TEXAS Health and Human Services

Form 2935
October 2023

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

Parent's Email_____

General Information

Operation's Name: Little Creations Learning Center, LLC		Director's Name: Georgia Reese	
Child's Full Name:		Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian *(if different from the child's)*:	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			

I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.

Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:
Name:	Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

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

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance?

◯ Yes ◯ No

Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?

◯ Yes ◯ No

Do you want your child to wear a life jacket while in or near a swimming pool?

◯ Yes ◯ No

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

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

6. Days and Times in Care:

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

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

7. Receipt of Parent's Rights:

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Signature — Parent or Legal Guardian

Date Signed

8. Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯ Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian **Date Signed**

9. School Age Children

My child attends the following school:	School Area Code and Phone No.:

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

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

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

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

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

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

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

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

Admission Requirement

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

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

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

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

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

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature **Date Signed**

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

◯Positive ◯Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

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

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature **Date Signed**

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

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

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

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

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

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

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

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

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

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

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

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

Part 2: Skip this part.

Part 3: Skip this part.

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

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

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

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

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

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

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

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

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

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

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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

NAME:_____ ELIGIBILITY NUMBER: _____

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

Check here if no eligibility number ☐

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

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** **Note:** Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-monthly
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

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

An adult household member must sign this form. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the next page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

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

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Part 7. Sharing Information With Other Programs: OPTIONAL

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

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

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

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

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

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

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

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

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

Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) fax: (833) 256-1665 or (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

CACFP INFANT FEEDING PREFERENCE

Dear Parent/Guardian,

This childcare provider participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires childcare providers to follow specific meal patterns according to the age of the infant.

If your child is exclusively breastfed, childcare providers participating in the CACFP can feed your infant the breast milk you supply and meet the meal pattern requirements. Breastfeeding is widely recognized as the best source of nutrition for infants.

The Institute of Medicine and the American Academy of Pediatrics recommend that "adults/caregivers, who work with infants and their families, promote and support exclusive breastfeeding for the first six months and continuation of breastfeeding in conjunction with complementary foods for 1 year or more, and the Texas Department of Agriculture (TDA) encourages child care provider's to dedicate a space for mothers to breast feed their infants on site."

Childcare providers participating in the CACFP **are required** to offer at least one infant formula for infants who are enrolled for childcare. You may decline the infant formula offered, and supply breast milk and/or your own preferred infant formula.

Additionally, when you determine in consultation with your physician that your child is developmentally ready, the child are provider will also be **required** to offer infant cereal and other foods. As with infant formula, you can decline the infant cereal and other foods offered and provide those items to your childcare provider. It is important to note that your childcare provider will not receive reimbursement for meals that contain more than one parent provided component. Speak to your childcare provider to understand what components are required for your infant's meal and the exceptions made for infants with disabilities, so that your infant receives the most nutritious meal possible.

It is very important that you indicate your preferences on the form that follows so we can honor the nutrition choices you have made for your family. Please complete the information below to designate your preference for infant formula, infant cereal and other foods.

June 2023

Center Name_____ Code _____

This childcare provider offers the following infant formula(s)_____

Infant's Name_____ Infant's Date of Birth_____

Birth through 5 months

A. Please mark your preference
(Choose only one – if baby is getting any formula, choose 2 or 3)

- ☐ 1. Serve only expressed breast milk to my infant.
- ☐ 2. I want the childcare provider to provide the infant formula it offers for my infant.
- ☐ 3. I will bring the infant formula for my infant. Please list the kind of infant formula you will bring:
  _____

Parent's (or guardian's) Signature: _____

Date of Signature: _____/_____/_____

6-11 months

B. Please mark your preference
(choose only one – if baby is getting any formula, choose 2 or 3)

- ☐ 1. Serve only expressed breast milk to my infant.
- ☐ 2. I want the childcare provider to provide the infant formula it offers for my infant.
- ☐ 3. I will bring the infant formula for my infant. Please list the kind of infant formula you will bring:
  _____

C. Please mark your preference
(choose only one – update each month until baby is ready for solid foods)

- ☐ 1. My child is developmentally ready for solid foods. I want the childcare provider to provide the infant cereal and other foods for my infant.
- ☐ 2. My child is developmentally ready for solids. I will bring the infant cereal and/or other foods for my infant.
- ☐ 3. My child is NOT developmentally ready for solid foods. I will inform the provider when and designate the solid food(s) to be introduced to my infant at that time.

Parent's (or guardian's) Signature: _____

Date of Signature: _____/_____/_____

1. This form must be kept on file for each infant enrolled for childcare.
2. This form must be kept current and accurate for each infant enrolled for childcare until the infant reaches one year of age.
3. If the mother breast-feeds her child on site, the meal may be claimed for reimbursement.
4. Parents can provide one (1) meal component and the site is still allowed to claim meals and snacks for reimbursement.
5. If the parent provides two (2) or more components, the meals and snacks may NOT be claimed for reimbursement.
6. Sites must have the parent update this form when the child turns 6 months of age.
7. Sites must submit the updated form to FP Assistance in order to claim 6-11 month meals.

FP Assistance
Feeding the Future

Enrollment Form

Center Name: _____ Site Code: _____

Child's Name: _____ Date of Birth: ____/____/____

Admission date: ____/____/____ Withdrawal Date: ___/____/____ Classroom: _____

1. Circle the days that your child will <u>normally</u> attend the center:

Mon Tue Wed Thu Fri Sat Sun

2. Circle the meals <u>normally</u> served to your child in the center:

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

3. What hours will your child <u>normally</u> be in the center:

____:_____ to ____:_____

4. Participant's ethnic and racial identities

Ethnicity (choose one ethnic identity):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: (choose one or more racial identities):

☐ Asian ☐ American Indian or Alaska Native
☐ White ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American

	Parent Signature	Date of Signature	Day Time Phone Number
1)	_____	_____	(____) ____-____
2)	_____	_____	(____) ____-____
3)	_____	_____	(____) ____-____
4)	_____	_____	(____) ____-____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Little Creations
Learning Center

Transportation Request Form

Parent/Guardian Name _____ **Phone Number** _____

Alternate Parent/Guardian Name _____ **Phone Number** _____

	Child Name	School Name	Grade	Drop Off To School Service	Timeframe for Drop Off	Pick Up From School Service	Timeframe for Pick Up	School Card Required To Pick Up
1				☐		☐		☐
2				☐		☐		☐
3				☐		☐		☐
4				☐		☐		☐
5				☐		☐		☐
6				☐		☐		☐
7				☐		☐		☐

Special Instructions

LITTLE CREATIONS LEARNING CENTER
PHOTOGRAPHIC CONSENT AND RELEASE FORM

I hereby authorize Little Creations Learning Center, and those acting in pursuant to its authority to: (a) Record my likeness and voice on a video, audio, photographic, digital, electronic or any other medium. (b) Use my name in connection with these recordings. (c) Use, reproduce, exhibit or distribute in any medium (e.g. print publications, video tapes, CD-ROM, Internet/www) these recordings for any purpose that the learning center, and those acting pursuant to its authority, deem appropriate, including promotional or advertising efforts. I release the learning center and those acting pursuant to its authority from liability for any violation of any personal or proprietary right I may have in connection with such use. I understand that all such recordings, in whatever medium, shall remain the property of the learning center. I have read and fully understand the terms of this release

Individual consent for participants 18 and older	
First Name	
Last Name	
Phone Number	
E-mail Address	

Participant Signature: _____ Date: _____

Complete the section below for any children under 18 years of age	
Parent or Guardian's First Name	
Parent or Guardian's Last Name	
Child's Full Name	
Child's Full Name	
Child's Full Name	
Child's Full Name	
Child's Full Name	
Child's Full Name	
Child's Full Name	
Phone number	
E-mail address	

Parent Signature: _____ Date: _____