DOB:** _____
 Last First Middle Initial

White Black Hispanic/Latino Am. Indian/Alaskan Native Hawaiian/Alaskan Asian/Pacific Islander
 (Circle one – needed for statistical reporting)

Start Date: _____ **Arrival Time:** _____ **AM/PM** **Departure Time:** _____ **AM/PM** **Shift Work:** Yes/No

Normal days of week Participant(s) is/are in care (circle all that apply): **Mon Tues Wed Thurs Fri Sat Sun**

Meals eaten at Providers/Center: (Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant):
Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART 2A – HOUSEHOLDS NOW GETTING FOOD STAMPS OR ABC (FORMERLY AFDC): Complete this Part and Part 3 – DO NOT complete Part 2B and C.

Food Stamps Case Number: _____ **ABC Case Number:** _____

PART 2B – Foster Child (A Foster Child is a ward of the State and a copy of the custody order is required for documentation): Complete this Part and Part 3. DO NOT complete Part 2A or C. If this is a foster child, check here [] and write the child's income and how often it is received here:

\$ _____ / _____

PART 2C – HOUSEHOLD INCOME – If you do not need to complete Part 2A or Part 2B, complete this Part and Part 3.

NAMES	CURRENT INCOME (Please indicate by Week/Bi-Wk/2x's Mo/Month/Year)			
List Names of All Household Members (Attach Any Additional Members)	Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or any Other Income
1	\$	\$	\$	\$
2	\$	\$	\$	\$
3	\$	\$	\$	\$
4	\$	\$	\$	\$
5	\$	\$	\$	\$

PART 3 – SIGNATURE: An adult household member must sign the form before it can be approved.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Food Stamps Number or ABC Number is correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify this information on the statement and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult _____ Signature of Adult _____ Date _____

Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____

(Your Social Security Number is **NOT** needed if you listed a Food Stamps or ABC Number, or the participant is a foster child [Part 2A or Part 2B of this form], or Headstart eligible. For more information, please see instructions for PART 3 on the back of this form.)

Sponsor Use Only: Food Stamps/ABC household/Head-Start categorically eligible for program benefits:
 (If Yes, circle one) [] YES [] NO

Total Family Income: _____ Family Size: _____ (Include all Participants)
Monthly Income Conversion: Weekly x 4.33; Every Two Weeks x 2.15; Twice a Month x 2

Eligible For: FREE [] REDUCED [] PAID [] (NOT Eligible for Free or Reduced or refused income declaration)

Determining Official Signature: _____ Date: _____

Downtown Hampton Child Development Center

USDA ENROLLMENT FORM

_____ Age or DOB _____ is enrolled at:
Name of Child _____

Name of Center _____

Address of Center _____

Starting on _____
(Month/Day/Year)

Normal Days in Child Care: **M T W TH F**

Normal Meals Expected to be served daily: **Breakfast** ___ **Lunch** ___ **PM Snack** ___

Please explain any unusual circumstances related to child's attendance at the center:

Signature: _____ **Date:** _____
(Parent or Guardian)

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, age, or disability. To file a complaint of discrimination, write 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 or TDD). USDA is an equal opportunity provider and employer.

Optional fields for parent or guardian:

Address: _____ Telephone: _____

For Center Use Only:

Participant Withdrew on _____
(Date)