Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Dear Parents,

Please take a moment to look over all the information provided to you in this packet. We understand that there are a lot of forms to fill out and this can be time consuming. However, you must have every form in this packet completed and turned into the Infant and Toddler office. The forms in this packet include the following:

- **Admission Information Packet**: Please sign all areas on this form where it is indicated. Each item is very important and either provides you with information from us or provides us with information about you and your child. Please provide name, **complete address**, and telephone number for the emergency contact persons in the area provided on the form. **If something is not applicable for your child just put N/A.**
    - ✓ A medical statement signed by an approved health professional is **required** of all children. This medical statement must be submitted to the office upon admission and before the start of Spring semester for every year that your child attends Moody Early Childhood Center.
    - ✓ Feeding Schedule
    - ✓ Supply List
    - ✓ Tuition and Payment Information
- **Additionally to the Admission Information Packet the following forms must be completed:**
    - ✓ Operational Discipline and Guidance Policy
    - ✓ Operational Policy on Infant Safe Sleep
    - ✓ ***GISD Physician's Diet Modifications (if applicable)***
    - ✓ ***FARE – Food Allergy & Anaphylaxis Emergency Care Plan (if applicable)***
    - ✓ CACFP Enrollment Form
    - ✓ CACFP Meal Benefit Income Eligibility
    - ✓ Infant Declaration Form for infants only ***(if applicable)***
    - ✓ Teen Health Clinic Parent Consent
- You must also provide the following documents:
    - ✓ A copy of your child's **current** immunization record
    - ✓ Child's Birth Certificate
    - ✓ Parent/ Guardian Photo Identification
    - ✓ Proof of Residency
- Parent Ressources **http://moodychildhoodcenter.org/en/resources/parent-portal-info**
    - ❖ Parent Handbook
    - ❖ Pandemic Plan
    - ❖ Calendars
    - ❖ Menu

Thank you so much for providing these forms to us. It will be your responsibility to keep us informed of changes to your information as it occurs. Change of Information forms are available at the front office. If you have any questions about the packet provided to you just give us a call. Again, thank you for choosing Moody Early Childhood Center.

Moody Early Childhood Center

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ADMISSION INFORMATION

NOTE: THIS ENTIRE FORM MUST BE UPDATED SEMI-ANNUALLY

Child's Legal Last Name:	
Child's Legal First Name:	
Child's Legal Middle Name:	
Date of Birth	
Gender	☐ Male ☐ Female
Ethnicity (MUST – check one): ☐ Hispanic ☐ Non-Hispanic	Race (MUST – Check One or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White
Child Lives With	☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian Custody Documents on File: _____
Child's Home Address	
Name of Parent of Guardian Completing Form	

Karin Miller
Executive Director
1110 21st Street
Galveston, Texas 77550

For MECC Use Only

Entry Date _____

Withdrawal Date_____

Tuition _____

Parent/Guardian 1:	**Parent/Guardian 2:**
Name:	Name:
Home Address:	Home Address:
Home Phone:	Home Phone:
Employer/School:	Employer/School:
Employer/School Address:	Employer/School Address:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Authorized to Pick-Up Child: YES ☐ NO ☐	Authorized to Pick-Up Child: YES ☐ NO ☐

AUTHORIZATION FOR RELEASE

Authorized Person other than a parent to whom the child may be released:

1. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
2. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
3. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
4. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____

EMERGENCY CONTACTS

When parents cannot be reached, list at least two people who may be contacted in case of an *emergency*:

1. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
2. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
3. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____
4. Name:	Relationship to Child:
Full Address:	Telephone Home _____ Work _____ Cell _____

SCHOOL AGE CHILDREN

My child attends the following school:

Name of School:	School Phone Number:

My child has permission to (check all that apply):

☐ Walk to or from school or home ☐ ride the bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address:

Signature – Parent of Legal Guardian	Date Signed

CONSENT INFORMATION

Check ALL that apply:

I acknowledge that I have read and understand the facility's Operational Policies/Parent Handbook found at http://moodychildhoodcenter.org/en/resources/parent-portal-info.

☐ Discipline and guidance	☐ Procedures for release of children
☐ Suspension and expulsion	☐ Illness and exclusion criteria
☐ Emergency plans	☐ Procedures for dispensing medication
☐ Procedures for conducting health checks	☐ Immunization requirement for children
☐ Safe sleep	☐ Meals and food service practices
☐ Procedures for parent to discuss concerns with the director	☐ Procedures to visit the center without securing prior Approval
☐ Procedures for parents to participate in operation activities	☐ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website
Signature – Parent of Legal Guardian	Date Signed

CONSENT INFORMATION

MEALS

I understand that the following meals will be served to my child while in care:

☐ Breakfast	☐ Morning Snack	☐ Lunch
☐ Afternoon Snack	☐ Supper	☐ Evening Snack
☐ None		

DAYS AND TIMES IN CARE

My child is normally in care on the following days and times:

Day of the Week	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Signature – Parent of Legal Guardian	Date Signed

CONSENT INFORMATION

Child's Name:

Check ALL that apply:

1. Transportation

I give consent for my child to be transported and supervised by operation's employees:

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips

☐ I give consent for my child to participate in field trips.

☐ I **do not** give consent for my child to participate in field trip

Comments:

3. Water Activities

I give consent for my child to participate in the following water activities:

☐ water table play ☐ on sprinkler play ☐ splashing/wading pools ☐ aquatic playgrounds

4. I ☐ give ☐ do not give Moody Early Childhood Center permission for my child to receive all necessary health and developmental screenings, assessments and laboratory tests required by the program. These may be performed by MECC and GISD staff.

5. I understand that Mental Health professionals will be making routine Mental Health observations at MECC. I hereby ☐ give ☐ do not give my permission for the Mental Health professional to review my child's records and to advise on behavior issues.

6. I ☐ do ☐ do not understand that my child may receive a dental and medical examination and that I will accompany my child for these exams if at all possible. I will receive information on results and needed follow-up.

7. I ☐ give ☐ do not give my authorization for my child's Developmental Screening, Assessment and Summary of Services to be transferred to the public school, if requested by either parent or school.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signature of Parent/Guardian **Date**

PERMISSION TO PHOTOGRAPH

I,_____, give permission for Moody Early Childhood Center to photograph my child,_____, for the following purposes:

Type of Use:	(Please check one) Grant Permission	Decline Permission
Still Photographs:		
Display photos in the child's classroom	◯	◯
Display photos on bulletin boards outside classroom	◯	◯
Display photos on center's bulletin boards, shown to current and prospective students	◯	◯
Display still photos on center's website *	◯	◯
Display photos on center's Facebook page	◯	◯
Use photos in promotions materials	◯	◯
Videos:		
Give video to current parents	◯	◯
Display video on facility website	◯	◯
Use videos in promotional materials	◯	◯
Other (please list):		

** No names of students will be displayed on the facility website, in social media, or video. First names with last initial may be displayed throughout the center to identify student's personal items and work.*

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____

Signature of Parent/Guardian **Date**

CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

If no special needs write **NONE**.

Does your child have diagnosed food allergies? ☐ Yes ☐ No Plan Submitted on

If yes, GISD Physician's Diet Modifications and FARE – Food Allergy & Anaphylaxis Emergency Care Plan must be completed by child's physician and turned in prior to admission.

FARE Submitted on

GISD Physician's Diet Modification Submitted on

Plan Submitted on

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature – Parent of Legal Guardian	Date Signed:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician:	Address	Phone Number:
Name of Emergency Care Facility	**Address:**	**Phone Number:**

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature – Parent of Legal Guardian Date Signed

ADMISSION REQUIREMENT

Child's Name: _____

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Check **only one** option:

1. ☐ **HEALTH CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

Health Care Professional's Signature:	Date Signed:

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. **Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.**

Name of Health Care Professional	Address of Health Care Professional
Signature — Parent or Legal Guardian	Date Signed

A medical statement signed by an approved health professional is required of all children. This medical statement must be submitted to the office before the start of Spring semester for every year that your child attends Moody Early Childhood Center.

A copy of child's current immunization record must be provided upon admission

PANDEMIC PLAN	
I acknowledge that I have read and understand the Pandemic Plan found at http://moodychildhoodcenter.org/en/resources/parent-portal-info.	
Signature – Parent of Legal Guardian	Date Signed

I acknowledge that the information on this enrollment form is complete and accurate.

Signature of Parent/Guardian **Date**

Moody Early Childhood Center

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Discipline and Guidance Policy

Discipline must be:

1) Individualized and consistent for each child;
2) Appropriate to the child's level of understanding; and
3) Directed toward teaching the child acceptable behavior and self-control.

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:

1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
2) Reminding a child of behavior expectations daily by using clear, positive statements;
3) Redirecting behavior using positive statements; and
4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:

1) Corporal punishment or threats of corporal punishment;
2) Punishment associated with food, naps, or toilet training;
3) Pinching, shaking, or biting a child;
4) Hitting a child with a hand or instrument;
5) Putting anything in or on a child's mouth;
6) Humiliating, ridiculing, rejecting, or yelling at a child;
7) Subjecting a child to harsh, abusive, or profane language;
8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures
Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) What behaviors would warrant the use of these measures; and
  - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date _____

Child's name: _____

Signed by: _____

Role: ☐ Parent/Guardian ☐ Caregiver/Employee ☐ Household Member (CH. 747 only)

DFPS Form 1099
Minimum Standards Related to Discipline
- Title 26, Chapter 746 Subchapter L: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y
- Title 26, Chapter 747 Subchapter L http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y
- Title 26, Chapter 744 Subchapter G: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y

Moody Early Childhood Center is a United Way Partner Agency.

The Moody Early Childhood Center is a private nonprofit 501 (c) (3) and does not discriminate on the basis of sex, race, color, national origin, disability, religion or age in the administration of its educational policies, admissions policies, and all other school-administered programs.

TEXAS Health and Human Services

Form 2550
October 2019-E

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at Moody Early Childhood Center and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Safe Sleep Policy

All staff, substitute staff, and volunteers at Moody Early Childhood Center will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415(b) and §747.2315(b)]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415(b) and §747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing _____(insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415(b) and §747.2315(b)].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2428 and §747.2328].

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

Signatures

This policy is effective on: _____ Child's name: _____

_____ Signature — Director/Owner

_____ Date Signed

_____ Signature — Staff member

_____ Date Signed

_____ Signature — Parent

_____ Date Signed

Child Assessment Form

Child Name (last, first, middle)		Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)		City	County	Zip
Mailing Address (if different) -- Street or P.O. Box		City	County	Zip
Telephone No. (include A/C)				

* If applicable.

1. Health

Does your child have any allergies?	☐ Yes	☐ No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

3. Behavior:

Does your child have any special fears?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	

4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?		☐ Yes	☐ No

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	

I verify that the above assessment was discussed with the parent(s) of _____

_____

_____

_____ _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

_____ _____

Signature of Parent Date Signed

Additional Comments:

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

This form must be completed by a medical provider

CHILD HEALTH STATEMENT FOR CHILD CARE

AT

MOODY EARLY CHILDHOOD CENTER

(Doctor's office may use their own form or this form)

Doctors may fax the form to **(409) 750-7177**

This is to certify that I have examined_____(print child's name)

on_____(date), and found him/her to be healthy, free of contagious disease and able to participate in school/daycare activities.

Health Care Professional Name _____

Health Care Professional Contact Information

_____

_____

_____

Health Care Professional Signature _____

The Moody Early Childhood Center is a private nonprofit 501 (c) (3) and does not discriminate on the basis of sex, race, color, national origin, disability, religion or age in the administration of its educational policies, admissions policies, and all other school-administered program

Moody Early Childhood Center

Health Services Form

Student's Name _____ Date of Birth ___/___/___ Grade _____
Home Address _____

EMERGENCY COTACT NUMBERS

Mother/Guardian Name _____ Home Phone No. _____
Cell No. _____ Work No. _____ Email _____
Father's Name _____ Email _____
Cell No. _____ Work No. _____
Other Emergency Contact Name: _____ Phone No. _____
Other Emergency Contact Name: _____ Phone No. _____

INDICATE ANY THAT Y OUR CHILD HAS HAD

Please explain checked items on separate sheet of paper

	Heart disease/murmur		**Neurologic problem**		**Seizures/convulsion**
	Kidney disease		**Diabetes**		**Rheumatic Fever**
	Asthma (mild or severe)		**Lung problem**		**Chicken pox, date____**
	Muscle/bone problem		**Tuberculosis**		**Frequent headaches**
	Weight loss or gain		**Fainting spells**		**Serious accident**
	Overactive		**Dizziness**		**Special needs**
	Hearing/speech problems/tubes		**Frequent behavior problems**		**Dental problems**
	Operations		**Glasses/vision problems**		**Other**
	Allergy _____				**EPI-PEN**

List any medications your child takes at home/school _____
List any other medical problems not listed above _____

List other sibling attending MECC or other GISD school

Name	School	Grade

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. YES____ NO___

I give my permission to exchange information with my child's physician/counselor for the purpose of referral, diagnosis, and treatment. YES _____ NO _____

I give permission for my child to receive over the counter medication if I as the parent provides the medication to the school in the original container along with my written consent. YES _____ NO _____

EMERGENCY MEDICAL CARE: I give my permission for the above mentioned child to be given emergency medical or surgical management (indicated diagnostic studies and treatment) at the Emergency Room in the event the parent or guardian cannot be located.

Parent/Guardian Signature _____ Date _____

Galveston ISD Child Nutrition Department
409-766-5162 (Fax) 409-766-7040

FAX TO: 409-766-7040 ATTN: Jennifer Douglas

PHYSICIAN'S DIET MODIFICATIONS

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals.

Parent/Guardian Name_____ Student Name_____
Campus Name_____ Date of Birth _____
As parent or guardian, I give **permission for Galveston ISD to contact the Physician's office** regarding my child's dietary needs. _____(Signature)

PART A – STUDENTS WITH LIFE THREATENING FOOD ALLERGIES ONLY COMPLETE THIS PART

(If there is NO LIFE THREATENING FOOD ALLERGY, SKIP THIS SECTION, and GO TO PART B on back of page)

PHYSICIAN'S STATEMENT Date _____

I_____**, (physician) declare the child listed above to possess**
Physician's Name (please PRINT)
the following LIFE THREATENING FOOD ALLERGY.

1. Life threatening food allergy – Omit these foods:
____fluid milk ____peanuts ____tree nuts ____eggs ____fish ____shellfish ____wheat ____soy

2. Can the student consume foods where the allergen is an ingredient in the food product? _____yes _____no
(Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed)
Explain_____

3. Other life threatening food allergies (list all) – Omit these foods:
_____

4. Explanation of why this disability restricts diet: _____

5. Major life activity affected by the life threatening food allergy (check all that apply):
(NOTE: .Galveston cannot honor this document unless at least one life activity is marked.)
_____eating ____caring for one's self ____performing manual tasks ____walking ____seeing
_____hearing ____speaking ____breathing ____learning

6. Foods to Substitute *(NOTE: .Galveston ISD cannot honor this document unless substitutions are listed below.)*
_____

_____
Physician's Signature

_____ _____
Telephone Clinic/Facility Name & Address

Galveston ISD Child Nutrition Department
409-766-5162 (Fax) 409-766-7040

FAX TO: 409-766-7040 ATTN: Jennifer Douglas

The U.S. Department of Agriculture School Meals Program requires that ALL QUESTIONS BE ANSWERED in order for ANY diet modification or substitution to be made in school meals. _____Campus _____

Parent/Guardian Name_____Student Name_____Date of Birth_____
As parent or guardian, **I give permission for Galveston ISD to contact the Physician's office** regarding my child's dietary needs. _____(Signature)

PART B – STUDENTS WITH DISABILITIES COMPLETE THIS PHYSICIAN'S STATEMENT

Date _____

I_____**, (physician) declare the child listed at top of page to possess**
Physician's Name (please PRINT)
the following DISABILITY.

1. List any disability requiring meal modification: _____

2. Explanation of why this disability restricts diet: _____

3. Major life activity affected by the DISABILITY (check all that apply):
(NOTE: Galveston ISD cannot honor this document unless at least one life activity is marked.)
_____eating ____caring for one's self ____performing manual tasks ____walking ____seeing
_____hearing _____speaking ____breathing ____learning ____other, specify_____

4. Foods to Omit:

_____
_____
_____

5. Foods to Substitute *(NOTE: Galveston ISD cannot honor this document unless substitutions are listed below.)*

_____
_____

_____
Physician's Signature

_____ _____
Telephone Clinic/Facility Name & Address

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

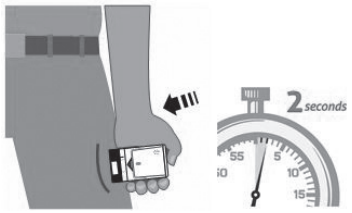
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

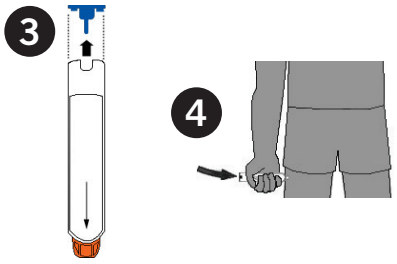
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



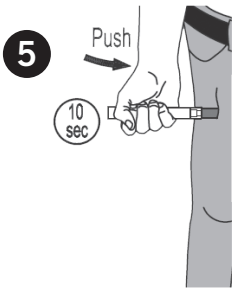
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 1/2019

Child's Name _____ Child's Birthday _____ Date Plan Completed _____

Meals:

Is your child on formula or milk? _____

What type of formula/milk is used? _____

Amount of formula/milk to be given: _____

Approximate Times and Amounts of Feedings:

Time	**Amt**
_____	_____
_____	_____
_____	_____
_____	_____

Moody Early Childhood Center

Instructions for the introduction of solid foods:

Food likes:

Food dislikes:

Breakfast_____ (approximate time)
Type and approximate amount of food:

Lunch _____ (approximate time)
Type and approximate amount of food:
If yes, when? _____

Dinner _____ (approximate time)
Type and approximate amount of food:

NAPS:

Does child take a pacifier? ☐ Yes ☐ No

Morning Nap _____ (approximate time)
Afternoon Nap _____(approximate time)

Parent/Guardian Signature_____ Date_____

*Infant feeding plan needs to be updated **every month**, or as needed, regarding adding new foods or other dietary changes with a new parent/guardian signature and date. Feeding schedules are required to be visibly posted in room.*

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Supply List for Infant and Toddlers

Infant (0-9 Months)	Toddler (10-12 Months)	Toddler (12-17 Months)	Toddler (18+ Months)
2 Bottles of Clorox Wipes	2 Bottles of Clorox Wipes	2 Bottles of Clorox Wipes	2 Bottles of Clorox Wipes
2 Bottles of Lysol Spray	2 Bottles of Lysol Spray	2 Bottles of Lysol Spray	2 Bottles of Lysol Spray
2 Bottles of Hand Sanitizer	2 Bottles of Hand Sanitizer	2 Bottles of Hand Sanitizer	2 Bottles of Hand Sanitizer
2 Boxes of Kleenex	2 Boxes of Kleenex	2 Boxes of Kleenex	2 Boxes of Kleenex
2 Boxes of Wipes – As Needed	2 Boxes of Wipes – As Needed	2 Boxes of Wipes – As Needed	2 Boxes of Wipes – As Needed
2 Bottles of Hand Soap	2 Bottles of Hand Soap	2 Bottles of Hand Soap	2 Bottles of Hand Soap
1 Box of Non Latex Gloves	1 Box of Non Latex Gloves	1 Box of Non Latex Gloves	1 Box of Non Latex Gloves
Diapers	Diapers	Diapers/Pull-Ups	Diapers/Pull-Ups
Bottles	Sippy Cups	Sippy Cups	Sippy Cups
Full Change of Clothes	Full Change of Clothes	Full Change of Clothes	Full Change of Clothes
Formula/Distilled Water	Bibs	Any Personal Items	Any Personal Items
Bibs	Any Personal Items		
Baby Food/Utensils			
Pacifiers			
Any Personal Items			
All –in- All PJ's			

The Moody Early Childhood Center is a private nonprofit 501 (c) (3) and does not discriminate on the basis of sex, race, color, national origin, disability, religion or age in the administration of its educational policies, admissions policies, and all other school-administered programs.

Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Tuition and Payment Information

Tuition is based on enrollment not attendance

- 6 weeks to 23 months $195 a week or $780 a month
- 24 months to 3+ $165 a week or $660 a month
- After School PK3 or PK4 $65 a week or $260 a month
- Pre-K 3 $430 a month
- Holiday Care for After School Care Students $150 a week

MECC will offer a 25% discount for siblings. The 25% reduction will be taken from the tuition of the oldest child attending.

Payments may be made on a weekly or monthly basis. Payments are made through **bill.com** account.

- **Weekly Tuition:** Payments are due by the close of the business day on Monday. Payments not received by the close of day will incur a late fee of $20 that will be added to the tuition payment. An additional $20 will be added each additional week the outstanding balance is not paid in full.
- **Monthly Tuition:** Payments are due by closing on the first business day of each month. Payments not received by the close of day will incur a late fee of $20 that will be added to the tuition payment. An additional $20 will be added each additional week the outstanding balance is not paid in full.

- Illness: Refunds or credits will not be issued for illnesses
- Vacations: (For students in the Infant & Toddler program only), refunds or credits will not be issued for vacations that are less than 2 weeks in duration. For vacations for 2 weeks or more…
  - Parent/guardian must give a note to the Director of Administrative Services at least 2 weeks prior to a vacation
  - Tuition may be reduced to half price for the time the child is on vacation.
- Holidays: Refunds or credits will not be given for holiday closings
- Inclement weather closings: Refunds or credits will not be given for inclement weather closings

Check One…

☐ **Option 1: I/We prefer to pay weekly (due on Monday of each week).**

☐ **Option 2: I/We prefer to pay monthly (due on the 1st of each month).**

I have read and understand the above information and agree to adhere to the policies throughout the school year.

Parent/Guardian Signature_____ Date_____

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Moody Early Childhood Center

"Giving all Galveston children the opportunity to soar"

Financial Assistance

For those families requesting financial assistance, the Moody Early Childhood Center, will be collaborating with Workforce Solutions. To see if you meet eligibility requirements, go to **https://www.wrksolutions.com/for-individuals/financial-aid/financial-aid-for-child-care .**

To be eligible for MECC financial assistance, you must:

- Complete MECC Scholarship application **http://moodychildhoodcenter.org/en/resources/parent-portal-info**
- Submit the required scholarship documents
- Complete and submit a Financial Aid/Services application through Workforce Solutions **https://www.wrksolutions.com/for-individuals/financial-aid/financial-aid-for-child-care .**
- Be placed on the Workforce Solution waiting list
- Be approved for MECC Scholarship
- Pay your child's temporary tuition rate until approval from Workforce is received and/or scholarship ends
- Meet weekly with your designated MECC family advocate.
- Adhered to the scholarship parent agreement requirements

Please understand your tuition rate may increase or decrease once your receive subsidy.

Any questions please call (409) 761-6930.

CACFP STUDENT ENROLLMENT

CM-1500

Moody Early Childhood Center **participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to annually review and make changes to enrollment data.**

CHILD INFORMATION

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M-F
M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU

Normal Hours in Care
Center's Hours of Operation: 7:00 AM - 6:30 PM
☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: AMS PMS
BRK ☐ AMS ☐ LUN ☐ PMS ☐ SUP ☐ EVS ☐

Ethnic Identity (Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
☐ White
☐ Black / African American
☐ Am. Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander

Gender
☐ Male
☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: __/__/____
Re-Enroll Date __/__/____

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M-F
M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU

Normal Hours in Care
Center's Hours of Operation: 7:00 AM - 6:30 PM
☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: AMS PMS
BRK ☐ AMS ☐ LUN ☐ PMS ☐ SUP ☐ EVS ☐

Ethnic Identity (Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
☐ White
☐ Black / African American
☐ Am. Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander

Gender
☐ Male
☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: __/__/____
Re-Enroll Date __/__/____

Center Enroll Date ☐☐ / ☐☐ / ☐☐☐☐

Child's First Name

Child's Last Name

Child's Birth Date ☐☐ / ☐☐ / ☐☐☐☐

Normal Days in Care
Center's Days of Operation: M-F
M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU

Normal Hours in Care
Center's Hours of Operation: 7:00 AM - 6:30 PM
☐ AM ☐ PM to ☐ AM ☐ PM

Meals/Snacks Child Receives
Meals/Snacks Served at Center: AMS PMS
BRK ☐ AMS ☐ LUN ☐ PMS ☐ SUP ☐ EVS ☐

Ethnic Identity (Check One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Racial Identity (Check all that apply)
☐ White
☐ Black / African American
☐ Am. Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander

Gender
☐ Male
☐ Female

SITE / SPONSOR USE ONLY
Withdrawal Date: __/__/____
Re-Enroll Date __/__/____

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature _____ **Date** _____

Parent First Name

Parent Last Name

Cell Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐

SITE / SPONSOR USE ONLY

Non – Discrimination Statement

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: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, 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 (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; This institution is an equal opportunity provider.

Moody Early Childhood Center

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. Moody Early Childhood Center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Meal Benefit Form for each of my children in day care?** You may complete and submit one CACFP Meal Benefit Income Eligibility Form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to the child care center's director.**

2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) can get free meals. Foster children (reference question #8 for more information on foster children) and children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) and have not entered kindergarten) are also eligible for free meals. Households with children enrolled in a HSP, EHSP or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

3. **Who can get reduced price meals?** Your children can get low cost meals if your household income is within the reduced price limits on the Income Chart, sent with this application. Children in households participating in WIC may be eligible for reduced price meals.

4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.

5. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.

6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

8. **What if I have foster children?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, *Placement Authorization Foster Care/Residential Care*, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

10. ***(Pricing program only)*** **Will the information I give be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?**

You can talk to Amy Pringle, either in person or by telephone at (832) 282-1351. You may ask for a hearing by calling or writing to Max Taylor, Advance Child Care, Inc.; 523 West First Ave; Corsicana, Texas 75110, (903)872-5231.
In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call Amy Pringle at (832) 282-1351.

Sincerely,
Antonio Ford,

Texas Department of Agriculture

Form H1625-A
March 2021

Income Eligibility Guidelines for Determining Free or Reduced-Price Benefits July 1, 2021 – June 30, 2022

Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.

Ingresos máximos para determiner la elegibilidad para beneficios gratuitos o a precio reducido 1 de julio de 2021 - 30 de junio de 2022

Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	$23,828	$1,986	$993	$917	$459
2	$32,227	$2,686	$1,343	$1,240	$620
3	$40,626	$3,386	$1,693	$1,563	$782
4	$49,025	$4,086	$2,043	$1,886	$943
5	$57,424	$4,786	$2,393	$2,209	$1,105
6	$65,823	$5,486	$2,743	$2,532	$1,266
7	$74,222	$6,186	$3,093	$2,855	$1,428
8	$82,621	$6,886	$3,443	$3,187	$1,589
For each additional family member add:	$8,399	$700	$350	$324	$162

Center Name
Moody Early Childhood Center

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	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 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME: _____ ELIGIBILITY NUMBER: _____

Part 3. (Applies only to parents/guardians with children enrolled in a day care home) If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME _____ ELIGIBILITY NUMBER: _____

Check here if no eligibility number ☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	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	$200/bi-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 next 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: * * * - * * - _ _ _ _ ☐ I do not have a Social Security Number

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. 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
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

☐ **I do elect to allow my household information to be disclosed.**

☐ **I do not elect to allow my household information to be disclosed.**

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

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

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

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) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

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: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, 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;

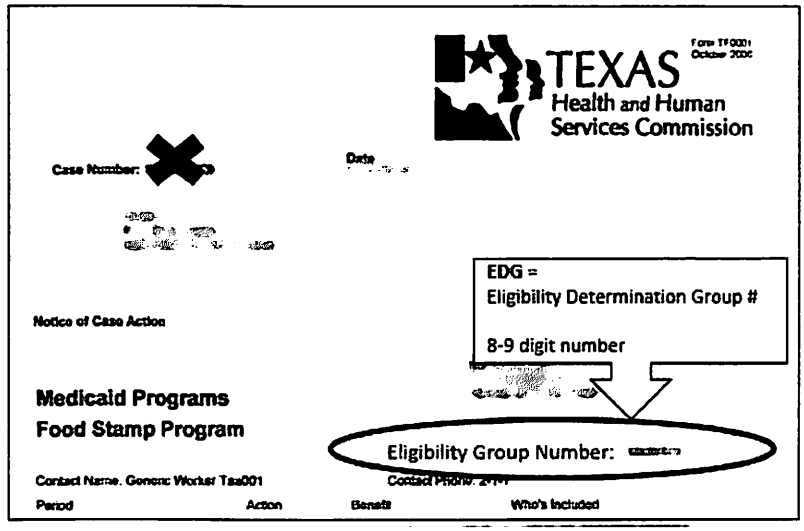
(2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

INSTRUCTIONS FOR
CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM
(CHILD CARE)

Follow these instructions, if your household gets SNAP, TANF or FDPIR:

Part 1: List all enrolled children and household members.
Part 2: List the eligibility number for any household members (including adults) receiving SNAP or TANF or FDPIR benefits. The SNAP or TANF number must be the 8 or 9 digit EDG# assigned by HHSC (see image).
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.



If you are applying on behalf of a FOSTER CHILD, follow these instructions:

If **all** children you are applying for are foster children, or if you are only applying for benefits for the foster child:

Part 1: List all foster children. Check the box indicating that the child is a foster child.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Skip this part.
Part 5: Sign the form. A Social Security Number is **not** necessary.
Part 6: Answer this question if you choose.
Part 7: Answer this question if you choose.

If some of the children in the household are foster children.

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster child.
Part 2: If the household does not have an eligibility number, skip this part.
Part 3: **Applies only to parents/guardians of children in Tier II Day Care Homes**. Sponsors must provide the *List of Eligible Federal/State Funded Programs* (H1660), with this form to households with children enrolled in Tier II Day Care Homes. Parents/Guardians can enter the program name and number as applicable.
Part 4: Follow these instructions to report total household income from this month or last month.
Column A – Name: List only the first and last name of **each** person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and **other deductions. You should be able to find it on your stub or your boss can tell you.**

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, TANF, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box."

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. *For ONLY the self-employed, report income after expenses in Box 1*. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children. Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's Child and Adult Care Food Program

Questions? Concerns?

Call USDA at
1-866-873-2263

OR

Food and Nutrition at
1-800-TELL-TDA
(835-5832)

Your child care at *Moody Early Childhood Center*

Contact Information

Address: *1110 Moody AVE, Galveston, TX 77550*
Phone Number: *409-370-0284*
Email Address: *cacfpinfo@advcc.org*

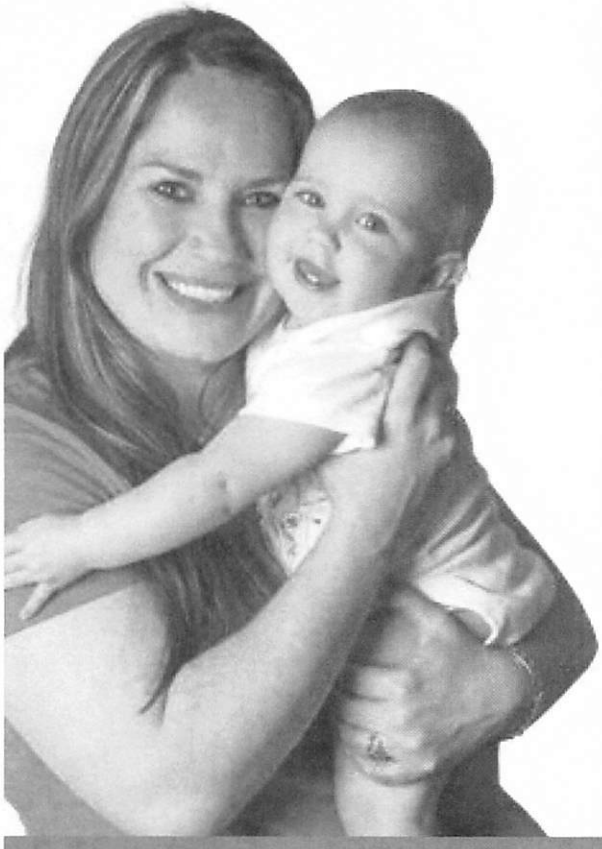
Fraud Hotline: 1-866-5-FRAUD or 1-866-537-2834
P.O. Box 12847 Austin TX 78711
www.SquareMeals.org
USDA is an equal opportunity provider and employer.

Join Texas WIC

We're here for you

"Thanks to WIC, I now have the tools I need to make sure my family stays on the path to a healthy lifestyle."

—Roxie, WIC Client



As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	$2,686	$32,227
3	$3,386	$40,626
4	$4,086	$49,025
5	$4,786	$57,424
6	$5,486	$65,823

Effective May 1, 2021

* A pregnant woman's household is increased by the number of infants she is expecting. If you have any income questions, call 1-800-942-3678.

Start now. Call 1-800-942-3678 or visit TexasWIC.org

TEXAS Health and Human Services | TEXAS WIC

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