BUILDING BLOCKS LEARNING CENTER
4402 HAINES ROAD
DULUTH, MN 55811
218-722-2252
WWW.BUILDINGBLOCKSDULUTH.COM

Dear Parent,

Thank you for your interest in our program! Building Blocks Learning Center is open to children ages six weeks to five years of age. Our infant, toddler, and preschool programs are available Monday through Friday, 6:30 a.m. to 5:30 p.m.

At BBLC, our mission is to provide children with a safe, nurturing, and educational environment where creativity, exploration, and questioning is at the forefront of learning. We prepare children to be 21st-century learners and provide them with life skills, technology skills, and social skills to thrive and become prepared for their academic futures. Children will learn through sensory exercises, self-inquiry, and working together with their classmates to develop crucial skills that will prepare them for future endeavors.

Our school provides a balanced program of learning experiences designed to foster the cognitive, motor, as well as social, emotional, and aesthetic development of the preschool child. Our environment is structured to stimulate the child's curiosity and encourage self-directed learning. Children alternate between independently exploring and questioning in a planned environment and teacher led group instruction. Age and developmental level will determine placement in groups. The children have the same teacher for small group time, language arts, and music and movement. The daily program includes outdoor play, art and music experiences, technology integration, and opportunities to develop pre-academic skills in math, science, and language. Because we believe that learning for the young child takes place where there is direct interaction with the environment, our curriculum will be based on experiences that emphasize functional learning at the child's age of development. We strive to structure an environment that provides natural opportunities for language development, manipulation of materials, sensing of meanings and relationships, developing work habits, establishing friendships, and obtaining social maturity.

In addition to a quality education program, we also provide well-balanced and nutritious meals and snacks, approved by the Minnesota Department of Agriculture.

For more information, you can visit our website at www.buildingblocksduluth.com , or call us at 218-722-2252 x1. We are so happy you are with us, and look forward to watching your child learn and grow with us!

Sincerely,

Building Blocks Learning Center
Staff and Management

BUILDING BLOCKS LEARNING CENTER
4402 HAINES ROAD
DULUTH, MN 55811
218-722-2252 Option 1
WWW.BUILDINGBLOCKSDULUTH.COM

INFORMATION SHEET 2019-2020

We serve children six weeks through five years of age. Age designations are as follows: Infants 6 weeks through 16 months, Toddlers 16 months through 33 months, Preschoolers 33 months through 5 years.

OPERATION: Monday through Friday year-round
Building Blocks Learning Center will be closed on the following Holidays:

New Year's Day
Memorial Day
Fourth of July (Friday July 3rd, 2020)
Labor Day
Thanksgiving (Thursday and Friday)
Christmas Eve
Christmas Day
New Year's Eve

PRICING:

	Haines Road Pricing Open 6:00 a.m. - 6:00 p.m.	Hermantown Road Pricing Open 6:30 a.m. - 5:45 p.m.
Infant	$44	$44
Toddler	$40	$40
Preschool	$37	$37

ATTENDANCE REQUIREMENTS:

- Children must be six weeks old to begin school.
- Variable schedules will not be accepted
- All new incoming students are billed for 5 days a week.
- A $25.00 non refundable registration fee is required.
- A $300.00 non refundable deposit is required. This will be applied to your account.

PAYMENTS MUST BE KEPT CURRENT FOR YOUR CHILD TO REMAIN IN OUR PROGRAM. INTEREST WILL BE CHARGED ON PAST DUE ACCOUNTS.

Welcome to the Building Blocks Learning Center Infant Room!

We are very excited to have you with us as part of our BBLC family! We know that the first day is always the hardest, so we want to help make it easier for you! Below are lists of supplies and paperwork infants need on their first day. If there is anything else we can do to make the first day more comfortable, please let us know!

Supplies you need to bring on your first day of school:

*Diapers
*Wipes
*2-3 bottles (if still using bottles)
*3-4 bibs (will be sent home with you to wash)
*2-3 sets of extra clothes
*Diaper cream (optional)
*Pacifier (optional)

Paperwork you need to bring on your first day of school:

*Registration form
*Payment contract
*Emergency contact cards
*Immunization records
*Infant information sheet
*Health summary record
*Infant basket information
*Infant meal notification letter
*Diaper cream/sun lotion authorization form

Foods Building Block Learning Center supplies: Simply Right Complete formula (comparable to Similac Advance), Similac Soy formula, Whole milk, Gerber baby rice, Gerber baby oatmeal, Gerber baby fruits (applesauce, peaches, pears, bananas), Gerber baby vegetables (squash, carrots, sweet potatoes, peas, green beans), A variety of healthy table foods for fruits and vegetables, and a catered lunch everyday.

Other items BBLC supplies: toys, music, art supplies (markers, crayons, paint, chalk, etc.), sippy cups, bowls, spoons, books, and baskets for bottles.

Please use permanent marker to label all of your infant's things with first and last name. It sometimes helps to write on bottles and then put clear packing tape on top so the name doesn't come off as easily.

We are honored you have chosen us to be part of your infant's life! Please stop by the infant room, set up a conference, or call if you ever have questions, comments, or concerns!

Thank You Again,

The Infant Room Teachers

(For school use only) Date_____ Reg. Fee_____Deposit_____ Check # _____ or Receipt # _____

BUILDING BLOCKS LEARNING CENTER

Registration Form

Please complete all items on this form. This information is required by law and must be submitted on or before first day of attendance!

Person responsible for this account _____

**Please enclose a non-refundable $25.00 registration fee. NOT REQUIRED IF CURRENTLY REGISTERED AT BBLC. Also enclose a $300.00 non-refundable deposit. This deposit will be applied to your account. A two-week notice is required when leaving the program.*

Child's Name _____ DOB_____ Sex_____

Address_____ Zip _____ Phone_____

Parent/Guardian 1 _____Occupation_____

Place of Employment _____ Wk Phone _____ Cell _____

Address, if different from child _____

Email address _____

Parent/Guardian 2 _____Occupation _____

Place of Employment _____Wk Phone_____ Cell_____

Address, if different from child _____

Email address _____

Names and ages of other children in family _____

Any other information we should know _____

_____

PERSONS TO CONTACT WHOM ARE ALLOWED TO PICK UP YOUR CHILD IN CASE OF EMERGENCY (IF PARENTS CANNOT BE CONTACTED)

1. Name _____Address_____

Relationship _____Home #_____ Work #_____ Cell #_____

2. Name _____Address_____

Relationship_____Home #_____Work #_____ Cell #_____

Child's Physician _____Phone_____ Address_____

Child's Dentist_____Phone_____Address_____

Hospital of choice _____ Phone #_____

WHO MAY PICK UP YOUR CHILD? (Please notify us of any changes.)

Name Relation Phone Cell Address

_____

_____

_____

WHO MAY NOT PICK UP YOUR CHILD? (Please notify us of any changes.)

Name Relation Phone Cell Address

_____

_____

_____

SUMMER REGISTRATION

PLEASE NOTIFY US IF YOU WILL BE ON VACATION DURING THE SUMMER PROGRAM. A WEEK'S ADVANCE NOTICE IS REQUIRED IF YOU WISH A TUITION REFUND.

PERSON RESPONSIBLE FOR PAYMENT ON ACCOUNT _____

(SLC Assistance) Name of social worker _____Phone_____

(Please read and sign below.)

I authorize Building Blocks Learning Center to act on behalf of my child in an emergency situation when another parent/guardian or I cannot be reached, or there will be a delay in reaching me or another parent/guardian.

Signed_____ Date_____

Child's name:_____DOB:_____

PERMISSION SLIP FOR DIAPER CREAM/SUNSCREEN/LOTION/POWDER

Please check all boxes that apply:

- ❑ My child can ONLY use_____(Brand Name) *diaper cream* that I have provided for him/her.

- ❑ I **do not** wish for my child to use diaper cream.

- ❑ My child can ONLY use_____(Brand Name) *sunscreen* that I have provided for him/her.

- ❑ My child can use any brand of sunscreen.

- ❑ I **do not** wish for my child to use sunscreen.

- ❑ My child can ONLY use_____(Brand Name) *lotion* that I have provided for him/her.

- ❑ I **do not** wish for my child to use lotion.

- ❑ My child can ONLY use_____(Brand Name) *powder* that I have provided for him/her.

- ❑ I **do not** wish for my child to use powder

Parent/Guardian's signature:_____Date:_____

Parent/Guardian's signature:_____Date:_____

INFANT INFORMATION SHEET

FIRST & LAST NAME: BIRTH DATE: _____

DRINKS: BREAST MILK/ UP & UP FORMULA / UP & UP SOY FORMULA/WHOLE MILK/ OTHER: _____

BOTTLE: DRINKS _____OZ. OF FORMULA/BREAST MILK/WATER/WHOLE MILK EVERY_____HOURS

SIPPY CUP (WITH MEALS): DRINKS _____OZ. OF FORMULA/BREAST MILK/WATER/WHOLE MILK

CEREAL: RICE/OATMEAL _____OZ. MIXED WITH FORMULA/BREAST MILK/WATER/WHOLE MILK

BABY VEGGIES: GREEN BEANS/CARROTS/SQUASH/PEAS/SWEET POTATOES _____OZ.

BABY FRUITS: APPLES/PEARS/BANANAS/PEACHES/PRUNES_____OZ.

BABY FOOD EATING TIME(S): 9:00 A.M./11:00 A.M./1:00 P.M.

TABLE FOOD EATING TIME(S): 9:00 A.M. BREAKFAST/12:00 P.M. LUNCH/3:00 P.M. SNACK

USES A PACIFIER: YES/NO MAY SLEEP WITH BLANKET: YES/NO

MAY CUDDLE WITH A BLANKET: YES/NO MAXIMUM NAP TIME LENGTH: _____ HOURS

MAY FALL ASLEEP IN: SWING/CHAIR (ALL INFANTS MUST BE MOVED TO A CRIB AFTER FALLING ASLEEP)

CHANGE DIAPERS: EVERY _____ HOURS USE DIAPER CREAM: ALWAYS/WHEN NEEDED

SPECIAL NOTES:

INFANT INFORMATION SHEET

FIRST & LAST NAME: BIRTH DATE: _____

DRINKS: BREAST MILK/ UP & UP FORMULA / UP & UP SOY FORMULA/WHOLE MILK/ OTHER: _____

BOTTLE: DRINKS _____OZ. OF FORMULA/BREAST MILK/WATER/WHOLE MILK EVERY_____HOURS

SIPPY CUP (WITH MEALS): DRINKS _____OZ. OF FORMULA/BREAST MILK/WATER/WHOLE MILK

CEREAL: RICE/OATMEAL _____OZ. MIXED WITH FORMULA/BREAST MILK/WATER/WHOLE MILK

BABY VEGGIES: GREEN BEANS/CARROTS/SQUASH/PEAS/SWEET POTATOES _____OZ.

BABY FRUITS: APPLES/PEARS/BANANAS/PEACHES/PRUNES_____OZ.

BABY FOOD EATING TIME(S): 9:00 A.M./11:00 A.M./1:00 P.M.

TABLE FOOD EATING TIME(S): 9:00 A.M. BREAKFAST/12:00 P.M. LUNCH/3:00 P.M. SNACK

USES A PACIFIER: YES/NO MAY SLEEP WITH BLANKET: YES/NO

MAY CUDDLE WITH A BLANKET: YES/NO MAXIMUM NAP TIME LENGTH: _____ HOURS

MAY FALL ASLEEP IN: SWING/CHAIR (ALL INFANTS MUST BE MOVED TO A CRIB AFTER FALLING ASLEEP)

CHANGE DIAPERS: EVERY _____ HOURS USE DIAPER CREAM: ALWAYS/WHEN NEEDED

SPECIAL NOTES:

CHILD CARE EMERGENCY CONTACT INFORMATION AND CONSENT FORM

Child's Name: _____ Birth Date: _____

Address: _____

Parent/Guardian #1 Name: _____

Telephone: Home _____Work _____Beeper/Cell _____

Parent/Guardian #1 Name: _____

Telephone: Home _____Work _____Beeper/Cell _____

EMERGENCY CONTACTS (to whom child may be released if guardian is unavailable)

Name #1: _____ Relationship: _____

Telephone: Home _____Work _____Beeper/Cell _____

Name #2: _____ Relationship: _____

Telephone: Home _____Work _____Beeper/Cell _____

CHILD'S PREFERRED SOURCES OF MEDICAL CARE

Physician's name: _____

Address: _____ Telephone: _____

Dentist's name: _____

Address: _____ Telephone: _____

Hospital name: _____

Address: _____ Telephone: _____

Ambulance Service: _____

Telephone: _____

(Parents are responsible for all emergency transportation charges)

CHILD'S HEALTH INSURANCE

Insurance Plan: _____ ID # _____

Subscriber's Name (on insurance card): _____

SPECIAL CONDITIONS, DISABILITIES, ALLERGIES, OR MEDICAL EMERGENCY INFORMATION

_____

_____

PARENT/GUARDIAN CONSENT AND AGREEMENT FOR EMERGENCIES:

As parent/guardian, I consent to have my child receive first aid by facility staff and, if necessary, be transported to receive emergency care. I will be responsible for all charges not covered by insurance. I consent for the emergency contact person listed above to **ACT ON MY BEHALF** until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Infant Information Sheet

Child's Name_____ Birthdate_____

Position in Family? (1st Born, 2nd Born, Etc.)_____

Sleeping Habits

*All children at Building Blocks Learning Center will sleep in a crib.

How does your child fall asleep? (With a bottle, pacifier, noise, crying, etc.)

- _____

Feeding Habits

What is your child currently eating? (Formula, Breast Milk, Solids, Crackers, Etc.)

- _____

How often is your child eating?

- _____

Please list what we can feed your child while attending Building Blocks Learning Center.

- _____
- _____

Do you have any dietary restrictions for your child?

- _____
- _____

If your child is sleeping would you like BBLC staff to wake them at feeding time? _____

Diaper Changing

How often would you like your child to be changed? BBLC changes diapers every three hours.

- _____

Communication/Play Habits

What words does your child say? How does your child best communicate?

- _____
- _____

What is the best way to comfort your child? (Rocking, Singing, Reading, Etc.)

- _____

While awake, please note some of your child's favorite activities:

- _____
- _____

What do you hope Building Blocks Learning Center will provide for your child as he/she grows?

- _____
- _____

BUILDING BLOCKS LEARNING CENTER PAYMENT CONTRACT

CHILD _____ DATE_____

AGE (circle) INFANT TODDLER PRESCHOOL/SCHOOL AGE

START DATE_____OR CHANGE DATE _____

REGISTERED FOR _____SESSIONS PER WEEK

AM (6:00-NOON) MON____ TUES____ WED____ THURS____ FRI____

PM (NOON-6:00) MON____ TUES____ WED____ THURS____ FRI____

Tuition for the above is _____ per week for the year. Payment is due weekly unless other arrangements are made. Extended hours are due weekly and due upon receipt.

Families whose accounts are over $500.00 or in arrears will not be able to continue in our program. Interest will be charged on past due accounts. A two-week notice is required when leaving our program. Building Blocks Learning Center may close in extreme cases of inclement weather. Tuition will be charged for these days and holidays.

You are billed for all absent days, unless you have earned a week of vacation after being at BBLC for one year.

*Accounts that are sent to collections will be assessed a service fee equal to the amount owed.

All billing inquiries should be directed to the business manager at 218-722-2252 option 1.

I have read the above. (initial) _____

I agree to pay my tuition weekly (initial) _____

(Please fill out if on Childcare Assistance)

St. Louis County: Worker Name_____Number_____

My co-pay is _____ every 2 weeks, due at the beginning of the period.

Parent Signature: _____ Date: _____

(Please submit this contract on or before your child's first day of attendance)
(A copy of this signed contract is available upon request)

Building Blocks Learning Center Information for Parents

Important phone numbers for you to know:

Center Number: 218-722-2252
Fax Number: 1-218-319-7069
Holly's E-mail: hpetrich@gmail.com or holly@buildingblocksduluth.com

Drop-Off and Pick-Up Times:

Please try to stick to the pick up time you choose each day. We count on parents picking up by certain times to allow staff to leave on time each day. Thank you for your cooperation with this! **If you are late picking up your child (past 6:00 p.m.), you will be charged a $35 late fee. State does not allow us to operate past 6:00 p.m. and we can get citations if found in operation past 6:00 p.m.**

When your child is sent home: (Must be fever free for 24 hours and no more loose BMs for 24 hours before they can return).

When a temperature of 101.0 degrees or higher is reached
When your child has 3 or more loose BMs
When your child vomits 2 or more times
When your child has behavior problems and all tactics have already been tried

***Please keep your child home until they are well enough to return to school and are not risking infecting the other children in their classroom.

Days we are closed: (You are billed for these days-holidays and snow days)

New Year's Day
Memorial Day
Fourth of July
Labor Day
Thanksgiving Day and the day after
Christmas Eve and Christmas Day

We may also close due to weather. You will be notified as soon as we make a decision independent from the school districts. If your child is in our school-age program, and will not be attending on days they have off from school, you are still billed their standard weekly rate to hold their spots.

Vacation Days:

You earn vacation days after you have been here for a year or longer. The number of paid days off you get is equal to the number of days your child comes each week. So, if your child comes 3 days a week, you are allowed to take 3 paid days of vacation. Vacation days must be used in the same week (all 3 days in the same week, etc.). You get one vacation week per family, not per child.

Payments:

You are able to make payments by check or by using the sign-in kiosk when you check your child in. You can sign up to have payments automatically withdrawn from a checking account or credit card. Payments are due every Friday and you are billed for the week ahead. Please keep your bill current-paid in full. **Bills over $500 will be charged 6% monthly interest beginning January 2, 2017.**

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® – a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below referenced credit card account **(Section A)** OR, initiate debit entries to my (our) Checking or Savings Account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

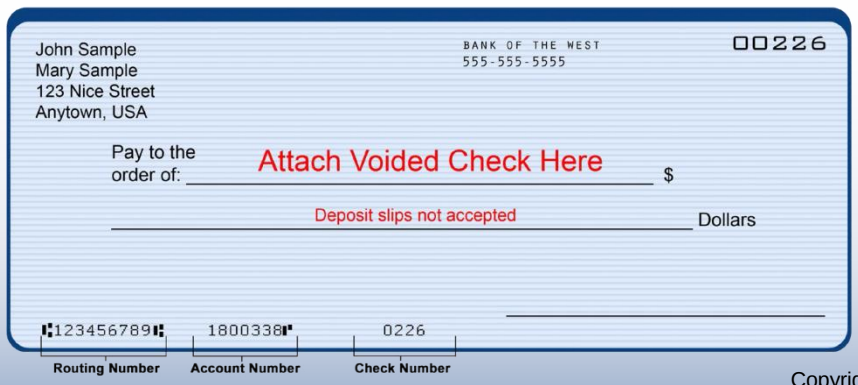
Bank or Credit Union Name _____

Bank or Credit Union Address _____ City _____ State _____ Zip _____ ☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____

For Official Use Only

Date Received
Employee Signature



A service of

procare SOFTWARE®

Child Care Immunization Form

*Must be on file **before** a child attends child care*

Name _____ Birthdate _____

Date of Enrollment _____

Minnesota law requires children enrolled in child care to be immunized against certain diseases or file a legal medical or conscientious exemption.

Parent/Guardian:

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

Type of Vaccine DO NOT USE (✓) or (×)	**1st Dose Mo/Day/Yr**	**2nd Dose Mo/Day/Yr**	**3rd Dose Mo/Day/Yr**	**4th Dose Mo/Day/Yr**	**5th Dose Mo/Day/Yr**
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP) • 3 doses during 1st year *(at 2-month intervals)* • 4th dose at 12-18 months • 5th dose at 4-6 years *Indicate vaccine type: DTaP or DTP*					5th dose not required if 4th dose was given on or after the 4th birthday
Polio (IPV, OPV) • 2 doses in the first year • 3rd dose by 18 months • 4th dose at 4-6 years					4th dose not required if 3rd dose was given on or after the 4th birthday
Measles, Mumps, and Rubella (MMR) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
***Haemophilus influenzae* type b (Hib)** • 2-3 doses in the first year • 1 dose required after 12 months or older • For unvaccinated children 15-59 months, 1 dose is required • Not required for children 5 years or older					
Varicella (chickenpox) • Required for children 15 months and older • 1st dose on or after 1st birthday • 2nd dose at 4-6 years					
Pneumococcal Conjugate Vaccine (PCV) • Required for children age 2 - 24 months • 3 doses in the first year • 4th dose after 12 months • At least 1 dose is recommended for children 24-59 months in child care					
Hepatitis B (hep B) • 2-3 doses in the first year • 3rd dose (final dose) by 18 months					
Hepatitis A (hep A) • 2 doses separated by 6 months for children 12 months and older					
Recommended					
Rotavirus (2-3 doses between 2 and 6 months)					
Influenza (annually for children 6 months or older)					

Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Children who are 15 months or older:

For children who are 15 months or older and who have received all the immunizations required by law for child care:

I certify that that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

_____
Signature of Parent / Guardian OR Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_____ Date

B. Children who are 15 months or younger:

For children who are younger than 15 months OR have not received all required immunizations:

I certify that the above-named child has received the immunizations indicated. In order to remain enrolled this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

_____
Signature of Physician / Nurse Practitioner / Physician Assistant / Public Clinic

_____ Date

2. Exemptions to Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:
No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

_____
Signature of physician / nurse practitioner / physician assistant

_____ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)

_____
Signature of physician / nurse practitioner / physician assistant (If disease occured before September 2010, a parent can sign.)

B. Conscientious exemption:
No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

_____
Signature of parent or legal guardian

_____ Date

Subscribed and sworn to before me this:
_____ day of _____ 20____

_____
Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT(S) OR GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

_____

What is the status of the child's. . . Vision _____

Hearing _____

Speech _____

Please list below the important health problems

Important Health Problems	Followed By You	Followed By Other Med Source (Name)	Requires Special Attention at Center

Other information helpful to the child care program _____

_____

_____

Phone _____

Signature of Health Source _____ Address _____

Date _____ _____

MS-2083

Minnesota Department of Education

Infant Meal Notification Letter

To: Parents and guardians of infants under one year of age

From: Center: Building Blocks Learning Center

Topic: Infant Meals

All children enrolled in this child care center, including infants, are eligible for meals through the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). Child care centers who participate in this program are reimbursed by USDA to help with the cost of serving nutritious meals that meet CACFP guidelines to all enrolled children. To fully meet CACFP requirements, this center is required to provide formula and other required infant foods* to enrolled infants until they turn one year of age.

The iron-fortified infant formula this center offers is: Similiac Advanced

***Other infant foods provided by this center include:** iron-fortified infant cereal, bread or bread alternate made from whole grain or enriched meal or flour, fruits and vegetables, meat/meat alternates and 100 percent full strength juice.

You may choose to bring your own iron-fortified infant formula or breast milk and other infant foods that meet the CACFP Infant Meal Pattern requirements. A copy of the CACFP Infant Meal Pattern is printed on the back of this letter. The center will claim reimbursement for your infant's meals only when a meal contains breast milk or iron-fortified infant formula regardless of who supplies it. Please note that the center will also introduce semi-solid foods to your infant according to the decisions made by you and your infant's doctor.

PLEASE CHECK YOUR PREFERENCES:

Formula or Breast Milk: (check one)

☐ I want the center to supply formula for my infant.

☐ I will provide the following formula for my infant: _____

Note: I understand that I will need to submit a Special Diet Statement if I provide a low-iron infant formula or other special formula for my infant.

☐ I will provide breast milk for my infant.

Solid Food: (check one)

☐ I want the center to supply solid food for my infant when he/she is developmentally ready.

☐ I will provide my own choice of infant cereal and/or other foods instead of accepting the iron-fortified infant cereal and/or other foods provided by this center.

Infant's name: _____ Birthdate: _____

Parent/Guardian signature: _____ Date: _____

Minnesota Department of Education

CACFP Infant Meal Pattern
Birth to First Birthday

The infant meal pattern must contain, at a minimum, each of the following components in the amounts indicated for the specific age group. The minimum quantity of food must be provided to the infant in order to qualify for reimbursement, but may be served during a span of time consistent with the infant's eating habits.

Infant Meal Pattern

Meal Type	Birth Through 3 Months	4 Through 7 Months	8 Months to First Birthday
BREAKFAST	4 - 6 fl. oz. formula[1] or breast milk [5,6]	4 - 8 fl. oz. formula[1] or breast milk[5,6] 0-3 T. infant cereal[2,7]	6 - 8 fl. oz. formula[1] or breast milk[5,6] 1 - 4 T. fruit and/or vegetable 2 - 4 T. infant cereal[2]
LUNCH OR SUPPER	4 - 6 fl. oz. formula[1] or breast milk [5,6]	4 - 8 fl. oz. formula[1] or breast milk[5,6] 0 - 3 T. fruit and/or vegetable[7] 0 - 3 T. infant cereal[2,7]	6 - 8 fl. oz. formula[1] or breast milk[5,6] 1 - 4 T. fruit and/or vegetable 2 - 4 T. infant cereal[2] **and/or** 1 - 4 T. meat, fish, poultry, egg yolk, or cooked dry beans or peas, **or** 1/2-2 oz. cheese **or** 1-4 oz. cottage cheese, cheese food, or cheese spread
SUPPLEMENT	4 - 6 fl. oz. formula[1] or breast milk[5,6]	4 – 6 fl. oz. formula[1] or breast milk[5,6]	2 - 4 fl. oz. formula[1], breast milk[5,6], or fruit juice[3] 0 - 1/2 bread[4,7] or 0 - 2 crackers[4,7]

[1] Must be iron-fortified infant formula.
[2] Must be iron-fortified dry infant cereal.
[3] Must be full-strength fruit juice.
[4] Must be from whole-grain or enriched meal or flour.
[5] It is recommended that breast milk be served in place of formula from birth to first birthday.
[6] For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered, with additional breast milk offered if the infant is still hungry.
[7] A serving of this component is required when the infant is developmentally ready to accept it.

Required Guidelines for Infant Meal Pattern

Definition of Infant. Any child less than 12 months of age.

Definition of Infant Formula. Infant formula defined by USDA is “any iron-fortified infant formula intended for dietary use as a sole source of food for normal healthy infants served in liquid state at manufacturer’s recommended dilution.” A medical statement is required in order for a center to serve/claim an infant formula that does not meet this definition.

Definition of Enrolled Child. A child whose parent or guardian has submitted to an institution a signed document which indicates that the child is enrolled for child care. All infants and children who are considered enrolled in a child care center (group or home) must be included in the total number of enrolled children, whether or not their meals are being claimed for reimbursement.

Obligation to Provide Infant Meals. All centers participating in the CACFP, and licensed to care for infants, must supply all infant foods required by the Infant Meal Pattern including at least one infant formula that meets the definition of infant formula. Centers are strongly encouraged to select an infant formula that satisfies the needs of one or more of the infants in their care.

Breast-fed Infants. Infant meals or snacks, including human breast milk as the milk source, are reimbursable in the CACFP if the center bottle-feeds the infant his/her mother's breast milk. This is to provide the incentive for child care centers to encourage breast-feeding while the center is still providing a "service" by preparing the bottle and feeding the infant. Breast-fed infants will receive improved nutritional benefits during their first year of life.

Parent Providing Infant Formula/Breast milk. The decision regarding which infant formula to feed an infant is one for the infant’s doctor and parents/guardian to make together. Therefore, parents or guardians may elect to decline the center’s infant formula and supply their own formula or breast milk.

Parent Decline Form—Infant Meal Notification Letter. Centers must inform parents that an iron-fortified infant formula, including the specific name of the formula, iron-fortified infant cereal, and other semi-solid foods listed under the CACFP Infant Meal Pattern are provided by their sponsorship. Parents/Guardians who choose to provide their own formula and/or other foods must complete the Parent Decline Form—Infant Meal Notification Letter. This documentation must be kept on file.

Reimbursement for Infant Meals. (A) An infant meal (as defined by the CACFP Infant Meal Pattern) containing only breast milk or infant formula (which meets program requirements) may be claimed for reimbursement with proper documentation (meal counts and infant menus), regardless of whom supplies the formula. (B) When the infant is developmentally ready for other food items (as defined by the CACFP Infant Meal Pattern), reimbursement can be claimed for the infant’s meal only when: (1) another food component(s) is supplied by the center according to the meal pattern; (2) the center maintains individual infant menus and meal counts; and (3) all meal components that the infant is developmentally ready to eat are provided in accordance with the age-specific CACFP Infant Meal Pattern. Regardless of whether the parent or the center provides the formula and infant foods to meet the CACFP Infant Meal Pattern requirements, the decision to offer an infant other meal component(s) should be made by the infant’s doctor and parents/guardians.

Minnesota Department of Education

Infant Meal Patterns

Meal	Birth through 3 months	4 through 7 months	8 through 11 months
Breakfast	4-6 fluid ounces of formula[1] or breastmilk[2,3]	4-8 fluid ounces of formula[1] or breastmilk[2,3] 0-3 tablespoons of infant cereal[1,4]	6-8 fluid ounces of formula[1] or breastmilk[2,3] and 2-4 tablespoons of infant cereal[1] and 1-4 tablespoons of fruit or vegetable or both
Lunch or Supper	4-6 fluid ounces of formula[1] or breastmilk[2,3]	4-8 fluid ounces of formula[1] or breastmilk[2,3] 0-3 tablespoons of infant cereal[1,4] and 0-3 tablespoons of fruit or vegetable or both[4]	6-8 fluid ounces of formula[1] or breastmilk[2,3] 2-4 tablespoons of infant cereal[1] and/or 1-4 tablespoons of meat, fish, poultry, egg yolk, cooked dry beans or peas or ½ - 2 ounces of cheese or 1-4 ounces (volume) of cottage cheese or 1-4 ounces (weight) of cheese food or cheese spread and 1-4 tablespoons of fruit or vegetable or both
Snack	4-6 fluid ounces of formula[1] or breastmilk[2,3]	4-6 fluid ounces of formula[1] or breastmilk[2,3]	2-4 fluid ounces of formula[1] or breastmilk[2,3] or fruit juice5 and 0 – ½ bread[4,6] or 0 – 2 crackers[4,6]

[1]Infant formula and dry infant cereal must be iron-fortified.
[2]Breastmilk or formula, or portions of both, may be served; however, it is recommended that breastmilk be served in place of formula from birth through 11 months.
[3]For some breastfed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered, with additional breastmilk offered if the infant is still hungry.
[4]A serving of this component is required when the infant is developmentally ready to accept it.
[5]Fruit juice must be full-strength.
[6]A serving of this component must be made from whole-grain or enriched meal or flour.

Source: USDA Food and Nutrition Service

Dear Parent/Guardian:

We provide nutritious meals every day to the children at our center.

The Child and Adult Care Food Program (CACFP) helps our center to pay for meals. The amount of help we get depends on the incomes of households with children in care. **Please complete the enclosed CACFP Household Income Statement** following the instructions. If your household income is higher than the guidelines shown on the instructions page, please just write "over income" on the Household Income Statement, include your children's names, and return the form.

Return your completed Household Income Statement to:
Luke Petrich C/O Building Blocks Learning Center, 4402 Haines Road Suite 1 Duluth MN, 55811. Email luke@buildingblocksduluth.com

How will my information be used? We will use your information to request CACFP assistance for meal services.

How will my information be kept? We will keep your information on file as private data. The back page of the form has more information about data privacy.

I already get MFIP or SNAP benefits. Do I meet CACFP income guidelines? Yes. You only need to provide your case number on the form if anyone in your household is approved for one of these programs: *Minnesota Family Investment Program* (MFIP), *Supplemental Nutrition Assistance Program* (SNAP) or *Food Distribution Program on Indian Reservations* (FDPIR).

Also foster children meet CACFP guidelines without providing income information.

Your household *may* meet CACFP income guidelines if you are approved for the *Women, Infants and Children* program (WIC) or *Medical Assistance* program (MA). Please fill out a Household Income Statement.

Who should I include as members of my household? Include yourself and all other people living in the household, related or not (such as grandparents, other relatives or friends). Include anyone who is temporarily away, for example a college student.

What if my income is not always the same? List the amount that you normally get. For example, if you normally get $1,000 each month, but you missed some work last month and only got $900, put down that you get $1,000 per month. Include overtime pay if you regularly work overtime.

Do I need to provide my Social Security number? If household incomes are on the form, the person signing the form must write in just the last four digits of their Social Security number. If you don't have a Social Security number, indicate that on the form.

May I fill out a Household Income Statement if someone in my household is not a U.S. citizen? Yes. You or your children or other household members do not have to be U.S. citizens for you to fill out a CACFP Household Income Statement.

If you have other questions or need help, call **218-722-2252 x 1 or email luke@buildingblocksduluth.com**

Sincerely, **Lucas Petrich**

Instructions for Completing the CACFP Household Income Statement

Fill out a *Child and Adult Care Food Program - Household Income Statement* if any of the following apply to your household:

- Any person in your household already is approved for one of these programs*: Minnesota Family Investment Program* (MFIP), *Supplemental Nutrition Assistance Program* (SNAP) or *Food Distribution Program on Indian Reservations* (FDPIR).
- You have one or more foster children in the household (a welfare agency or court has legal responsibility for the child).
- Your total household income (income before deductions, *not* take-home pay) is less than or equal to the income shown below for your household size. These income guidelines are effective from July 1, 2014, through June 30, 2015. Include any foster children as members of the household, but do not include any foster care payments as income.

Maximum Household Income

Household Size	$ Per Year	$ Per Month	$ Twice Per Month	$ Per 2 Weeks	$ Per Week
1	21,590	1,800	900	831	416
2	29,101	2,426	1,213	1,120	560
3	36,612	3,051	1,526	1,409	705
4	44,123	3,677	1,839	1,698	849
5	51,634	4,303	2,152	1,986	993
6	59,145	4,929	2,465	2,275	1,138
7	66,656	5,555	2,778	2,564	1,282
8	74,167	6,181	3,091	2,853	1,427
Add for each additional person	7,511	626	313	289	145

Section 1: Children and Foster Status List all children in your household through grade 12 in Section 1. Indicate foster care status for a child by checking the box. Include any regular income to children, for example SSI. Do not include occasional earnings like babysitting.

Section 2: Benefits Fill out Section 2 if anyone in your household already is approved for one of the assistance programs listed there. If you fill out Section 2, skip Section 3.

Section 3: Adults / Household Incomes Write in the **names of all adults** in the household, whether related or not, in Section 3. Include any adults who are temporarily away, such as a student away at college.

Write in the **incomes** for each adult household member (gross incomes, not take-home pay) and **how often** each income is received. For example "W" for Weekly. If an **hourly income** is listed, also write in the number of hours per week. If an **income varies**, list the amount usually received. For **farm/self-employment income** only, list net income after subtracting business expenses. Examples of "**other income**" to include in the last column are farm/self-employment, Veterans benefits and disability benefits. Check the "**No Income**" column after a person's name if they have no income.

Do *not* include as income: foster care payments, federal education benefits, value of assistance received from MFIP, SNAP, WIC, or FDPIR, combat pay or Military Privatized Housing Initiative pay.

Section 4: Signature You must sign the form. The person signing the form must be an adult household member.

Social Security Number If you filled out Section 3 (household incomes), you also must include just the last four digits of your Social Security number.

Minnesota Department of Education

CHILD AND ADULT CARE FOOD PROGRAM—CHILD CARE CENTERS

June 2014

HOUSEHOLD INCOME STATEMENT

The information requested on this form is private data and will be used to receive assistance for meals from the Child and Adult Care Food Program (CACFP). Also please complete the voluntary Civil Rights Survey on the back page. Return your completed form to the center. If your household income is higher than the attached income guidelines, and you do not have a foster child or a case number, just write "Over Income" and your children's names on the form.

1. Names of all Children in your household *including* Foster Children. Attach additional page if necessary.

First Name	Last Name	Age	✓ if enrolled at this center	✓ if Foster Child *	Any Regular Income to Child Example: SSI
			☐	☐	$____ per___
			☐	☐	$____ per___
			☐	☐	$____ per___
			☐	☐	$____ per___
			☐	☐	$____ per___

2. Benefits (if applicable)

If anyone in your household receives benefits from a program listed below, write in the name of the person and their case number, and check the box for the program that provides benefits. Skip Section 3.

_____ _____

Name Case Number

☐ Minnesota Family Investment Program (MFIP)
☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Food Distribution Program on Indian Reservations

- Medical Assistance and WIC do *not* qualify -

* The child is the legal responsibility of a welfare agency or court. If all children applied for are foster children, skip Sections 2 and 3.

3. Names of all Adults in your household (all household members not listed in Section 1)**.** Include all adults living in your household, related or not. Write in **each income** (income before deductions, *not* take-home pay). Also write in **how often** each income is received: write in **W** for weekly, **BW** for bi-weekly (every other week), **TM** for twice per month, **M** for monthly or **Y** for yearly. Do *not* write in an hourly wage. If income fluctuates, write in the amount normally received. For farm or self-employment income only, list net income (after deductions). Attach additional page if necessary.

First Name	Last Name	✓ if NO income	Gross Wages/ Salaries —all jobs (*before* deductions)	Pension, SSI, Retirement, Social Security	Public Assistance, Child Support, Alimony	Unemployment, Worker's Comp, Strike Benefits	Any Other Income, including *net* Farm/ Self-Employment
		☐	$_____ per ____	$_____ per ____	$_____ per ____	$_____ per ____	$_____ per ____
		☐	$_____ per ____	$_____ per ____	$_____ per ____	$_____ per ____	$_____ per ____
		☐	$_____ per ____	$_____ per ____	$_____ per ____	$_____ per ____	$_____ per ____

4. I certify (promise) that all information I have provided on this form is true and that I have reported all household members and incomes. I understand that the center will get federal funds based on the information I give. I understand that if I purposely give false information, my children may lose meal benefits and I may be prosecuted.

Signature of Adult Household Member (required)

_____

Printed Name: _____ Date: _____

Last 4 digits of Social Security number (required if Section 3 is completed):

*** * * - * * -** __ - __ - __ - __ Or ☐ I do not have a Social Security number.

Sponsor Use Only—Do Not Write Below

Total Household Members: _____ Total Income: $_____ per _____

Approved: ☐ A—Foster ☐ A—Case Number

☐ A—Income ☐ B—Income ☐ C

Effective Dates: From: _____ through _____

Sponsor Signature _____ Date: _____

CIVIL RIGHTS SURVEY (voluntary)
This information is requested solely for the purpose of checking that this program is administered in a nondiscriminatory manner, and will not affect your application.

1. Ethnicity (check one):
- ☐ Hispanic or Latino
- ☐ Not Hispanic/Latino

2. Race (check one or more):
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American
- ☐ White

Civil Rights Survey completed by: ☐ Adult Household Member ☐ Center Representative

PRIVACY ACT STATEMENT
The Richard B. Russell National School Lunch Act requires the information on this Household Income Statement. 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), Minnesota Family Investment Program (MFIP), or Food Distribution Program on Indian Reservations (FDPIR) case number 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.

FARMER OR SELF-EMPLOYED
Income is your *net* income (after deducting business expenses) during the year, which is generally shown on Schedule C or F from the federal tax return. A loss from self-employment must be listed as zero income and does not reduce other income for the purpose of completing this form.

SEASONAL WORKER
Income is your *average income* before deductions (gross income, *not* take-home pay) during the year. List *average gross income* per month or other frequency.

NONDISCRIMINATION STATEMENT
This explains what to do if you believe you have been treated unfairly:

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by USDA. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at USDA Complaint Filing website, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing 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.