Dear PreK Applicants:

PreK applications will be accepted beginning March 4, 2024, for students ages 3 and 4 years old by August 1.

Please note: Your application is not approved until you receive a letter of acceptance in the mail. Please ensure your address is correct to prevent miscommunication. Acceptance of the PreK application is not a guarantee of acceptance to the NLRSD ABC PreK program. PreK applications will not be processed until all required documents have been submitted. Families must qualify based on Arkansas Better Chance Grant requirements. Slots are limited.

Should you have any questions or need any assistance please contact our PreK department at 501-771-8170.

Eligibility for PreK

Eligible children for the ABC program shall have at least one of the following characteristics:

- Family with gross income not exceeding 200% of FPL (see chart)
- Parents without a high school diploma or GED
- Low birth weight (Below 5 pounds 9 ounces)
- Parent under the age of 18 at the time of the child's birth
- Immediate family member with documented history of substance abuse/addiction
- Child has a developmental delay that was identified through screening
- Eligible for services under IDEA
- Limited English Proficiency
- Parent has a history of abuse or neglect or is a victim of abuse or neglect (documented)

An age eligible child who falls into one of the following categories shall be exempt from family income requirements:

- Foster Child
- Child in custody of or living with a family member other than the mother or father
- Child with immediate family member arrested for or convicted of drug-related offenses
- Child with parent activated for overseas military duty

2024-2025 school year age requirements must be met for enrollment

Children enrolling in a four year old class, must be 4 on or before August 1, 2024.

- Birth date ranges from 8/2/2019-8/1/2020

Children enrolling in a three year old class, must be 3 on or before August 1, 2024.

- Birth date ranges from 8/2/2020-8/1/2021.

Family Size	200%FPL
2	$39,440
3	$49,720
4	$60,000
5	$70,280
6	$80,560
7	$90,840
8	$101,120

For families/households with more than 8 people, add $5,140 for each additional person.

Pre-Kindergarten Registration Checklist

The following items are required for processing:

- ☐ Completed Pre-Kindergarten Eligibility Checklist
- ☐ Completed ABC Application
- ☐ Completed Student Health Form
- ☐ Proof of Income (1 month of income) Ex. Paycheck Stubs (must be consecutive), 2023 W-2 form, Tax Return, Etc.

★Must Meet 200% of Poverty Guidelines or

- ☐ Verification of Zero Income Form

- ☐ Child's Birth Certificate
- ☐ Child's Up-To-Date Immunization Record
- ☐ Child's Social Security Card *(if applicable)*
- ☐ Child's Medicaid/ARKIDS Card *(if applicable)*
- ☐ Proof of Address or
  - ☐ Verification of Residence Form
- ☐ Completed EPSDT(1) Well Child Screening Form *(only the provided form will be accepted)* - To be completed by a healthcare provider.
- ☐ Completed EPSDT(2) Well Child Screening Form - To be completed by parent / caregiver
- ☐ Legal Documents pertaining to student's medical, safety, and/or custody issues
- ☐ Documentation of receiving Special Services (Ex. Speech, OT, PT, Behavior, Cognitive)

Parents are responsible for notifying the NLRSD PreK Office at 501-771-8170 of any changes in address or phone number.

NORTH LITTLE ROCK SCHOOL DISTRICT

Early Childhood Program

Pre-K Student Application

2024 - 2025 SCHOOL YEAR

PRE-K OFFICE USE ONLY:
Possessed By:
Date All Components Completed:

3 YR-OLD **4 YR-OLD**

APPLICANT (CHILD) NAME: _____

PRIMARY CAREGIVER INFORMATION (IN HOUSEHOLD WITH CHILD APPLICANT

NAME OF PARENT/GUARDIAN (First, middle last):			
DATE OF BIRTH:	GENDER:		
CURRENT STREET ADDRESS:			
CITY:	STATE:	ZIP CODE:	COUNTY:
START DATE AT THIS ADDRESS:	HAS FAMILY MOVED IN PREVIOUS 24 MONTHS?	OWN ___ RENT___ LIVE WITH FAMILY ____	
HOME PHONE:	CELLULAR #:	EMERGENCY #:	EMAIL:
PRIMARY LANG.:	OTHER LANG.:	LANG. SPOKEN AT HOME:	INTERPRETER NEEDED:
RACE:	ETHNICITY:	LEVEL OF EDUCATION (HIGH SCHOOL, COLLEGE, OTHER)	
DISABLED:		MARITAL STATUS:	
EMPLOYMENT STATUS:	NAME OF EMPLOYER OR SCHOOL:		
WORK/SCHOOL ADDRESS:	CITY:	STATE:	ZIP CODE:
WORK/SCHOOL TELEPHONE:		ANNUAL EARNED INCOME:	

SECONDARY CAREGIVER INFORMATION (IN HOUSEHOLD WITH CHILD APPLICANT AND PRIMARY CAREGIVER)

NAME OF PARENT/GUARDIAN (First, middle last):			
DATE OF BIRTH:	GENDER:		
CURRENT STREET ADDRESS (Must be the same as Primary Caregiver):			
CITY:	STATE:	ZIP CODE:	COUNTY:
START DATE AT THIS ADDRESS:	HAS FAMILY MOVED IN PREVIOUS 24 MONTHS?	OWN ___ RENT___ LIVE WITH FAMILY ____	
HOME PHONE:	CELLULAR #:	EMERGENCY #:	EMAIL:
PRIMARY LANG.:	OTHER LANG.:	LANG. SPOKEN AT HOME:	INTERPRETER NEEDED:
RACE:	ETHNICITY:	LEVEL OF EDUCATION (HIGH SCHOOL, COLLEGE, OTHER:	
DISABLED:		MARITAL STATUS:	
EMPLOYMENT STATUS:		NAME OF EMPLOYER OR SCHOOL:	
WORK/SCHOOL ADDRESS:	CITY:	STATE:	ZIP CODE:
WORK/SCHOOL TELEPHONE:		ANNUAL EARNED INCOME:	

NORTH LITTLE ROCK SCHOOL DISTRICT

PRESCHOOL PROGRAM

Preschool Program Student Application

2024-2025 SCHOOL YEAR

APPLICANT (CHILD) NAME: _____

HOUSEHOLD INFORMATION

DOES FAMILY RECEIVE FOOD STAMPS (SNAP)?	NUMBER IN HOUSEHOLD:	NUMBER IN FAMILY:

LIST THE NAMES **AND** RELATIONSHIP TO CHILD APPLICANT OF ALL HOUSEHOLD MEMBER: ONLY FAMILY MEMBERS ARE UTILIZED FOR ELIGIBILITY

NAME	AGE / SCHOOL (IF APPLICABLE)

CHILD APPLICANT INFORMATION

COMPLETE INFORMATION IS NEEDED: HEALTH/OTHER PROBLEMS DO NOT DISQUALIFY CHILDREN

NAME OF CHILD APPLICANT (First, Middle, Last)			
DATE OF BIRTH:	GENDER:	RACE:	ETHNICITY:
SOCIAL SECURITY #:	IS THIS CHILD A UNITED STATES CITIZEN?		
DOES THIS CHILD LIVE WITH THE PRIMARY AND SECONDARY CAREGIVER?			
DID THIS CHILD ATTEND A STATE-FUNDED PRESCHOOL BEFORE? (ABC/VOUCHER/HIPPY)?			
IF SO, WHERE AND WHEN?			
IS THIS CHILD CURRENTLY ENROLLED AT ANOTHER PRESCHOOL PROGRAM? (HEADSTART, PRIVATE, OTHER)			
IF SO, WHERE?			
HAS THIS CHILD BEEN DISMISSED FROM ANOTHER PRESCHOOL PROGRAM(S) DUE TO ANY PROBLEMS EXPERIENCED?			
IF SO, WHERE AND WHEN?			
PRIMARY LANGUAGE:		OTHER LANGUAGE:	
LANGUAGE USUALLY SPOKEN AT HOME:		CHILD'S LEVEL OF SKILL IN ENGLISH LANGUAGE:	
MEDICAL INSURANCE (LIST)		DOES CHILD HAVE ANY HEALTH PROBLEMS?	
IS THIS CHILD RECEIVING SPECIAL EDUCATION SERVICES?		IS THIS CHILD IN FOSTER CARE?	

Signature: _____ Date: _____

North Little Rock School District

2400 Willow Street • North Little Rock, Arkansas 72114 • (501) 771-8000 • www.nlrsd.org

SCHOOL SELECTION

Applications are **not** processed on a first come, first serve basis. Children are placed according to need and the number of qualifying factors they have.

Four year olds (children that are 4 by August 1) have priority for Pre-K slots in elementary schools. Any slots that have not been filled by June 30 will be offered to three year olds (children that are 3 by August 1).

Please indicate your school selection by ranking them 1st, 2nd, etc. We will do our best to place your child at one of your first choices; however, the more choices there are, the more likely your child will be placed. Please do not rank any school that you are unwilling to attend. We will notify parents of children that were not placed at one of their choices once we have finished placing all other children.

Parents are responsible for notifying the Early Childhood Office at (501) 771-8170 of any changes in address, phone number, and/or income.

THREE AND FOUR YEAR OLDS:

Place a "1" by 1st Choice, "2" by 2nd Choice, and "3" by 3rd Choice.

You may rank as many schools you want as long as you are willing and able to transport your child to that side. **The North Little Rock School District does not transport Pre-K children.**

Please indicate below where you want your child to attend for the **2024 - 2025** school year:

_____ Amboy Elementary Pre-K _____ Boone Park Elementary Pre-K

_____ Glenview Elementary Pre-K _____ Meadow Park Elementary Pre-K

_____ Seventh Street Elementary Pre-K

_____ Pike View Early Childhood Center

Your child's teacher will contact you in August to set a time for you to come see your child's classroom and meet his/her teachers.

** If you have a teacher preference indicate here: _____

Arkansas Department of Education
Division of Elementary and Secondary Education

ARKANSAS BETTER CHANCE PROGRAM
WELL CHILD SCREENING (EPSDT) FORM

To Parent or Guardian:
In order to provide the best learning experience for your child, the teacher must understand your child's health needs. State regulations require any child enrolled in the Arkansas Better Chance Pre-K Program to have a well child check-up. In addition, the child must be current on all required immunizations. Please complete section "Part-I" of the form, sign it and give to your child's physician or licensed nurse practitioner. Once the form is completed and signed on both sides, return the form to your Pre-K program.

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

Address, City and Zip Code

Name of Pre-K Program Where Enrolled	Pre-K Program Phone Number

Type of Health Insurance	
☐ AR Kids A	☐ Private Insurance
☐ AR Kids B	☐ Other:

Part I – To be completed by parent or guardian before well child screening.

Check answers to the following questions. Explain any "yes" answers in the space provided.

	Yes	No	
1.	☐	☐	Do you have any concerns about your child's general health?
2.	☐	☐	Has your child been diagnosed with any chronic disease (such as asthma or diabetes)?
3.	☐	☐	Does your child have any allergies (like to food, medicine, dust)?
4.	☐	☐	Does your child take any medications (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech?
6.	☐	☐	Has your child had any hospitalization, operation, major illness or injury?
7.	☐	☐	In the past 12 months, has your child experienced any difficulty with wheezing or night coughing?
8.	☐	☐	In the past 12 months, has your child experienced excessive weight loss or weight gain?
9.	☐	☐	Has your child had a dental examination in the last 12 months?
10.	☐	☐	Would you like to discuss anything about your child's health with the health care provider?

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent/Guardian Permission and Release:
I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled in the Arkansas Better Chance program.

Signature of Parent/Guardian _____ Date _____

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:

This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part II – To be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight	Height	BMI	Temp	Blood Pressure
lb. %ile	in. %ile	%		/

History Update

☐ Yes ☐ No Any changes in patient health since last visit? Explain: _____
☐ Yes ☐ No Any family history of heart disease for anyone under 55 years of age?
☐ Yes ☐ No Any family history of abnormal cholesterol?

Health

☐ Good appetite
☐ Drinks low-fat milk
☐ Encourage diet of fruit and vegetables
☐ Limits fast food
☐ Picky or variable eater
☐ Brushes teeth, sees dentist

Social and Behavioral

☐ Parents discipline appropriately
☐ Dresses self, helps at home
☐ TV and video games are limited
☐ Praised for good behavior
☐ Has friends & playmates

PHYSICAL EXAM

	Norm	Abnormal
General		
Head		
Neck		
Eyes		
Ears		
Nose		
Throat		
Mouth		
Teeth		
Lungs		
Heart		
Femoral Pulses		
Genitals		
Extremities		
Gait		
Spine		
Skin		
Neuro		

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision Test type:	L_____ R		
Hearing Test type:			
TB Risk: Yes / No			
Hemoglobin Risk: Yes / No			
Cholesterol Risk: Yes / No	mg/dL		

Immunizations

☐ Yes ☐ No All immunizations are current.
☐ Yes ☐ No Child has had all immunizations possible at this time.
Child needs: ☐ DTaP ☐ IPV ☐ HepB ☐ HiB ☐ MMR ☐ Varivax ☐ PCV-7 at_____years/_____months

Referrals

Follow up visit needed in _____ weeks / months
Return check at_____years_____months
Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions

Well child, normal growth and development

_____

_____, MD / DO / NP

Date_____

CLINIC INFORMATION (or stamp)

Name_____
Address_____
City_____
Zip Code_____Phone_____

Revised 06-2022

STUDENT HEALTH HISTORY

Name: _____ **Grade:**_____ **Age:** _____ **Birthdate:** _____

Parent/Guardian_____

Address: _____ **Best Number:** _____

Home Number _____ **Cell Phone** _____ **Work Phone:** _____

Student's Doctor_____ **Doctor's Phone #**_____

History

Does this child have a history of any of the following health concerns:

- ❑ Diabetes _____ ❑ Asthma/Lung problem _____
- ❑ Seizures _____ ❑ High Blood Pressure_____
- ❑ Heart Disease_____ ❑ Cystic Fibrosis _____
- ❑ Irregular Heart Beat_____ ❑ Fainting Spells _____
- ❑ Stomach/Bowel problem _____ ❑ Cancer_____
- ❑ Bladder/Kidney problems _____ ❑ Sickle Cell Disease/Trait _____
- ❑ Heat exhaustion _____ ❑ Organ Transplant _____
- ❑ Musculoskeletal (include any past fractures, etc.) _____

Does this child have any allergies? ❑ Yes ❑ No

If "yes", please list: _____

Has the allergy required emergency treatment? ❑ Yes ❑ No

If "yes", please explain: _____

Has this allergy been verified by a medical professional? ❑ Yes ❑ No

If "yes", please attach documentation of proof.

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No

If "yes", please describe: _____

Are there any current medical concerns/injuries? ❑ **Yes** ❑ **No**

If "yes", please list: _____

Does this child take any medication regularly at home? ❑ Yes ❑ No

Require medication at school? ❑ Yes ❑ No

If "yes", please list: _____

Please list any additional concerns or information: _____

_____

Who lives with the child in his/her primary household? _____

Does child spend a significant amount of time in another household? ❑ **Yes** ❑ **No**

If "yes", please describe: _____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

Is your child experiencing:

Eating Problems	❑ Yes	❑ No
Sleeping Problems	❑ Yes	❑ No
Vision Problems	❑ Yes	❑ No
Hearing Problems	❑ Yes	❑ No

Does your child wear glasses or contacts? ❑ Yes ❑ No

When was he/she last seen by the eye doctor? _____

Medical Procedures and Treatments at School ❑ Does not apply to my child.

If my child needs **specialized medical care** at school, **I agree to provide a current doctor's order and all necessary supplies.** If I do not provide the necessary items, my child may be excluded from school until I provide them. My child needs the following at school: (please list below)

_____

_____

First Aid Treatment * **Most wounds or abrasions will be cleansed with mild soap and water**

I authorize my child to receive any of the following topical treatment if available and deemed appropriate by the school nurse: ❑ Yes ❑ No

Hand Sanitizer, Isopropyl Alcohol, Antibacterial Ointment, Anti Itch Cream/Lotion, Saline Solution, First Aid Spray/Wound Wash, First Aid Burn Cream, Hydrogen Peroxide, Sting Relief Swab/Wipes, Bandages.

Screenings

Arkansas public school mandates that students must be screened for the following items in grades noted below, parents shall have the right to opt their student out of the exams or screenings by using form 4.41F or by providing certification from a physician that he/she has recently examined the student. I give permission for my child to participate in the following health screening:

Vision/Hearing (Grades- PK, K, 1st, 2nd, 4th, 6th, 8th) ❑ Yes ❑ No
BMI (Grades- K, 2nd, 4th, 6th, 8th) ❑ Yes ❑ No
Scoliosis (Grades- 6th Girls Only, 8th Boys and Girls) ❑ Yes ❑ No

Is there anything the school needs to know about your child that will help in providing health services? If so, please list: _____

SCHOOL EMERGENCY MEDICAL AUTHORIZATION

If the above named student becomes seriously ill or injured at school and the family can't be reached immediately for instructions, I hereby authorize school personnel to call and/or arrange for transportation of the student to the nearest facility for emergency care.

It is understood that I am responsible for the cost incurred for emergency transportation and care unless otherwise covered by insurance.

Note: Parents/Guardians are responsible for notifying the school about any change of information contained on this form.

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

Vision and Hearing Screenings 2023-2024

The North Little Rock School District provides free yearly Vision and Hearing Screenings to students in grades PK, K, 1st, 2nd, 4th, 6th, and 8th grades . Please SIGN BELOW to consent to release education records related to vision and hearing screenings.

In compliance with the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 123g; 34 CFR Part 99)

I, _____, give permission for my child, _____'s

(Parent/Guardian Name) (First and Last Name)

Personally identifiable information/student education records to be disclosed to a Third Party Billing Agent for the purpose of billing Medicaid and/or private insurance for vision and hearing screening.

_____ _____

Parent/Guardian Signature Date Signed

School Campus Name_____

_____Distrito Escolar de North Little Rock

Visión y audición proyecciones

El distrito escolar de North Little Rock proporciona visión anual libre y exámenes de audición a los estudiantes en los grados PK, K, 1st, 2nd, 4th, 6thy8vo grado. Por favor signo debajo para consentimiento para liberar registros educativos relacionados con la visión y exámenes de audición.

En cumplimiento de los derechos educativos de la familia y ley de privacidad (FERPA) (20 U.S.C. § 123 g; 34 CFR parte 99)

_____ doy permiso a mi hijo _____

(parent Name) (Nombre del padre/tutor) (Student Name) (Nombre y apellido)

personalmente información identificable/estudiante educación registros a divulgarse a un tercer partido de facturación Agente a efectos de facturación de Medicaid o un seguro privado para la visión y audición.

_____ _____

Firma del padre/tutor (parent signature) Fecha Firma (date)

Escuela Campus Name_____

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name _____ **Page 1**

PART 1. NAME OF ENROLLED CHILDREN

***OPTIONAL – Participant's ethnic and racial data**

Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

NAME OF ENROLLED CHILDREN	AGE	DATE OF BIRTH	FOSTER CHILD?	HISPANIC OR LATINO Yes	HISPANIC OR LATINO No	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White
				☐	☐					
				☐	☐					
				☐	☐					
				☐	☐					

ADDITIONAL HOUSEHOLD CHILDREN _____ **TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD:** _____

PART 2. Benefits: If any member of your household received [State SNAP], [FDPIR], 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	
1. _____	_____	NOTE: A Case number is not the number found on the EBT card or an individual's Social Security number.
2. _____	_____	
3. _____	_____	

PART 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Your School, Homeless Liaison, or Migrant Coordinator

☐ Homeless ☐ Migrant ☐ Runaway

PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income.

*** Weekly / Every 2 Weeks / Twice a Month / Monthly / Annual ***

Names of all Household Members, except children listed above	Earnings from work before deductions	Welfare, Child Support, Alimony	Pensions, SSI, VA Benefits, Social Security, Retirement	All other income	Check here if No Income
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	
	$_____	$_____	$_____	$_____	

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Facility Name _____

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

An adult household member must sign this form. **If Part 3 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 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: _____ (form valid for one (1) year from this date)

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ **I do not have a Social Security Number**

(required)

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_____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year Household Size: _____

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

Reason: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature:_____ Date:_____

Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid".

HNP Representative Initials/Date (for use during CACFP Reviews)

_____

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.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

PLEASE RETURN THIS FORM TO THE NLRSD CHILD NUTRITION OFFICE VIA EMAIL TO fservices@nlrsd.org

CHILD CARE FOOD PROGRAM

ENROLLMENT FORM

(to be completed by parent or guardian)

Provider's Initial: _____

Date: _____

For Facility/Provider Use Only:

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information may be verified. The meal times, the meal pattern and the daily menus should be posted and available for parents at all times. If you have questions, or comments, or would like to learn more about the Child and Adult Care Food Program, contact our office.

_____ _____

Name of Day Care Facility Address

_____ _____

Telephone Address

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are given below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious, well balanced meals/snacks to day care children.

My child(ren) will be served the following meals:

(Please Circle): Breakfast AM Snack Lunch PM Snack Supper Late Snack

Child(ren) Information (please print)

First Name	Last Name	Age	Birthdate	Hrs of Care	Days /Week	Gender
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F
			/ /	from to	SAT - SUN M – T – W – TH - FR	M F

Note here any food allergies or special dietary needs your child(ren) have: _____

_____

Doctor's Name:_____ Doctor's Telephone: _____

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex, or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider.

In case of emergency, please call: HOME #_____ WORK # _____

Parent Address: _____

Parent Signature:_____ Date: _____

(form valid one (1) year from this date)