FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

OUT OF SCHOOL CARE & ELEARNING ASSISTANCE

Crossroads YMCA for grades K-6th

PROGRAM INFORMATION

Our program is available Monday through Friday

- **Before Out of School Care:** Free time, activity, craft, games
  - **Before……6-8:00am**
  - Includes before care & bus transportation from Hammond and Whiting YMCA to Griffith YMCA-Ready site. Southlake YMCA has before care and will stay onsite for Core-Out of School program.
- **Core-Out of School Care**: 8:00am-4:00pm at one of two sites (Griffith YMCA-Ready site, 5 days; Southlake YMCA, 3 day hybrid schedule)
  - Time during the day for:
    - ELearning/school work assistance
    - Physical Activities, Crafts, Outdoors
    - Lunch/Snacks
- **After Out of School Care:** Free time, activity, craft, games, homework
  - **After……4- 6:30pm**
  - At location student completed Core-Out of School Care (Griffith or Southlake)

PROGRAM FEES

Parents/guardians will need to pay at the Welcome Center, in advance, for Childcare Services. Registration must be completed by Wednesday, the week before you need care. Please note that your child **will not** be added to the roster if you have not paid in advance.

- **Pricing is as follows per child:**
  - Before-Out of School Care $25/week (at Griffith, Hammond, Whiting YMCAs) or
    Before-Out of School Care $15/week (Southlake YMCA)
  - Griffith YMCA only: Core-Out of School Care Program (5 day option): $125 members; $165 guests per week
  - Southlake YMCA only: Core-Out of School Care Program (3 day option): $90 members; $130 guests per week
  - After-Out of School Care where student completed Core-Out of School program $25/week (Griffith YMCA)
    After-Out of School Care where student completed Core-Out of School program $15/week (Southlake YMCA)

***Late pick up will incur a charge of $1 per minute after 6:30pm**

PAYMENTS

Payments must be made by the Wednesday, the week before you need care. If you pay for a week and your child does not come, there will be **NO credits/refunds given.** If you do not register your child in advance you will be subject to **a late processing fee of $10.** Payments can be made in person or by calling:

Payments can be made at:
Griffith YMCA (219 750 1082)
Hammond YMCA (219 845 1507)
Southlake YMCA (219 663 5810)
Whiting YMCA (219 370 5091)

PROGRAM POLICIES

ACCIDENT/INJURY

Any injury a child receives while in the care of Y staff will be documented in writing and followed by a contact to the parent/guardian in regards to incident.

BEHAVIORAL MANAGEMENT

Our staff will set limits for your child that will encourage responsibility, respect, honesty and caring. We believe that all children are capable of listening, following directions and respecting others. The rules we set and disciplinary measures that we take are for the maintenance of safe order in groups. The following list is a brief statement of our discipline policy:

1) No child shall be insulted, belittled, demeaned or embarrassed. When possible, children will be called from the group and spoken to quietly and directly.
2) No child shall be physically disciplined by staff. However, a child may be restrained (if needed) for safety purposes.
3) Exclusion from participation (Time Out), when used as discipline, shall not exceed ten minutes at any time. Punishments will fit the inappropriate behavior.

BEHAVIORAL WRITE-UPS:

The following offenses will result in an immediate behavioral write-up from the YMCA include but are not limited to:

1. General unwillingness to obey staff or staff requests.
2. Any violent behavior with the intent to harm another staff member or child.
3. Intentional spreading of bodily fluid.
4. Biting
5. Offensive/Inappropriate Language

Upon receiving a behavior write-up, parents will be notified and may be required to pick up their child immediately. After receiving three behavioral write-ups in a program year, the child will be suspended from the program for 3 days. Any behavioral write-up received upon returning from a suspension may result in removal from the program.

CHILD ABUSE

The YMCA takes the importance of the protection and safety of the children involved in its programs very seriously. Child abuse is a special concern of the Y, because of the organizations role in promoting the personal growth and development of children and families. The YMCA will document any incident of abuse in writing and report in accordance with relevant state or local child abuse reporting requirements and will cooperate to the extent of the law with any legal authority involved. The YMCA will not release a child to a parent or any authorized person who appears to be under the influence of drugs or alcohol.

ELECTRONICS POLICY

Parents who wish that their child use a personally owned digital device within Crossroads YMCA Branches and remote sites must read and sign this agreement and submit it to the YMCA with registration paperwork. The student takes full responsibility for his or her device and to keep their device safe at all times. The YMCA is not responsible for the security of the device. The student is responsible for the proper care of their personal device, including any costs of repair, replacement or any modifications needed to use the device at the YMCA. Violations of any YMCA policies or procedures involving a student's personally owned digital device may result in the loss of privilege to use the device in the YMCA and may result in disciplinary action. Full policy and agreement is attached to this registration paperwork.

HOURS

Childcare services are available Before-Out of School Care from 6-8:00am (as signed up for), Core-Out of School program 8:00am-4:00pm and After-Out of School Care 4-6:30pm (as signed up for). **There is an additional fee of $1 for every minute a child is present past 6:30pm.**

ILLNESS POLICY

Children are not authorized to attend Y programming if they have an illness or other contagious symptoms. Once given authorization from a supervisor, staff will have the right to request a doctor's note before a child may return to the Y. Please notify staff immediately if your child displays any symptoms of any communicable diseases or contagious conditions. In order for your child to be allowed to return to the program after being ill, your child must be fever/symptom free for at least 72 hours without medication.

MEDICATION POLICY

The only medications we are authorized to distribute are inhalers and epi-pens with proper documents.

OUTSTANDING BALANCES

All outstanding balances **must** be paid before any childcare services will be provided.

PERSONAL BELONGINGS

Please leave all toys and any other valuables at home. We will follow a schedule of structured activities each day and will not allow children to play with items from home during this time. Anything brought to the Y from home must remain inside your child's back pack. The Y and its staff will not hold or take responsibility for a child's money. The Y and its staff will not be held responsible for any items brought from home that are lost, stolen or broken.

RATIOS

The ratio of staff to children for YMCA childcare programing is 1 staff member to every 15 children. To ensure the safety and proper supervision of all children in our care, children who frequently display behaviors that require staff to deviate from these ratios may be required to be accompanied by a caregiver to remain in the program. While we strive to provide what every child needs to succeed in-group care, we do not have the resources to implement or sustain a plan for managing all behaviors. It is a disservice to maintain a child in our program if we cannot meet the child's individual needs, while maintaining a safe and productive environment for children and staff.

SIGN IN / SIGN OUT

We require that an adult over the age of 18 to accompany each child to the drop off/pick up. Upon pick up parents and any other specified adults on each child's pick up list will be required to show a photo I.D. Anyone who is not listed on your child's pick up list or fails to produce proper identification will not be allowed to leave the building with your child.

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Crossroads YMCA for grades K-6th

INFORMATION RECORD

Please complete and return on or before the day attending

Child's Name: _____

Address: _____City:_____Zip:_____

Home Phone Number: _____Cell Phone: _____

Date of Birth: _____Age: _____ School: _____Grade: _____

Email: _____

Parent / Guardian Name: _____Occupation:_____
Where Employed: _____Business Phone#_____

Parent / Guardian Name: _____Occupation:_____
Where Employed: _____Business Phone#_____

Does your child have any allergies, physical conditions, or special behaviors we should know about?
Please list: _____
_____

Are there any special circumstances that we need to know about to better serve your child? Please list:
_____
_____

Child lives with: ☐ both ☐ mother ☐ father ☐ other_____

DROP-OFF AND PICK-UP LIST RELEASE & EMERGENCY CONTACTS

- Sign child in and out upon drop off and pick up.
- Please supply in writing names of persons who may pick up your child.

Authorized to pick up my child/Emergency Contact Relationship to Child Phone

1._____
2._____
3._____
4._____
5._____
6._____

DENIAL OF PICK-UP

I hereby acknowledge that the Crossroads YMCA will assume that either parent of the child may pick up the child at any time during the program, unless there is **pertinent court documentation on file at the Y** that indicates otherwise.

1._____Relationship_____

2._____Relationship_____

3._____Relationship_____

PHOTO RELEASE

We understand in any event that the youth is photographed for purposes of promoting and publicizing the Crossroads YMCA program, we hereby waive all rights to the photographs in which the child appears. We understand that sole ownership and copyright belong to the Crossroads YMCA. The photographs, may be used whole, in part, or in composite as a program sees fit in publication of education material, and the advertising thereof, and any other lawful purpose.

Signature_____Date_____

PARENT STATEMENT OF UNDERSTANDING

The following information is important for the safety and protection of your child. Please read the information, sign this form and return it to the YMCA. Please keep and refer to your copy of the Crossroads YMCA childcare polices. Your signature below indicates that you have received them.

- I understand that the Y staff and volunteers are not allowed to babysit or transport children at any time outside of the Y program. Immediate disciplinary action will be taken by the YMCA toward staff if a violation is discovered.
- I understand that I am not to leave my child in any Y program unless a Y staff is there to supervise my child.
- I understand that my child will not be allowed to leave the program with any unauthorized person. Any person authorized to pick-up my child must either be listed with the Y or other arrangements must be made by calling the Y office to inform them of a change.
- I understand that should a parent or any unauthorized person arrive to pick up my child who appears to be under the influence of drugs or alcohol my child will not be released into their care.
- I understand that the Y is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- I understand that any belongings brought to the Y by my child are the responsibility of my child only. The Y and its staff will not replace or take responsibility for any lost or broken items.
- I release The Crossroads YMCA from any liability, whatsoever, that may result from injuries and subsequent medical attention and will look to The Crossroads YMCA only in the unlikely event of gross negligence and/or willful and want on misconduct. I hereby grant permission for the staff of the YMCA to take whatever steps necessary to obtain medical care for my child if warranted. These steps include the following: (1) To administer First Aid; (2) To contact parent/guardian or person listed on emergency contact. If necessary, an ambulance will be called to transport the child to an emergency medical center. I understand that I will be held responsible for all medical/ambulance charges.
- **I understand that I must pay all tuition fees/outstanding balances before any services will be provided.**
- Rates and policies are subject to change. All childcare payments are non-refundable.

We do our best to serve every family; however, if a child causes our staff to frequently deviate from our ratio, you may have to send your child with a caregiver. We are unable to accommodate any child that may require one-on-one supervision.

I have read and understand this copy of the Crossroads YMCA childcare policies/procedures and Parent Statement of Understanding.

Signature: _____Date:_____

ANY INFORMATION YOU CHOOSE TO DISCLOSE IS CONFIDENTIAL.

While in program, are there any health conditions that you would like us to be aware of?

☐ No ☐ Yes,_____

While in program, are there allergies that we should be aware of?

☐ No ☐ Yes,_____

Allergic reaction (describe): _____

Are there activities that your child should be exempt from due to health reasons?

☐ No ☐ Yes,_____

Please describe your child's interactions with children of the same age:

_____

How would you describe your child's personality?

_____

Does your child have any fears that we should be aware of?

_____

Is there any other information that you would like to share so that we may better understand and work with your child?

☐ No ☐ Yes,_____

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ELECTRONIC USE POLICY FOR CROSSROADS YMCA

Parents who wish that their child use a personally owned digital device within Crossroads YMCA branches and remote sites must read and sign this agreement and submit it to the YMCA with registration paperwork.

The student takes full responsibility for his or her device and to keep their device safe at all times. The YMCA is not responsible for the security of the device. The student is responsible for the proper care of their personal device, including any costs of repair, replacement or any modifications needed to use the device at the YMCA. Violations of any YMCA policies or procedures involving a student's personally owned digital device may result in the loss of privilege to use the device in the YMCA and may result in disciplinary action. The student must comply with a staff member's request to stop using, shut down, or close the screen of the personal device when asked. Students are not permitted to use any electronic device to record audio or video media or capture still images of any student or staff member without their permission. The distribution of any such unauthorized media may result in discipline including but not limited to suspension, criminal charges, and expulsion. Nor can any images or audio/video recorded at the YMCA be transmitted or posted at any time without the express permission of a staff member. The student should only use their device to access information for educational purposes. The student will use the YMCA's wireless network while on the school campus. Student personally owned digital devices and content including messages and digital photos, may be searched by the staff of the YMCA under limited circumstances. Specifically, staff may search student personally owned devices including accessing and reading of their messages and digital images, if the staff (1) have reasonable suspicion, based on objective and articulable facts, that the search will provide evidence that the particular student was violating either the law or a YMCA rule; and (2) the scope of the search is reasonably related to the objectives of the search and not excessively intrusive in light of the nature of the infraction.

DETACH AND RETURN TO THE YMCA. RETAIN THE INFORMATION ABOVE.

Child's Name: _____

Parent or Guardian's Name: _____

❑ I give my consent for my child to use a personally owned digital device.
❑ I DO NOT GIVE my consent for my child to use a personally owned digital device.

As a parent I understand that my child will be responsible for abiding by the above policy and guidelines. I have read and discussed them with her/him and they understand the responsibility they have in the use of their personal digital device.

Parent's Signature: _____Date: _____

I understand and will abide by the above policy and guidelines. I further understand that any violation of the above may result in the loss of network and/or device privileges as well as other disciplinary action.

Student's Signature: _____Date: _____

Griffith Family YMCA

Special Dietary Needs Form

Complete and submit this form to Griffith Family YMCA. The parent/guardian/adult participant will complete part 1 and 2, and the physician or medical authority (physician's assistant or nurse practitioner) will complete part 3. Refer to the information below for clarification. Attach a sheet with additional information if necessary. If changes are needed, the parent/guardian/adult participant is required to submit a new form.

GUIDANCE

Disability:

USDA requires substitutions or modifications in CACFP meals for participants whose disabilities restrict their diets. The definition of the term "disability" has broadened and nearly all physical and mental impairments constitute a disability.

Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and Departmental Regulations at 7 CFR Part 15b define a person with a disability as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment. (See 29 USC § 705(9)(b); 42 USC § 12101; and 7 CFR 15b.3.) "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (See 29 USC § 705(9)(b) and 42 USC § 12101.)

A physical or mental impairment does not need to be life threatening to constitute a disability. It is enough that the impairment limits a major life activity. Further, an impairment may be covered as a disability even if medication, or another mitigating measure, may reduce the impact of the impairment.

Forms or medical statements for disabilities must be signed by a licensed physician, physician's assistant or nurse practitioner and must identify: the child's medical condition; an explanation of why the disability restricts the child's diet; the major life activity affected by the disability; the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.

Special Dietary Needs That Are Not a Medical Condition:

Food service may make food substitutions for reimbursable meals, at their discretion, for individual children who do not have a disability/medical condition, but who have special dietary needs for other reasons such as religious, cultural, or other preferences when such substitutions meet the meal pattern. CACFP participating organizations are encouraged to accommodate reasonable requests, but are not required to do so. For these requests, the form may be signed by a parent/guardian/adult participant.

The form should include: an identification of the special dietary need that restricts the diet; the food or foods to be omitted; and the food or choice of foods to be substituted.

Part 1. To be completed by a Parent, Guardian, or Authorized Representative		
Participants' Name:		Birthdate: / /
Parent/Guardian/Authorized Representative name:		
Home Phone: ( )	Work Phone: ( )	
Address:		
City:	State:	Zip:

Part 2. Special Dietary Need that is not a Medical Condition	
Describe the participant's special dietary need:	
Foods to be omitted:	Substitutions:
Please list additional information regarding the diet:	
Parent/guardian/adult participant/rep. of adult participant signature	Date

Part 3. Disability/Medical Condition	
Describe the patient's medical condition and the major life activities that are affected:	
Foods to be omitted:	Substitutions:
Please list additional information regarding the diet (including texture changes such as chopped, ground, pureed, etc.):	
Licensed physician, physician's assistant or nurse practitioner signature	Date
Printed name and title	Telephone

CACFP Application for Free and Reduced Price Meals (Child Care)

Sponsor Name:	Phone Number:
Center:	FDC Provider:

Part 1. All Household Members Names of all household (First, Middle Initial, Last)	Birth Dates of Children	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children listed below are foster children, skip to Part 4 to sign this form.	Check if NO income
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Part 2. Benefits: If any member of your household received [Food Stamps] 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: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [Insert center contact and phone number] Homeless ☐ Migrant ☐ Runaway ☐

Part 4. Total Household Gross Income—You must tell us how much and how often Check if NO income ☐

A. Name (List only household members with income)	B. Gross income and how often it was received 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /
	$ /	$ /	$ /	$ /

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

An adult household member must sign this form. If Part 4 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 Privacy Act 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: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

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

_____ Initial here if you consent to allow [Provider's Name] to collect your form and provide it to the Sponsor. [Provider's Name] will not review your form.

Part 6: Other Benefits: The LAS allows us to tell Medicaid and Hoosier Healthwise that your children are eligible for free or reduced price meals. We may share your application information with Medicaid or Hoosier Healthwise unless you do not want us to. If you do not want us to share this information, please sign here:

_____
Signature of Parent or Guardian

For information about Hoosier Healthwise health insurance call 1-800-889-9949

CACFP Application for Free and Reduced Price Meals (Child Care)

A child enrolled in the day care facility may qualify for free or reduced price meals if the household income falls at or below the limits on this chart:

July 1, 2019 to June 30, 2020			
Household Size	Monthly Income	Household Size	Monthly Income
1	1,926	5	4,652
2	2,607	6	5,333
3	3,289	7	6,015
4	3,970	8	6,696
For each additional family member, add $682			

Part 7. Participant's Ethnic and Racial Identities (Optional)

Mark one ethnic identity:	Mark one or more racial identities:
☐ Hispanic or Latino	☐ Asian ☐ American Indian or Alaska Native
	☐ White ☐ Native Hawaiian or Other Pacific Islander
☐ Not Hispanic or Latino	☐ Black or African American

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 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.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW .
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Child Care Representative Use Only

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

Section A *Mark one of the boxes below to show how you are going to determine eligibility.*

☐ Food Stamp or TANF Household—The Food Stamp or TANF number meets the criteria for an acceptable case number. Complete Section B & C

OR

☐ Foster Child—Compare the foster child's personal income to the guidelines. Complete Section B & C

OR

☐ Household Income—Complete the information below and Complete Section B & C

Total Household Size: _____

Total Household Income

$_____ / _____

Example: $100/week

Compare total household income to current USDA Income Eligibility Guidelines. When the household incomes are listed for different pay periods, you must convert all income to monthly or annual income. Use the conversion listed above.

Section B

Based on the information provided, this application will be:

☐ Approved Free ☐ Approved Tier I

☐ Approved Reduced ☐ Approved Tier II

☐ Paid

Use this space for income calculation.

Section C

_____

Signature of Sponsor Representative

_____

Date of Approval

This form expires one year from the date it was approved

Policy Instruction 05-03

ENROLLMENT FORM

IDOE/CACFP
December 2015

Name of Institution_Crossroads YMCA   Sponsor-ID Number 1450012

Name of Facility Griffith Family YMCA

Child's Name: ______________________ **Birthdate:** ______________________

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Please enter the normal hours your child is in care on the specific days of care.							
Please check (√) the meals your child normally receives while in care.	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__	Breakfast___ AM snack___ Lunch______ PM snack___ Supper_____ Night snack__
If your school-age child will be in attendance outside of the regular hours indicated above (snow days, school breaks, etc) Please check (√) here ________							

This information is required by CACFP federal regulations at §226.15 (e)(2) and (3) for each enrolled participant, and must be updated <u>annually</u>.

Printed name of parent/guardian: ______________________ Phone Number: ______________

Signature of parent/guardian: ______________________ Date: ______________

This institution is an equal opportunity provider.

LICENSED CHILD CARE CENTER / HOME CONSENT

State Form 50548 (R2 / 7-08) / BCC 0080

To: Parents of licensed child care programs in Indiana

Subject: Your child's birth certificate and licensed child care programs

Indiana Code 12-17.2-2-1(8) requires each child care center or child care home to record proof of a child's date of birth before accepting the child for care. A child's date of birth may be proven by the child's original birth certificate or other reliable proof of the child's date of birth, including a duly attested transcript of a birth certificate. Refusing to share this information may result in your child's exclusion from a licensed child care program. Sharing the birth certificate information is NOT optional; signing the below is your decision and does not impact your use of child care facilities.

tear here

LICENSED CHILD CARE CENTER / HOME CONSENT

State Form 50548 (R2 / 4-08) / BCC 0080

This portion is to be kept on file at the licensed child care program.

I give my permission for _____ to report the name and date of birth
name of licensed child care program

of my child or children to the Division of Family Resources pursuant to IC 12-17.2-2-1.5.

Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)
Name of child	Date of birth (*month, day, year*)

Signature of parent, guardian, or custodian	Date signed (*month, day, year*)

PARENT'S NOTICE

State Form 49144 (R / 1-09) / BCC 0035

I understand that this day care ministry is not licensed under the laws of Indiana. However, I understand that this day care ministry complies with the State rules concerning sanitation and fire safety for the primary use of the structure in which it is conducted. I understand that it is my responsibility to ensure that the nutritional and health needs of my child are met while my child is at the day care ministry.

Signature of Parent or Guardian

Name(s) of children enrolled

This notice does not absolve a day care ministry from liability for injury to a child while the child is at the day care ministry if the cause of the injury is negligence or intentional wrongdoing on the part of the day care ministry or an employee of the day care ministry.

Name of facility

Address of facility *(number and street, city, state, and ZIP code)*

County

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R4 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)		
Child lives with (*relationship*)	Name	Telephone number ( )

MEDICAL HISTORY			
Communicable Disease	**Month / Year**	**Condition**	**Explain if present**
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date** (*month, day, year*)		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION	
Date of exam (*month, day, year*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

HISTORY OF IMMUNIZATIONS

State Form 49445 (R4 / 4-12)

HISTORY OF IMMUNIZATIONS *(Indicate month and year)*

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
* Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			or Chicken Pox Disease	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
* HEPA		

	1	2	3
HBV (HEP B)			

* Not required but highly recommended.

Name of physician / nurse practitioner completing form *(please print)*	Telephone number ( )
Signature of physician / nurse practitioner	

Name of child	Date of birth *(month, day, year)*	Age
Name of child care facility		County

ADDITIONAL NOTES AND INSTRUCTIONS