

**Easterseals Iowa Bob and Billie Ray Child Development Center
File Checklist**

Name: _____ **Date of Birth:** _____
Doctor: _____ **Dentist:** _____
Address: _____ **Address:** _____
Phone#: _____ **Phone#:** _____

- _____ **Registration Form (page 2)**
- _____ **Emergency Information Sheet (page 3)**
- _____ **Authorization for Release of Child (page 3)**
- _____ **Emergency Care Release (page 4)**
- _____ **Communicable Disease Policy (page 5)**
- _____ **Parent Permission to Swim (page 6)**
- _____ **Parent Permission Signatures (page 7)**
- _____ **Web Cam Consent Form (page 8)**
- _____ **Childcare Enrollment Form (page 10)**
- _____ **CACFP Eligibility Application (pages 13-14)**
- _____ **Immunizations (page 15)**
- _____ **Physical (page 16) Date: ___ - ___ - ___**
- _____ **Professionally Prescribed Treatment (as needed)**

Annual Update of File

Date: _____ **Date:** _____
Date: _____ **Date:** _____

**Easterseals Iowa Bob and Billie Ray Child Development Center
Registration Form**

Child's Name: _____ Date of Birth: _____

Allergies/Medications/Medical Concerns: _____

Parent/Guardian's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Place of Employment: _____ Email Address: _____

Parent/Guardian's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Place of Employment: _____ Email Address: _____

**Easterseals Iowa Bob and Billie Ray Child Development Center
Emergency Information**

In case of an emergency please list three alternate contacts in the event that parents cannot be reached.

Emergency Contact #1

Name: _____ Relationship: _____ Phone # _____

Emergency Contact #2

Name: _____ Relationship: _____ Phone # _____

Emergency Contact #3

Name: _____ Relationship: _____ Phone # _____

My Child May Be Released To:

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____

My Child May NOT Be Released To:

Name: _____

****If it is the child's biological parent you must file the appropriate paperwork in order for us to enforce custody arrangement.**

Parent Signature: _____ Date: _____

**Easterseals Iowa Bob and Billie Ray Child Development Center
Emergency Care Release**

In the event of an emergency or accident, I hereby give permission to the staff of the Easterseals Iowa Bob and Billie Ray Child Development Center to transport my child _____ for emergency care to a clinic, hospital, or private doctor and secure treatment if needed. I am aware that any expenses incurred will be my responsibility.

Parent Signature: _____ Date: _____

Doctor: _____

Dentist: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Hospital: _____

Health Insurance Coverage

Address: _____

Name of Plan: _____

Phone #: _____

ID #: _____

Name of Insured: _____

Easterseals Iowa Bob and Billie Ray Child Development Center Communicable Disease Policy

In order to help ensure that the health of all Easterseals Bob and Billie Ray Child Development Center students/staff is safeguarded as much as possible, it is our policy that:

1. You immediately inform the school when it is known to you that your child has a communicable disease (i.e. measles, chicken pox, ect.)
2. Your child is not to return to school after having a communicable disease unless a written statement from your doctor is received stating that your child is in good health and free from communicable disease.
3. We inform all parents of Easterseals Bob and Billie Ray Child Development Center students within 24 hours of notification that a student has a communicable disease specifying its nature so that you may call a physician for information. Communicable disease information is posted in the entryway.

Has your child been exposed to C.M.V. or any other contagious illness or virus that we need to be aware of?

Yes _____

No _____

I have read and agree to the above statement concerning the communicable disease policy.

Child's Name: _____

Parent Signature: _____

Date: _____

**Easterseals Iowa Bob and Billie Ray Child Development Center
Swimming Activity Program Child Approval Form**

Child's Name: _____ Date of Birth: _____

Has this child ever been in water? Yes ____ No ____

Where? _____

Does your child have a fear of water? Yes ____ No ____

Does your child swim in deep water? Yes ____ No ____

Has your child ever been in a swimming class? Yes ____ No ____

Is there anything else the lifeguard should know about your child?

Has your doctor approved of this activity for your child? Yes ____ No ____

(Ear drops will be administered if medically indicated and ordered by a physician)

I grant permission for my child to be involved in swimming activities.

Parent Signature: _____ Date: _____

**Easterseals Iowa Bob and Billie Ray Child Development Center
Parent Permission Signatures**

Child's Name: _____ Expiration Date: _____

Field Trips:

I hereby give my permission for my child to be included in any field trips away from the Easterseals Iowa Bob and Billie Ray Child Development Center. I understand that I will be notified of these trips in advance.

Parent Signature: _____ Date: _____

Pictures:

I hereby assign all rights to the film/photograph/videotape/sound recording made of my child by Easterseals Iowa Bob and Billie Ray Child Development Center and authorize the use of same by Easterseals, and those associated with it permission, for the purpose of illustration, publication, or broadcast in connection with the work of Easterseals. I have read the foregoing release and authorization before affixing my signature and I verify that I fully understand the contents thereof.

Parent Signature: _____ Date: _____

Assessment:

I give my permission for educational and/or therapeutic evaluations to be administered to my child during the program year.

Parent Signature: _____ Date: _____

Easterseals Iowa Bob and Billie Ray Child Development Parent/Guardian Webcam Acknowledgement Statement

I acknowledge that I have been informed that the Easterseals Iowa Bob and Billie Ray Child Development Center have equipped their classrooms with Webcam. I understand that by attending the Easterseals Iowa Bob and Billie Ray Child Development Center, other families in my child's room will be able to view my child and their activities, but that no personal information about my child will be shared.

Parents/Guardians may subscribe to the Webcam viewing service to receive live video of their children in their classrooms throughout the day through any computer connected to the internet. The Easterseals Iowa Bob and Billie Ray Child Development Center offers this extra service as a way to help families utilize our open door policy.

For the privacy of all children within the facility, I agree that I will not screenshot, or screen record any activity on the live feed video. If I have questions or comments about the activity on the live feed, I will address them with the classroom teacher. If I have further questions or comments I will address them with the director or assistant director.

Web monitoring also allows management a less disruptive way of monitoring and supervising children and staff throughout the day, and a more accurate way to evaluate staff and maintain quality in the center. In no way is video monitoring used as a substitute for a teacher in our child:staff ratio-it is complimentary to these ratios.

Child's Name: _____

Parent/Guardian Signature: _____

Easterseals Iowa Bob and Billie Ray Child Development Center Webcam Information Sheet

Why use webcams?

Easterseals Iowa Bob and Billie Ray Child Development Center wanted to be able to provide parents a convenient way to visit our classrooms that support the open door policy. In addition to this, we wanted to be able to give the director an opportunity to monitor all classrooms. We also use the webcams for training opportunities to increase quality.

Is it safe?

Yes, it is a secure site that can only be accessed with a username and password. The cameras have been strategically placed to avoid changing tables and restrooms.

Will there be a cost for parents who wish to utilize the webcams?

No, this is an added benefit.

Where are the cameras located?

There is one camera in each of the classrooms, one camera in each of the hallways and outside on the fenced in playground.

Can I decline to have my child viewed on the webcam?

No, since the cameras are in the classrooms we cannot grant exclusion options.

What if I see something that upsets me?

We would ask that you handle your concern as you would handle any other concern. First speak with your child's teacher. If you are uncomfortable doing this or are not getting expected results, please visit with the director or assistant director. Finally if you still do not have resolution, you may file a grievance with the CEO Sherri Nielson who will make the final decision.

How can I assess the webcam?

Please see the Camera How To document.



Your child is enrolled in a center that participates in the Child and Adult Care Food Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to assist with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

May 2024

Iowa Child and Adult Care Food Program Child Care Enrollment Form

Last Name, First Name	Birthdate	Times of Care		Regular Days of Care						Meals Served During Care					Ethnicity/Race*			
		Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
 *Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander. This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it.

- Infants only (0 to 12 months):** I am not enrolling an infant (skip this section)
- As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages; you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:
- I will provide breastmilk for my infant. Yes No **If infant is still hungry and no breastmilk is available, list what to feed** _____
 - I would like to breastfeed on site, if this option is available¹. Yes No If yes, time(s) _____
 - I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____
 - I accept the center's formula for my infant. Name of iron-fortified formula: _____
 - I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____
 - I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.
 - I will provide solid foods for my infant². The center may supplement with additional solid foods when my infant needs them: Yes No

Parent Signature _____ Date: _____

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

Parent Signature _____ Date: _____ (Make any needed changes above, sign and date)

¹Ask your center if you can breastfeed on-site.
²The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 7/2025

Purpose: The attached Iowa Eligibility Application is used to determine eligibility for free and reduced price meal reimbursement. The instructions for completion are on the back of this letter.

Dear Parent or Guardian:

This center participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture (USDA). Participants are not charged separately for meals. However, by participating in this Program, the center receives partial reimbursement for nutritious meals served to children. The amount of reimbursement the center receives is determined by the information you provide. Providing information can help your center purchase nutritious food. Higher reimbursement will be given to the center for meals served to enrolled children from families whose income is at or below the level shown in the chart below. Please read the instructions on the back, complete, sign and return the attached income application as soon as possible. An application that does not contain all required information cannot be used by the center. If required information is missing, free or reduced-price meal benefits will be denied. Call your center if you need help with the form. The information reported on this form will be filed and treated as confidential.

A foster child who is the legal responsibility of a welfare agency or court may be certified as eligible for free meals regardless of your household income. See instructions on the back for more information.

If you do not qualify now to receive free or reduced-price meals, you may apply for benefits at any time during the year. If you have a decrease in household income, have an increase in family size, or have enrolled children that become eligible for SNAP or FIP, you may fill out an application at that time.

**Income Eligibility Guidelines for Reduced Price Meals
Effective 7-1-2025 to 6-30-2026**

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	\$28,953	\$2,413	\$1,207	\$1,114	\$557
2	\$39,128	\$3,261	\$1,631	\$1,505	\$753
3	\$49,303	\$4,109	\$2,055	\$1,897	\$949
4	\$59,478	\$4,957	\$2,479	\$2,288	\$1,144
5	\$69,653	\$5,805	\$2,903	\$2,679	\$1,340
6	\$79,828	\$6,653	\$3,327	\$3,071	\$1,536
7	\$90,003	\$7,501	\$3,751	\$3,462	\$1,731
8	\$100,178	\$8,349	\$4,175	\$3,853	\$1,927
For each additional family member add:	+ \$10,175	+ \$848	+ \$424	+ \$392	+ \$196

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

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 your child for free or reduced price meals. The last four digits of the social security number of the adult household member who signs the application must be listed. The social security information is not required when you apply on behalf of a foster child or if you list a SNAP number, or Family Investment Program number, 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

USDA Nondiscrimination 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/ad-3027.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.

Instructions for Completing the Iowa Income Eligibility Application

Step 1 – All households complete this section of the form.

- List the name and date of birth for each child up to grade 12 residing in the household.
- Check the box if the child is a student.
- List the child's school and grade.
- Check the box if the child living in the household remains the legal responsibility of the welfare agency or court. Foster children can be included as household members or included on a separate application.
- Check the box if the child is Homeless, Migrant or a Runaway and call the child's school.
- Provide Ethnic and Racial information if you choose

Step 2 – Complete this section if a member of the household participates in SNAP, FIP or FDPIR. If no household members participate in one of the listed programs, skip to Step 3.

- List one FIP or SNAP case number per household in the area provided.
- Use the case number listed in the Department of Health and Human Services Notice of Decision Letter.
- Use of Medicaid, Title XIX and EBT card numbers is not acceptable.

Step 3 – Complete this section if Step 2 was not completed.

- Enter the total number of children and adults in the household.
- If the application is being made on the basis of income, the adult signing the form must provide the last four digits of his or her social security number or check the "No SSN box". The application cannot be processed without this information.
- List the names of each person living in the household not listed in Step 1. The household decides whether to include the foster child on their household application with non-foster children. Attach another sheet of paper if needed.
- Report the amount of income earned from work in the appropriate Gross Earnings column (weekly, every 2 weeks, twice monthly or monthly). Gross income is the amount earned before taxes and other deductions.
- Report the amount of income received on a regular basis from welfare, child support, alimony or adoption subsidies in the Gross Public Assistance/Child Support/Alimony, if applicable.
- Report the amount of income received from pensions, retirement, Social Security and Veteran's Benefits in the Gross Pension/Retirement section, if applicable.
- Report the total gross income earned by all children listed in Step 1, if applicable in the Total Income Received by All Children section.

Step 4 – All households complete this section.

- Read the certification statement.
- Complete this section with the required information.

Iowa Non-Discrimination Statement: "It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, national origin, disability, age, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.6, 216.7, and 216.9. If you have questions or grievances related to compliance with this policy by this CNP Provider, please contact the Iowa Civil Rights Commission, Grimes State Office building, 6200 Park Ave Suite 100, Des Moines, IA 50321-1270; phone number 515- 281-4121, 800-457-4416; website: <https://icrc.iowa.gov/>."

2025-2026 Iowa Eligibility Application for Free and Reduced Price CACFP Meals Complete one application per household. Use a pen (not a pencil). Please read "Instructions for completing the Low Income Eligibility Application" in the attached parent letter for more information on completing this application.

STEP 1

List ALL Household Members who are infants, children, and students up grade 12 (if more spaces are required for additional names, attach the supplemental worksheet)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related." Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community.	Child's First Name	MI	Child's Last Name	Date of Birth	Student	Child's School and Grade	Foster Child	Homeless Migrant Runaway	OPTIONAL Responding to this section is optional and does not affect your child's eligibility for free/reduced price meals.	
	Ethnicity		Race		Check all that apply		Non-Hispanic/Latino		A=Asian W=White I=American Indian/Alaskan Native B=Black/African American P=Native Hawaiian/Other Pacific Islander	
					Yes No					
					<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

STEP 2

Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, FIP or FDPIR? If No, go to STEP 3. If you answered Yes, write a case number here then go to STEP 4 (Do not complete STEP 3). Write only one case number in this space. Medicaid and EBT card numbers are NOT acceptable

STEP 3

Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2) Apply Online:

A. Total Number of All Household Members (Children + Adults) B. Last Four Digits of Social Security Number (SSN) of Adult Household Member (last 4 digits) XXX-XX- C. Check No SSN (adult):

D. All Adult Household Members (include yourself): List all Household Members not listed in STEP 1 even if they do not receive income. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report. Applications with blank income fields will be processed as complete. If more spaces are required for additional names, attach the supplemental worksheet. The sources of income for adults section will help you with the adult income. Report all income in whole dollar amounts before deductions or taxes.

Names of All Adult Household Members	Gross Earnings from Work/All Other Income				Gross Public Assistance/Child Support/Alimony				Gross Pension/Retirement				
	Weekly	Every 2 Weeks	2x Month	Monthly	Annual	Weekly	Every 2 Weeks	2x Month	Monthly	Weekly	Every 2 Weeks	2x Month	Monthly
First and Last Names. Include children who are temporarily away at school or in college.	\$					\$				\$			
	\$					\$				\$			
	\$					\$				\$			
	\$					\$				\$			

E. Child Income: Sometimes children in the household earn or receive income. Please include the TOTAL gross earned income by all Children listed in STEP 1 here. The sources of income for children section will help you with the Child Income.

Total Income Received by All Children	Weekly	Every 2 Weeks	2x Month	Monthly	Annual
\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STEP 4

Contact information and Adult Signature

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of adult completing the form _____ Printed name of adult completing the form _____ Today's Date _____

Street Address (if available) Apt. # City State Zip Daytime Phone (optional) Email (optional)

DO NOT WRITE BELOW THIS LINE. FOR CACFP ADMINISTRATIVE USE ONLY Return completed form to:

Annual Income Conversion (if needed)	Household Size:	Total Income:	Date Received:
Every 2 Weeks (x26) 2x Month (x24) Monthly (x12)	Signature and Date of Determining Official	Signature and Date of Confirming Official	Application #
Application <input type="checkbox"/> Income <input type="checkbox"/> Foster Child <input type="checkbox"/> FIP/SNAP <input type="checkbox"/> Head Start (confirmation required) <input type="checkbox"/> Homeless/Migrant/Runaway-Local Official confirmation Required	Application Determination <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Free Milk <input type="checkbox"/> Incomplete <input type="checkbox"/> Application Denied <input type="checkbox"/> Over Income Limits	Signature and Date of Verification Follow-Up	<input type="checkbox"/> ERROR PRONE APPLICATION

PAGE TWO CONTAINS MORE INFORMATION

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 submit all needed information, we cannot approve your child 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 is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Family Investment Program (FIP) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

USDA Nondiscrimination 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/ad-3027.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:

*** mail:**

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
This institution is an equal opportunity provider.

fax:

(833) 256-1665 or (202) 690-7442; or

email:

program_intake@usda.gov

***Do not mail applications to this address, only complaints of discrimination.**

Translated applications are available at: <http://www.fns.usda.gov/school-meals/translated-applications>

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**Return completed form to:
Waiver Information**

<p>Sources of Child Income</p> <ul style="list-style-type: none"> Earnings from work Social Security (disability payments and survivor's benefits) Income from person outside the household Income from any other source

<p>Earnings from Work (Adult Income Sources)</p> <ul style="list-style-type: none"> Salary, wages, cash bonuses (before deductions or taxes) Net income from self-employment (farm or business) If you are in the U.S. Military: <ul style="list-style-type: none"> a. Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) b. Allowances for off-base housing, food and clothing 	<p>Public Assistance/Alimony/Child Support (Adult Income Sources)</p> <ul style="list-style-type: none"> Cash Assistance from State/local government Supplemental Security Income Unemployment benefits Worker's compensation Alimony or child support payments Veteran's benefits Strike benefits 	<p>All Other Income (Adult Income Sources)</p> <ul style="list-style-type: none"> Social Security Disability benefits Regular income from trusts or estates Annuities Investment income Rental income Regular cash payments from outside household
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Optional Supplemental Worksheet 2025-2026 Iowa Application for Free and Reduced Price CACFP Meals

Additional Children in Your Household (not listed on page 1)

Child's First Name	MI	Child's Last Name	Date of Birth	Student		Child's School	Grade	Foster Child	Homeless, Migrant, Runaway	OPTIONAL	
				YES	NO					Ethnicity	Race
				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			<small>Responding to this section is optional and does not affect your child's eligibility for free/reduced price meals.</small> Ethnicity: H=Hispanic or Latino, N=Non-Hispanic/Latino Race: A=Asian, W=White, I=American Indian/Alaskan Native, B=Black/African American, P=Native Hawaiian/Other Pacific Islander
				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			
				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			
				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			
				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			
				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			
				<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>			

Any income earned by the above listed children should be included under Step 3 E on the first page of the application.

Additional Adults in Your Household (Not listed on page 1)

Names of All Adult Household Members	Gross Earnings from Work/All Other Income				Gross Public Assistance/Child Support/Alimony				Gross Pension/Retirement			
	Weekly	Bi-weekly	2x Monthly	Yearly	Weekly	Bi-weekly	2x Monthly	Monthly	Weekly	Bi-weekly	2x Monthly	Monthly
First and Last Names. Include children who are temporarily away at school or in college.												
	\$								\$			
	\$								\$			
	\$								\$			
	\$								\$			
	\$								\$			
	\$								\$			

Self-Employment Income Calculations

This guidance will assist you in calculating the amount to report if you engage in farming, are self-employed or have income from other sources.

Self-employed persons may use income tax records for the preceding calendar year as a base to project the current year's net income, unless the current monthly income provides a more accurate measure. Report income derived from the business venture less the operating costs incurred in the generation of that income. Deductions for personal expenses such as interest on home payments, medical expenses, and other similar non-business deductions are not allowed in reducing gross business income. Additional income from other kinds of employment must be treated as separate and apart from the income generated or lost from your business venture. For example, if you operated a business at a net loss, but held additional employment for which a salary was received, the income for purposes of applying for reduced price or free meals would be the income from the salary only. The loss from the business cannot be deducted from a positive income earned in other employment. For purposes of this application, it is not possible to report a negative income from any business venture. The least income possible is zero (no income). The necessary information for arriving at allowable income from private business operation may be taken from your most recent U.S. Individual Income Tax Return - Form 1040 or 1040-SR and Schedule 1. Add together the amounts reported on the following lines:

- Capital Gain or (Loss) Form 1040 or 1040-SR, LINE 7 \$ _____
- Business Income or (Loss) Schedule 1 Part 1, LINE 3 \$ _____
- Other Gains or (Losses) Schedule 1 Part 1, LINE 4 \$ _____
- Rental real estate, royalties, partnerships, S corporations, trusts, etc. Schedule 1 Part 1, LINE 5 \$ _____
- Farm Income or (Loss) Schedule 1 Part 1, LINE 6 \$ _____

TOTAL \$ _____ Gross Annual Income Before Any Deductions. Report in Step 3 under All Other Income (Computed Monthly Income \$ _____ Gross Annual Income + 12)

Diet Modification Request Form

Complete this form (top section: parent/guardian, remainder: medical professional) and return to the provider.

Name of provider: _____
(school, head start, summer meal provider, day care, or home provider)

Student/Participant Name: _____ Birth Date: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____ Email: _____

USDA allows a parent/guardian to supply substitute foods. Check here if you wish to provide the substitute foods:

Infants under one year of age must receive iron-fortified infant formula or breast milk unless a Diet Modification Request Form is on file.

The parent/guardian may request a nutritionally equivalent substitute for fluid milk. This provider chooses to offer _____ as the nutritionally equivalent milk substitute. Check here if you would like to request the milk substitute listed in place of fluid milk and list the reason for the request: _____

Parent/Guardian signature: _____ Date: _____
(To provide permission for a medical professional to complete the form and share information as needed with the appropriate staff to make accommodations.)

The remainder of the form must be completed by an approved medical professional. In Iowa this includes Registered Dietitians or a "medical authority" that is authorized by state law to write medical prescriptions: Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Physician's Assistants (PA), Advanced Registered Nurse Practitioners (ARNP) or Dentists (DDS or DMD).

Medical professional: _____
(Name, print or type) (Title)

(Signature of medical professional) (Date)

Modifications are required by The U. S. Department of Agriculture (USDA) to accommodate a disability. Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

1) Describe the medical need related to the diet order and "major life activity" (see above) affected.
Example: Allergy to peanuts affects ability to breathe.

2) Explain what must be done to accommodate the medical need:

Food(s) or Formula to Omit:	Food(s) or Formula to Substitute:
If the request is for a food allergy, are foods made in a facility with the allergen acceptable: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Complete the back to provide additional details.

Check if a texture modification is requested (use International Dysphagia Diet Standardisation Initiative (IDDSI) terminology)
 Foods: Regular Easy to chew Soft & bite-sized Minced & Moist Pureed Liquidised
 Liquids: Thin Slightly thick Mildly thick Moderately thick Extremely thick
 Special Feeding Equipment: Not Applicable Equipment Needed: _____
(Example: large handled spoon, sippy cup, etc.)

Check the box in front of foods that should NOT be served and list the foods to be served instead.

<p>Lactose/milk – Do not serve the items checked below:</p> <p><input type="checkbox"/> Fluid milk as a beverage or on cereal? ¼ cup of fluid milk to be used on cereal? __yes __no</p> <p><input type="checkbox"/> Yogurt</p> <p><input type="checkbox"/> Milk based desserts such as ice cream and pudding</p> <p><input type="checkbox"/> Hot entrees with cheese as a prime ingredient such as grilled cheese, cheese pizza, or macaroni & cheese</p> <p><input type="checkbox"/> Cheese baked in products such as a casserole or on pizza</p> <p><input type="checkbox"/> Cold cheese such as string cheese or sliced cheese on a sandwich</p> <p><input type="checkbox"/> Milk in food products such as breads, mashed potatoes, cookies or graham crackers</p>	<p>Serve these items instead:</p>
<p>Soy - Do not serve the items checked below:</p> <p><input type="checkbox"/> Protein products extended with soy</p> <p><input type="checkbox"/> Processed items cooked in soy oil</p> <p><input type="checkbox"/> Food products with soy as one of the first three ingredients</p> <p><input type="checkbox"/> Food products with soy listed as the fourth ingredient or further down the list</p>	<p>Serve these items instead:</p>
<p>Egg - Do not serve the items checked below:</p> <p><input type="checkbox"/> Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold</p> <p><input type="checkbox"/> Eggs used in breading or coating of products</p> <p><input type="checkbox"/> Baked products with eggs such as breads or desserts</p>	<p>Serve these items instead:</p>
<p>Seafood – Do not serve the items checked below:</p> <p><input type="checkbox"/> Fish (Cod, tuna, tilapia, haddock, salmon, etc.)</p> <p><input type="checkbox"/> Shrimp</p> <p><input type="checkbox"/> Other: _____</p>	<p>Serve these items instead:</p>
<p>Peanuts – Do not serve the items checked below:</p> <p><input type="checkbox"/> Peanuts, individually or as an ingredient</p> <p><input type="checkbox"/> Foods containing peanut oil</p> <p><input type="checkbox"/> Foods items identified as manufactured in a plant that also handles peanuts</p>	<p>Serve these items instead:</p>
<p>Tree nuts – Do not serve the items checked below:</p> <p><input type="checkbox"/> All nuts</p> <p><input type="checkbox"/> Food items identified as manufactured in a plant that also handles nuts</p> <p><input type="checkbox"/> Other: _____</p>	<p>Serve these items instead:</p>
<p>Grains – Do not serve the items checked below:</p> <p><input type="checkbox"/> Foods containing wheat</p> <p><input type="checkbox"/> Foods containing gluten</p> <p><input type="checkbox"/> Oats</p> <p><input type="checkbox"/> Other: _____</p>	<p>Serve these items instead:</p>
<p>Sesame – Do not serve the items checked below:</p> <p><input type="checkbox"/> Foods containing sesame</p>	<p>Serve these items instead:</p>

Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (_____) _____

A representative of the local Board of Health or Iowa Department of Health and Human Services may review this certificate for audit purposes.

Vaccine	Vaccine Type	Date Given	Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/ DT/Td/Tdap			
Polio IPV/OPV			
Measles, Rubella MMR			
Haemophilus influenzae type b Hib			
Hepatitis B Hep B			
Varicella* Chickenpox			
Pneumococcal PCV			
Meningococcal MenACWY			

* If patient has a history of natural disease, write "Immune to Varicella".

I certify the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Name (Print): _____
 Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Signature: _____
 Physician (MD, DO), Physician Assistant, Nurse, or Certified Medical Assistant

Date: _____

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI – starting at age 24 mo.: _____

Head Circumference @ age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr.: _____

Hgb or Hct @ 12 mo.: _____

Lead Risk Assessment: _____

Blood Lead Level @ 1 yr. & 2 yr.: date _____ results _____

Sensory Screening:

Vision Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:

(n = normal limits) otherwise describe

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: Yes No

Exam Results: (n = normal limits) otherwise describe

HEENT

Oral/Teeth Date of Dental exam _____

Oral Health/Dental Referral Made Today: Yes No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____

Date of Birth: _____ Age: _____

Immunization and TB Testing: (check as indicated)

IDPH Certificate of Immunization reviewed and signed

TB testing completed (only for high-risk child)

Health provider authorizes the child may receive the following at child care: (include over-the-counter medications)

	Name	Dosage
<input type="checkbox"/>	Diaper cream/ointment:	
<input type="checkbox"/>	Fever or Pain reliever:	
<input type="checkbox"/>	Sunscreen:	
<input type="checkbox"/>	Other	

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at <https://hhs.iowa.gov/hcci/products>

Additional Referrals made:

- _____
- _____

Health Provider Assessment Statement:

The child may participate in developmentally appropriate early care/learning with **NO** health-related restrictions.

The child may participate in developmentally appropriate early care/learning **with restrictions** (see comments).

The child has a special needs care plan
Type of plan _____

(Please complete and give to parent for child care templates at <https://hhs.iowa.gov/hcci/products>)

Comments:

May use stamp

Signature _____

Circle Provider Type: MD DO PA ARNP Chiropractor

Address: _____ Telephone: _____

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767288.1525543973.1674849857-346854326.1661880588

PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

Growth - I am concerned about my child's growth.

Appetite - I am concerned about my child's eating/feeding habits or appetite.

Rest - I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child had a serious illness, injury, or surgery.

Please describe:

Physical Activity - My child must restrict physical activity.

Please describe:

Development and Learning - I am concerned about my child's behavior, development, or learning.

Please describe:

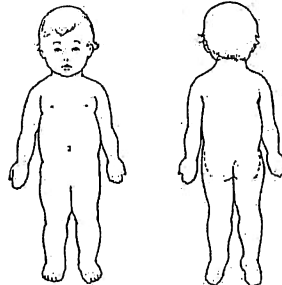
Allergies - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

Please describe:

Special Needs Care Plan - My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

Body Health - My child has skin problems, birthmarks, Mongolian spots, etc.

Map and describe color/shape of skin markings
birthmarks, scars, moles



- Eyes \ vision, glasses
- Ears \ hearing, hearing aids or device, ear-aches, tubes in ears
- Nose problems, nosebleeds, runny nose
- Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
- Nervous System, headaches, seizures
- Breathing problems, asthma, cough, croup
- Heart, heart murmur
- Stomach aches, upset stomach, spitting-up
- Using toilet, toilet training, urinating
- Bones, muscles, movement, pain when moving, uses assistive equipment.
- Needs special equipment.

List equipment:

Medication¹ - My child takes medication.

<u>Medication Name</u>	<u>Time Given</u>	<u>Reason for Medication</u>

Child has Emergency Medication - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at <https://hhs.iowa.gov/hcci/products>

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature (required) _____ Date: _____

¹ Please review the child care program's policies about the use of medication at child care.

Parent's/Guardian's Permission To Apply Sunscreen To Child

(Name of Child) _____

As the parent or guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at:

(Child Care Business) _____

to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- I do not know of any allergies my child has to sunscreen.
- Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.
- I have provided the following brand/type of sunscreen for use on my child:

My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

- For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

Parent/Guardian full name (print): _____

Parent/Guardian signature: _____ Date: _____