Easterseals Iowa Bob and Billie Ray Child Development Center
File Checklist

Name: _____ Date of Birth: _____

____ Registration Form

____ Emergency Information Sheet

____ Authorization for Release of Child

____ Emergency Care Release

____ Communicable Disease Policy

____ Parent Permission to Swim

____ Parent Permission Signatures

____ Web Cam Consent Form

____ Childcare Enrollment Form

____ CACFP Eligibility Application

____ Immunizations

____ Physical

____ Sunscreen Permission Form

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: _____

Six-Digit Code for Building Access: _____

Parent/Guardian's Name: _____

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

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

Place of Employment: _____ Email Address: _____

Six-Digit Code for Building Access: _____

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: _____

Address: _____

Phone #: _____

Dentist: _____

Address: _____

Phone #: _____

Hospital: _____

Address: _____

Phone #: _____

Health Insurance Coverage

Name of Plan: _____

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.

CHILD & ADULT CARE FOOD PROGRAM

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 2026

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
Last Name, First Name	Birthdate	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 available[1]. If yes, time(s) _____

❑ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA with limited exception): _____

❑ 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 infant[2]. 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)

[1]Ask your center if you can breastfeed on-site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. HHS 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.

This institution is an equal opportunity provider.

Iowa CACFP Child Care Center Parent/Guardian Letter - Non-pricing (front) 6/2026

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 7-1-2026 to 6-30-2027

Household Size	Reduced Price Meals				
	Yearly	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$29,526	$2,461	$1,231	$1,136	$568
2	$40,034	$3,337	$1,669	$1,540	$770
3	$50,542	$4,212	$2,106	$1,944	$972
4	$61,050	$5,088	$2,544	$2,349	$1,175
5	$71,558	$5,964	$2,982	$2,753	$1,377
6	$82,066	$6,839	$3,420	$3,157	$1,579
7	$92,574	$7,715	$3,858	$3,561	$1,781
8	$103,082	$8,591	$4,296	$3,965	$1,983
For each additional family member add:	+ $10,508	+ $876	+ $438	+ $405	+ $203

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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

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/."

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 grade12 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.

2026-2027 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 Iowa 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.

OPTIONAL: Responding to this section is optional and does not affect your children's eligibility for free/reduced price meals.

Race: A=Asian W=White I=American Indian/Alaskan Native B=Black/African American P=Native Hawaiian/Other Pacific Islander

Child's First Name	MI	Child's Last Name	Date of Birth	Student: Yes	Student: No	Child's School and Grade	Foster Child (Check all that apply)	Homeless Migrant Runaway (Check all that apply)	Ethnicity: Hispanic or Latino	Ethnicity: Non-Hispanic/ Latino	Race
				☐	☐		☐	☐	☐	☐	
				☐	☐		☐	☐	☐	☐	
				☐	☐		☐	☐	☐	☐	
				☐	☐		☐	☐	☐	☐	

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

Case Number: _ _ _ _ _ _ - _ _ _ - _ - _

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 — First and Last Names. Include children who are temporarily away at school or in college.

Gross Earnings from Work/All Other Income — How often? (Mark "X" in box)

Gross Public Assistance/Child/Support/Alimony — How often? (Mark "X" in box)

Gross Pension/Retirement — How often? (Mark "X" in box)

Names of All Adult Household Members	Earnings $	Weekly	Every 2 Weeks	2x Month	Monthly	Annual	Public Assistance $	Weekly	Every 2 Weeks	2x Month	Monthly	Pension $	Weekly	Every 2 Weeks	2x Month	Monthly
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

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
$	☐	☐	☐	☐	☐

STEP 4

Contact Information and Adult Signature

PAGE TWO CONTAINS MORE INFORMATION

"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)

Weekly (x52)	Every 2 Weeks (x26)	2x Month (x24)	Monthly (x12)	**Household Size:** ________	**Total Income:** $________	Application #: ________ Date Received: ________ ☐ ERROR PRONE APPLICATION

Signature and Effective Date of Determining Official	Signature and Date of Confirming Official	Signature and Date of Verification Follow-Up

Application ☐ Income ☐ Foster Child ☐ FIP/SNAP ☐ Head Start (confirmation required) ☐ Homeless/Migrant/Runaway-Local Official confirmation Required

Eligibility Determination ☐ Free ☐ Reduced ☐ Free Milk Application Denied ☐ Incomplete ☐ Over Income Limits

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, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

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

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/."

Return completed form to:

Waiver Information

Sources of Child Income
• Earnings from work • Social Security (disability payments and survivor's benefits) • Income from person outside the household • Income from any other source

Earnings from Work (Adult Income Sources)	Public Assistance/Alimony/Child Support (Adult Income Sources)	All Other Income (Adult Income Sources)
• Salary, wages, cash bonuses (before deductions or taxes) • Net income from self-employment (farm or business) • If you are in the U.S. Military: 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	• Cash Assistance from State/local government • Supplemental Security Income • Unemployment benefits • Worker's compensation • Alimony or child support payments • Veteran's benefits • Strike benefits	• Social Security • Disability benefits • Regular income from trusts or estates • Annuities • Investment income • Rental income • Regular cash payments from outside household

Optional Supplemental Worksheet 2026-2027 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 Responding to this section is optional and does not affect your children's eligibility for free/reduced price meals.	
				YES	NO			Check all that apply		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
				☐	☐			☐	☐		
				☐	☐			☐	☐		
				☐	☐			☐	☐		
				☐	☐			☐	☐		
				☐	☐			☐	☐		
				☐	☐			☐	☐		

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				
	How Often? (mark "X" in box)						How Often? (mark "X" in box)					How Often? (mark "X" in box)				
First and Last Names. Include children who are temporarily away at school or in college.		Weekly	Bi-weekly	2x Month	Monthly	Yearly		Weekly	Bi-weekly	2x Month	Monthly		Weekly	Bi-weekly	2x Month	Monthly
	$						$					$				
	$						$					$				
	$						$					$				
	$						$					$				
	$						$					$				
	$						$					$				

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)

Iowa Department of Public Health
Certificate of Immunization

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

Parent/Guardian: _____ Address: _____ Phone: _____

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

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. **Routine vaccination begins at 2 months of age.**	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses if the applicant received 1 dose before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age, unless the applicant has a reliable history of natural disease.
	24 months of age and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older. **Hib vaccine is not required for persons 60 months of age or older.**
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 24 months of age; or 2 doses if the applicant received 1 dose before 24 months of age; or 1 dose if the applicant did not receive any doses before 24 months of age. **Pneumococcal vaccine is not required for persons 60 months of age or older.**
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age, unless the applicant has had a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/ Pertussis[4, 5]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000[2]; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but on or before September 15, 2003[2]; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2003[2, 3];and 1 time dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) for the applicant in grades 7 and above, if born after September 15, 2000; regardless of the interval since the last tetanus/diphtheria-containing vaccine.
		Polio	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003[7] ; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003.[6] **Polio vaccine is not required for persons 18 years of age or older.**
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born on or before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born after September 15, 2003, unless the applicant has a reliable history of natural disease.[8]
		Meningococcal (A, C, W, Y)	1 dose of meningococcal vaccine received on or after 10 years of age for the applicant in grades 7 and above, if born after September 15, 2004; and 2 doses of meningococcal vaccines for the applicant in grade 12, if born after September 15, 1999; or 1 dose if received when the applicant is 16 years of age or older.

1 Mumps vaccine may be included in measles/rubella-containing vaccine.

2 DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus and diphtheria-containing vaccine should be used.

3 The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.

4 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.

5 Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.

6 If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.

7 If both OPV and IPV were administered as part of the series, a total of 4 doses are required.

8 Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.

Infant, Toddler, Preschool Age (including Kindergarten entry)
Child Health Form

HEALTH PROFESSIONAL COMPLETE PAGE

Date of Exam: _____

Height/Length: _____ Weight: _____
BMI - starting at age 24 mo.: _____
Head Circumference age infant to 2 yr._____
Blood Pressure - starting age 3 yr.: _____
Hgb or Hct 12 mo.: _____
☐ TB testing completed (if high-risk child)
Lead Risk Assessment: _____
Blood Lead Level at 1 yr. & 2 yr.
Date _____ results _____

Sensory Screening:
Vison 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: ☐ Yes ☐ No

Exam Results: *(n = normal limits) or describe*
HEENT
Oral/Teeth Date of Dental exam: _____
Oral Health/Dental Referral: ☐ Yes ☐ No
Heart
Lungs
Stomach/Abdomen
Genitalia
Extremities, Joints, Muscles, Spine
Skin, Lymph Nodes
Neurological

Allergies: _____
☐ No known allergies

Child's Name: _____

Date of Birth: _____ Age: _____

Immunization (signed and dated):
check as indicated
☐ HHS Certificate of Immunization
☐ HHS Certificate of Immunization Exemption (Religious or Medical)
☐ HHS Provisional Certificate of Immunization

Health provider authorizes the child to receive the following at child care:

Name and Dosage

☐ Diaper cream/ointment:
☐ Fever or Pain reliever:
☐ Sunscreen:
☐ Other

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/programs/programs-and-services/child-care/hcci

Additional Referral made:

_____

Health Provider Assessment Statement:
☐ Child may participate in developmentally appropriate early care with ***NO*** health-related restrictions.
☐ Child may participate in developmentally appropriate early care ***with these restrictions***

_____

☐ The child has a special needs care plan
Type of plan _____
Please complete care plan and give to parent/guardian for child care, templates available at https://hhs.iowa.gov/programs/programs-and-services/child-care/hcci

May use stamp

Signature _____
Circle Provider Type
MD DO PA ARNP Chiropractor
Address: Telephone:

Infant, Toddler, Preschool Age (including Kindergarten entry)
Child Health Form

PARENT/GUARDIAN (complete annually)

Child's Name: _____
Age: _____

Tell us about your child's health. Please use an **X** in the box ☐ for statements that apply to your child.

☐ **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:

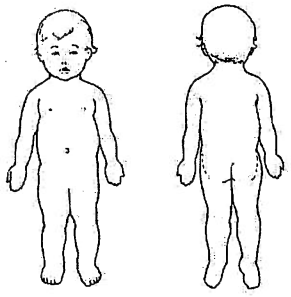
☐ **Development and Learning** - I am concerned about my child's behavior, development, or learning.

Please describe:

☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.). _____
☐ No known allergies

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss this 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
☐ Problems using toilet, urinating
☐ Toilet training.
☐ Problems with bones, muscles, pain when moving, uses assistive equipment.
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication or has emergency medication.

Medication Name	Time Given	Reason for Medication

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

Parent/Guardian Signature (required) _____ Date: _____

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: _____