St. Pius X Daycare Enrollment Package

Date_____

CHILD'S INFORMATION

Child's Full Name_____ Birth date_____/_____/_____

Preferred Name_____

Child's Street Address_____

City_____ State_____ Zip Code_____

PARENT/GUARDIAN'S INFORMATION

Mother's or Guardian's Name_____

Phone _____Work phone _____

Address (if different from child) _____

Place of Employment_____

License Plate Number: _____

Father's or Guardian's Name_____

Phone _____Work phone _____

Address (if different from child) _____

Place of Employment_____

License Plate Number: _____

Email Address: _____

Preferred Hospital: Owensboro Health Regional Hospital or_____

If parents or guardians cannot be reached in case of emergency call:

1. Name _____

Relationship _____

Phone _____

2. Name _____

Relationship _____

Phone _____

OTHER INFORMATION ABOUT THE CHILD:

Allergies _____

Birth Marks_____

Special Needs _____

CHILD'S PICK UP/VISIT PERMISSION

The following person(s) will be permitted to pick up or visit the child:

1. Name _____
Relationship _____
Phone _____

2. Name _____
Relationship _____
Phone _____

3. Name _____
Relationship _____
Phone _____

4. Name _____
Relationship _____
Phone _____

_____ _____

Signature of parent/guardian completing this form Date

Medical History

Name of Physician_____Phone Number_____

Disease (circle Y if your child has had the disease)

Whooping cough- Y or N Chicken Pox- Y or N Mumps- Y or N_____

Measles- Y or N Scarlet Fever- Y or N Polio-Y or N_____Typhoid- Y or N_

Has child's immunization program been started? Y__ or N__. Copy of current immunization record must be on file with the center.

I hereby authorize the Daycare staff to obtain emergency medical care for my child.

Date: _____ Signature of Parent or Guardian: _____

St. Pius X Daycare Center

Integrated Pest Management Initial Notification Form

_____ School Year or Date

Special Notice

Dear Parent/Guardian, District Employee, or Health Professional:

The St. Pius X Daycare Center has implemented a special program of Integrated Pest Management (I.P.M.) in order to control pests in a way that minimizes economic health and environmental risk via a monitoring and inspection program and the judicious use of pesticides. Those individuals applying pesticides will be properly certified in keeping with applicable legal requirements for I.P.M. program.

If you would like to be notified twenty-four (24) hours in advanced of a planned pesticide application, other than when bait is used, or as soon as possible when an emergency pesticide application is necessary, please mark below. You may also register by phone calling the Daycare at 270-684-7456.

Sincerely,

Brook Mattingly

Please mark below yes or no if you would like to be notified when pesticide is sprayed in or around the premises of the daycare center.

_____Yes, I would like to be given 24 hour notice of planned pesticide application.

_____No, I would not like to be given 24 hour notice of planned pesticide application.

Permission to Videotape/Photograph

CHILD'S NAME: _____

Indicate your preference by checking the appropriate box below:

☐ My child may be videotaped/photographed during the day for educational, or public awareness purposes, as well as for special occasions such as participation in classroom activities.

☐ My child may have pictures uploaded to St. Pius X Daycare's Facebook page. This is a private Facebook page for parents and employees.

NAME OF PARENT/GUARDIAN (Please print): _____

_____ _____

(Signature of Parent/Guardian) ***(Date)***

_____ _____

(Signature of owner/ Director) ***(Date)***

Sunscreen/Diaper Cream

I allow St. Pius X Daycare staff to apply sunscreen and diaper cream to my child as needed. I understand that I must supply the sunscreen and diaper cream. I understand that it must be labeled with my child's first and last name and must be in-date.

Director:

_____Date:_____

Parent:

_____Date:_____

CHILD ENROLLMENT FORM/INCOME APPLICATION

Participant Information: (To be completed by Parent/Guardian)

This household receives SNAP/KTAP Benefits (If yes, input the number here:) 1 1

If a child is a SNAP/K-TAP recipient or a Foster/Head Start participant, the child is automatically eligible to receive free Program meal benefits, subject to the requirements of 7 CFR 226.23.

If your participant receives assistance from the items below, they are automatically eligible for free meals. (Please complete and skip to section 2. If child receives Head start services, please proceed to complete Section 2. Household Income is not required.

Participant's Last Name	Participant's First Name *If under 12 months, please complete Infant Addendum*	Date of Birth	Meals Normally Eaten (Mark all that apply)	Headstart	Foster
			☐B ☐AM ☐L ☐PM ☐S ☐LN	☐	☐
			☐B ☐AM ☐L ☐PM ☐S ☐LN	☐	☐
			☐B ☐AM ☐L ☐PM ☐S ☐LN	☐	☐
			☐B ☐AM ☐L ☐PM ☐S ☐LN	☐	☐

***Parent/Guardian works multiple shifts and participants may be in care different days/hours ☐ Yes ☐ No**

1. Income Application Household Members and Monthly Income:

NAMES OF HOUSEHOLD MEMBERS Including Children Not Listed Above **Last, First**	**GROSS MONTHLY** Income From Work (Before Deductions)	**MONTHLY** Income From Welfare Payments, Child Support, Alimony	**MONTHLY** Income From Pensions, Retirement, Social Security, Unemployment Compensation	Any Other **MONTHLY** Income Including Money Received from Kinship/Foster Child
1.	**$**	**$**	**$**	**$**
2.	**$**	**$**	**$**	**$**
3.	**$**	**$**	**$**	**$**

2. Signature and Social Security Number:

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

X_____ _____

Signature of Adult Household Member **Home/Cell Phone Number**

X_____ ☐ No Social Security Number X_____

Last four digits Social Security Number* **Date**

FOR SPONSOR USE ONLY. DO NOT WRITE BELOW THIS LINE.

Application approved for:

- ☐ Free Meals
- ☐ Reduced Meals
- ☐ Paid Meals
- ☐ SNAP/KTAP
- ☐ Foster
- ☐ Headstart
- ☐ Income Household

Total Household Monthly Income_____

Household Size_____

_____
Signature of Determining Official

_____
Date

**7 CFR 226.15 (e)(2)*

(Revised February 2021)

"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 last four digits of the Social Security Number are 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."

St. Pius Tenth Daycare

Direct Debit Authorization

The undersigned hereby authorizes **St. Pius Tenth Daycare** (hereafter "Company") to initiate electronic debit entries (withdrawals) from my account identified below at the financial institution identified below for the payment of my [x] weekly **Childcare Services Fee.** If the debit entry amount is to be the same each week, that amount is hereby designated as $_____. If the undersigned has a past due balance on account, an **additional $25/week** will be withheld until paid in full. The debit entries are to be debited to my account on **Monday of each week**. There will be a **$25 NSF fee** charged on all debit transactions returned due to insufficient funds (2 occurrences may result in termination). The undersigned acknowledges and agrees that the financial institution named below has no duty or obligation to verify that a debit entry (withdrawal) from the subject account by Company is proper.

Name on Account

Financial Institution Name

Type of Account [ ] Checking [ ] Savings

_____ _____

Routing Number Account Number

The authority granted above is to remain in full force and effect until Company has received written termination notice from the undersigned, and Company has had a reasonable opportunity to act on it. The financial institution named above shall have the right to rely on the authorization granted herein until it receives notice that such authorization has been terminated and the financial institution has a reasonable opportunity to act on it.

_____ _____

Signature Date

_____

Print Name

Attach a Voided Check or Bank Printout

Please Remember to Sign all Forms

Please keep a copy of this authorization form for your record