Another Best Childcare at Whispering Pines
Thayer INC.
18133 52nd AVE W,
Lynnwood, Washington 98037
425-744-1212

Daycare Registration Form

Child's Full Legal Name____Sex____Age_______Birthdate____________

Address____

Apartment Number________________________ City__________________________________State_______ Zip Code_______________

Telephone_____________________________ Cell Phone____________________________Cell Phone_____________________________

Previous Care Giver Name____

____

Father/Guardian	**Mother/Guardian**
Name_______________________________	**Name**_______________________________
Address_____________________________	**Address**_____________________________
Home Phone__________________________	**Home Phone**__________________________
Employer____________________________	**Employer**____________________________
Address_____________________________	**Address**_____________________________
Phone_______________________________	**Phone**_______________________________
Social Security_______________________	**Social Security**_______________________

With whom does the child live? Both Parents_______Mother________Father__________Other_______________________

Names and ages of other children in the home ____
In the event of divorce who has legal custody of the child? __________________________________

The non-custodial parent (circle one) Does or Does Not have permission to pick up the child. (Court documents showing custody arrangements must be on file with this registration.)

Names, Addresses, relationship, and phone numbers (Home, Work, and Cell) of persons authorized to take child from Center:

____
Name Relationship Address Phone Numbers

____
Name Relationship Address Phone Numbers

____
Name Relationship Address Phone Numbers

Note: Notification by parents or guardian MUST be given in case someone other than persons listed will be picking up child.

I Authorize Another Best Childcare and Learning Center Inc. to provide care for my child. I certify that the information provided in this application is correct to the best of my knowledge.

Paid Registration_____________ Start Date_____________ Withdrawal Date______________________

Parent/Guardian Signature____ Date______________________

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Allergy Statement/Health Care Plan

Childs Full Legal Name____**Date of Birth**___________________________

Nature of Allergy____

Allergic to Bees? Yes or No **Epi Pen? Yes or No**

Asthma? Yes or No **Inhaler or Nebulizer? Yes or No**

Epilepsy? Yes or No **Medication? Yes or No**

Foods Child is Allergic to: **Substitute Foods**

________________________________ _____________________________________

________________________________ _____________________________________

________________________________ _____________________________________

________________________________ _____________________________________

Plan of Action in case of Allergic Reaction Recommended by Doctor

____
____
____

Plan of Action in case of Asthma attack Recommended by Doctor

____
____
____

Plan of Action in case of Seizure Recommended by Doctor

____
____
____

Health Care Practitioner Name____**Clinic**________________________________

Address____

Signature of Health Care Practioner____**Date**______________________________

You may have the Doctor fax us an individual health care plan to our center. Please have them call us first to inform us that they will be sending a fax. Please have them include your child's full name and date of birth.

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Food Allergy Statement

Dear

A patient of yours is enrolled for care in our program and we have been advised that ______________________is allergic to certain food items.

As a licensed child care program we are required to comply with certain minimum licensing requirements which are written to protect the child in care. One requirement is that a statement specifying the nature of the allergy and a list of foods that the child is allergic to be provided by a health care practitioner.

Please assist us by completing the form that is attached. Which asks you to list specific food(s) this child is allergic to and to recommend substitute food(s) which will provide nutrients of comparable value?

Thank you for your assistance.

Sincerely,

Another Best Childcare at Whispering Pines
Thayer INC.
18133 52nd AVE W,
Lynnwood, Washington 98037
425-744-1212

By affixing my signature as follows, I indicate my approval to release the information requested above to Another Best Childcare and Learning Center Inc.
Parent/Guardian Signature__________________________Date_____________________
Parent/Guardian Name Printed_______________________
Address____Phone_____________________

Another Best Childcare at Whispering Pines
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Consent for Emergency Treatment

I hereby give permission that my child _________________________________may be given emergency treatment by a qualified staff member at Another Best Childcare and Learning Center (Thayer Inc.)

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

In the event that I cannot be contacted, I further consent to medical, surgical and hospital care, treatment, and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health.

Child's Full Legal Name ______________________________D.O.B._________________________

Childs Physician____

Address____Phone___________________________

Preferred Hospital____

Clinic or Hospital Phone
number____

Insurance
Name__________________________________Address_________________________________
____

Insurance Policy Number_________________________Name of Insured__________________

Group Number____Phone_______________

Date of last Tetanus (or DTP)
Immunization____

Allergies (Drugs, Food, Bees)
____
____

Parent/Guardian Name ____________________________Work Phone______________________

Parent/Guardian Name ____________________________Work Phone______________________

Parent/Guardian Signature_________________________Date___________________________

Another Best Childcare at Whispering Pines
Thayer INC.
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Health Information and Consent Form

Current Date____________________(state law requires yearly update)

Childs Name ______________________________Home Phone _____________________ Birth date __________

Address____
City________________________________State____________________________________Zip________________

Father/Guardian Name ________________________________Cell/Work Phone____________________________

Mother/Guardian Name _______________________________Cell/Work Phone____________________________

EMERGENCY EMERGENCY EMERGENCY EMERGENCY EMERGENCY EMERGECY

In case of an emergency, if parents cannot be reached, contact:

Name________________________________Phone______________________________Relation______________
Name________________________________Phone______________________________Relation________________
Name________________________________Phone______________________________Relation________________

Child's Physician_________________________Clinic____

Phone_________________________Address____

If the above persons cannot be reached, or time is an important factor, will the arrangements listed in the Emergency Procedures Plan be acceptable to you? Yes or No (please Circle)

If Yes, my signature indicates that I have read, received a copy of and consent to my child being treated following the Emergency Procedures Plan. Signature________________________________Date____________________

I also give my permission for the above named child to be transported by aid car or ambulance to an Emergency Care Facility for treatment. Signature_______________________________Date_____________________

I also give consent for Tylenol to be given by center staff as directed by the Medication Administration Procedure for fever or mild discomfort, according to dosage on manufactures'' label for my child's comfort until arrangements can be made to have my child picked up from the center.
Signature______________________________Date_______________

I also consent to Syrup of Ipecac to be given to my child as directed by a physician or the Poison Control Center in the event of accidental ingestion of a potentially harmful substance.
Signature_____________________________________Date________________________

I further consent to the medical, surgical and hospital care, treatment or procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right to informed consent of treatment.
Signature ________________________Date_______

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Exception: I wish to make the following exception concerning hospital care:
____
____

Signature___________________________________Date___________________________________

Please indicate Medical Insurance information:

Subscriber Name____D.O.B.__________________________

Insurance carrier___________________ __________Policy Number______________________________

Please supply the dates of your child's last:

Physical Exam______________________________(Must state month and year. Must be within 1 year)

Dentist's Name________________________________ Last Dental Exam__________________________

Dentist's Phone___________________________________

Last Tetanus (or DPT)_______________________________Immunization

To update your child's immunization record, list any immunization or shot, including date given, your child has received in the past year:
____
____

Please list any medications taken by your child on a regular basis
____

Please list any allergies your child may have to medications or other substances
____

Signature____ Date__________________________

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Name of Child ____sex______ Birth Date_________

Date of last Physical Exam________________Illnesses:____

Does your child have? Check if your child has had any of these diseases or been frequently sick?

Frequent Colds_______ Dates _________
Frequent Sore Throats_____________ Dates ________
Frequent Ear Infection_____________ Dates________
Problems with skin/rash_________ Date ___________
Heart Trouble ____________Dates____________
Convulsions___________ Dates__________
Fainting Spells_________ Dates_________
Diabetes__________ Dates __________
Asthma __________Dates__________
Stomach upsets __________Dates________
Mumps __________Dates__________
Poliomyelitis __________Dates____________
Problems w/Soiling _____________Dates__________
Epilepsy ___________Dates________

Bronchitis__________ Dates________________
Ringworm__________ Dates _______________
Impetigo ________ Dates _______________
Head Lice __________ Dates _______________
Chickenpox_________ Date ________________
Hepatitis ___________ Dates ______________
Scarlet Fever _________Dates______________
Tuberculosis _________Dates_______________
Measles (HARD)________ Dates_____________
German Measles___________ Dates _________
Problems w/Diarrhea _______Dates_________
Problems w/Constipation _____ Dates________
Worms ____________ Dates________________
Other______________ Dates_______________

Has your child had illnesses other than above? (If so please explain.)

____

____

Has your child ever been hospitalized? (if so please explain.)

____

____

Has your child had injuries with fractures or loss of consciousness? (If so please explain.)

____

____

When was your child's vision and hearing last tested? (By whom?)

____

____

When did your child last visit the Dentist? _______________________

Has any other member of your family been seriously ill recently? ________________________________

Is there a family history of Asthma? ____ Allergies ______Epilepsy_____ Diabetes? ______

Please list allergies

____

____

Parent/Guardian Signature_______________________________________Date____________________

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Policy Awareness Verification

I, the undersigned, have been made aware of Another Best Childcare and Learning Centers Inc. Policies concerning: health care plan, pesticide use plan, and disaster plan. I am aware that they are available for review at my convenience. By signing below I agree to adhere to any policies concerning actions I may need to take in the event of any such occurrences. If I have any questions about information set forth within the policies I am aware that I may speak with the center director in writing or in person.

Printed Name____

Parent/Guardian Signature _______________________________Date ________________

Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (mm/dd/yyyy)**:** **Sex:**

I certify that the information provided on this form is correct and verifiable.

Symbols below: ◆ Required for School and Child Care/Preschool
● Required for Child Care/Preschool Only

Parent/Guardian Name (please print):

Parent/Guardian Signature Required **Date**

Vaccine	Dose	Date: Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● *Haemophilus influenzae* type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date: Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			

Office Use Only: Immunization information updated and verified with parent/guardian permission:

Printed Staff Name Date	Printed Staff Name Date
Printed Staff Name Date	Printed Staff Name Date

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.
Mark option 1, 2, 3, OR 4 below – see, back #5.

1) ❑ Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) ❑ Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A **OR** 2B below.
2A) ❑ Signed note from HCP attached **OR**
2B) ❑ HCP signed here and print name below:

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: ______________________________

3) ❑ Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: __________(initial) _________(date)

4) ❑ Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
Age/Date of disease:________________________
*Can **ONLY** verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	
❑ Hepatitis B	❑ Rubella	________________
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	________________

Licensed health care provider (HCP) Signature **Date**
(MD, DO, ND, PA, ARNP)
HCP Printed Name: ______________________________

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	**1**	01	12	2011
DTaP	**2**	03	20	2011
DTaP	**3**	06	01	2011

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

1) ❑ If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).

2) ❑ If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.

3) ❑ If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.

4) ❑ If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Reference Guide

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menactra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrcl)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	*Haemophilus influenzae* type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- ☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)
- ☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- ☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- ☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month – Tell us how much and how often (or net income if self-employed) (if None, Write "0")			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
Jane Smith (example)	*$200 / weekly*	*$150 / 2x/month*	*$100 / monthly*	
1.	$ /	$ /	$ /	
2.	$ /	$ /	$ /	
3.	$ /	$ /	$ /	
4.	$ /	$ /	$ /	
5.	$ /	$ /	$ /	
6.	$ /	$ /	$ /	

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

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; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing	☐ I do not have a Social Security Number
		Social Security Number (last four digits) XXX-XX-	
Address	City/State/Zip Code	Daytime Phone	

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, sex, age, or disability.

Race:

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

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 Basic Food, 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, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 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."

CENTER USE ONLY

☐ Child(ren) are categorically ☐ free based on ☐ Basic Food ☐ TANF ☐ FDPIR

☐ Foster child(ren) have been identified on this form and qualify for the ☐ free category.

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

☐ Child(ren) on this form who are not categorically eligible qualify as follows:

Check one:
- ☐ Free
- ☐ Reduced-Price
- ☐ Above-Scale

Total Income: $________________________
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

______________________________ Signature of Institution's Representative

______________________________ Date

Valid for one year from the date of the institution representative's signature. **Invalid without signature and date.**