EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.181 & 182; 3280.124 (a) (b), 3280.181 & 182; 3290.124 (a) (b), 3290.181 & 182

CHILD'S NAME	DATE OF BIRTH
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
EMPLOYER	EMPLOYER TELEPHONE NUMBER
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
EMPLOYER NAME	EMPLOYER TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S) NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL SITUATION
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST-AID PROCEDURES
X	X
WALKS AND TRIPS X	SWIMMING N/A
TRANSPORTATION BY THE FACILITY X	WADING N/A

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

WHITE COPY (Original) **YELLOW COPY** (Child Care Space) **PINK COPY** (Excursion)

CY 867 10/22

RELC- Washington Tuition Agreement

NAME OF CHILD

FEE AMOUNT PER DAY	DAY PAYMENT TO BE MADE
$_____ per day	Friday Prior to Week of Service

Services to be provided as part of the daycare fee (examples: care, meals, etc.)

_____ Room (Days of the Week _____)

Childcare
CACFP Breakfast, Lunch and Snack if child is in attendance during regularly scheduled times
INFANT: Similac Advance w/ Iron and age appropriate meals
School Age: Escorted to and from bus stop

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED (must match emergency contact list)

LATE FEE

$5.00 per 15 minutes <6pm or $25 + $10.00 per 5 min >6pm AND/OR $5.00 per 15 minutes early drop off without permission charges

Extra services to be provided at an additional fee if applicable

Enrollment and tuition deposit as applicable
Additional days may be added if space available with advance notice

I, the parent/guardian acknowledge that I will:

_____ Follow all procedures in the Parent Handbook, which contains written program information, that I received upon enrollment.

_____ Agree to update the emergency contact/parental information whenever changes occur and every 6 months per DHS regulation

_____ Complete a medication consent form when requesting medication administration.

_____ Notify the staff when my child is ill or any family member has a contagious disease.

_____ Obtain health assessments for my child according to the schedule recommended by the American Academy of Pediatrics. 2,4,6,9,12,18, 24 months and yearly thereafter

_____ Provide staff with any extra items necessary for my child's care, (i.e. pull ups, wipes, extra clothes, etc.).

_____ Agree to discuss my concerns that I may have with the Teacher/Program Director.

_____ Agree to pay for all days that my child is **enrolled** even if he/she does not attend. Schedules are set and not to vary

_____Agree to follow my child's scheduled drop off and pick up times contracted to- I will not bring my child early or pick up late

_____	_____	_____	_____
ADMINISTRATIVE SIGNATURE	DATE	SIGNATURE - PARENT OR GUARDIAN	DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW	
	_____	_____
DATE OF WITHDRAWL	SIGNATURE- PARENT OR GUARDIAN	DATE

12/3/25- LF

RELC- W Tuition Agreement

NAME OF CHILD	
FEE AMOUNT PER DAY $_____ per week - ELRC co-pay	DAY PAYMENT TO BE MADE Friday Prior to Week of Service

Services to be provided as part of the daycare fee (examples: care, meals, etc.)

_____ Room (Days of the Week _____)

Childcare
CACFP Breakfast, Lunch and Snack if child is in attendance during regularly scheduled times
INFANT: Similac Advance w/ Iron and age appropriate meals
School Age: Escorted to and from bus stop

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED (must match emergency contact list)
LATE FEE **$5.00 per 15 minutes <6pm or $25 + $10.00 per 5 min >6pm AND/OR $5.00 per 15 minutes early drop off without permission charges**		

Extra services to be provided at an additional fee if applicable

Enrollment and tuition deposit as applicable
Additional days may be added if space available with advance notice

I, the parent/guardian acknowledge that I will:

_____ Follow all procedures in the Parent Handbook, which contains written program information, that I received upon enrollment.

_____ Agree to update the emergency contact/parental information whenever changes occur and every 6 months per DHS regulation

_____ Complete a medication consent form when requesting medication administration.

_____ Notify the staff when my child is ill or any family member has a contagious disease.

_____ Obtain health assessments for my child according to the schedule recommended by the American Academy of Pediatrics. 2,4,6,9,12,18, 24 months and yearly thereafter

_____ Provide staff with any extra items necessary for my child's care, (i.e. pull ups, wipes, extra clothes, etc.).

_____ Agree to discuss my concerns that I may have with the Teacher/Program Director.

_____ Agree to pay for all days that my child is **enrolled** even if he/she does not attend. Schedules are set and not to vary

_____Agree to follow my child's scheduled drop off and pick up times contracted to- I will not bring my child early or pick up late

_____	_____	_____	_____
ADMINISTRATIVE SIGNATURE	DATE	SIGNATURE - PARENT OR GUARDIAN	DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW	
	_____	_____
DATE OF WITHDRAWL	SIGNATURE- PARENT OR GUARDIAN	DATE

12/3/25- LF

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME: Rainbow's End Learning Center		
FACILITY PHONE: 724-225-5668	COUNTY: Washington	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

RAINBOW'S END LEARNING CENTER
POLICY AGREEMENT

• Emergency Closings: In the event of extreme weather conditions, closings will be announced on ClassDojo. Parents will be responsible for the daily fee if their child was scheduled.

• Holidays: Rainbow's End Learning center is open Monday through Friday 6:30 AM-6:00 PM. We are closed most major Holidays. Tuition will be charged for closed holidays if your child is scheduled to attend on the day a holiday falls on.

• Tuition Fee: Tuition is based on the number of days you reserve in writing on your agreement.

•Tuition payments: Tuition is due Fridays by 6:00 pm prior to the week of service. If the payment is late there will be a penalty fee added. Failure to pay account in full (including penalty fee) will result in termination. Additionally after 4 delinquency notices within the year your child will be terminated and you will be considered a new enrollment.

• Absence Policy: Parents are responsible for payment of ALL scheduled days as per agreement.

• Enrollment fee: A $50 non-refundable enrollment is charged per child.

• Drop off and Pick Up Policy: Parents must accompany their child to and from the child's classroom and sign them in daily. Parents are required to adhere to times listed on the agreement. A late fee of $5 per every 15 minutes is charged if parent is late picking them up.

• After Closing Late Fee: A $25 fee + late charge of $10 per 5 minutes a parent is late picking up their child after 6:00 pm.

• Returned Check fee: A $40 fee will be assessed for any returned checks.

• Health Appraisals: Child Health exams must be updated according DHS. Past due child health reports can result in your child being excluded from care until the form is turned in.

• Sibling Discount: Parents are given $3.50 discount per day for multi children. There is a $2.50 discount per day for children enrolled 5 FT days a week.

Rainbow's End Learning Center admits students of any race, color, national and ethnic origin to all rights privileges, programs, and activities generally accorded or made available to students in the school. It does not discriminate on the basis of race, color, national or ethnic origin in administration of its admission policies and educational policies.

I have read the policies outlined here and in the Parent Handbook, I understand and agree to adhere to the policies set forth.

Parent Signature: _____ Date: _____

Director Signature: _____ Date: _____

yourrainbows.org | 655 Jefferson Avenue Washington, PA 15301 | O:724.225.5668 | FX:724.225.4934

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

Rainbow's End Health Policy

A child will be excluded from attending childcare in the following situations...

- If the child is unable to participate in daily classroom activities, generally lethargic, needing constant one on one attention, or not able to participate in large motor or outdoor play.
- If the child has a fever of 100.4 degrees or higher.
- Diarrhea- excess liquid in stool, occurring two or more times in a two-hour time period or if the stool can't be contained within the diaper. Food intolerance will be taken into consideration.
- Vomiting- first occurrence (Reflux will require a note from a physician.)
- A rash present on a child's body.
- Has symptoms of a contagious illness. The child will be excluded from care if one of the following illnesses is suspected- including, but not limited to the following:

Roseola	Scarlet Fever	Croup	Pink Eye
Impetigo	Ringworm	Lice	Fifths Disease
Chicken Pox	Pneumonia	Flu (3-5 days)	Strep Throat
Hand, Foot, and Mouth	RSV (5-8 days)	Covid-19	

The symptoms will be assessed by the staff, on the basis of prior experience and the *Managing Infectious Diseases in Child Care and Schools* reference guide published by the American Academy of Pediatrics.

Parents must arrange to pick up their child within 1 hour of the time they are notified of the illness.

A child may return to care if they meet *all* the following requirements:

- 24 hours after the second dose of an antibiotic has been administered when prescribed by a physician.
- No fever has been present for 24 hours and **no fever reducers** (Tylenol, Ibuprofen, etc.) **have been administered within the last 12 hours.**
- The child has not vomited in the last 24 hours.
- The child can participate in all daily activities, including outdoor play. The child is considered able to participate when the illness does not require more care than the childcare staff are able to provide without compromising the needs of the other children in care.
- In the event of a rash or contagious illness, the child will be readmitted with a physician's written release.

Reviewed 8/23/24

I have read and understand the Rainbow's End Health Policy and agree to abide by it.

Parent Signature / Date **Director's Signature / Date**

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

CONSENT AND RELEASE

I consent PathWays and their affiliates:

To take photographs, moving pictures, and videotapes of me and/or my child(ren), and to record my and/or my child(ren)'s voice.

To use, publish, or republish the same, and/or photographs I may provide to them, in furtherance of their work, with or without identification by name.

To use my name and/or my child(ren)'s name and/or information referring to me and/or my child(ren) in conjunction therewith, if they so desire.

In furtherance of their work, to release such photographs, moving pictures, videotapes, and recordings and to authorize any newspaper, media outlet, childcare application, social media platform, or other organization to use, publish, or republish the same, with or without identification by name, and to use my name and/or my child(ren)'s name and/or information referring to me and/or my child(ren) in conjunction therewith, if they so desire.

I further understand and agree that my child(ren) may appear on the childcare app utilized by PathWays and Rainbow's End Learning Center and on their official social media accounts for communication, educational, promotional, or informational purposes.

Print Child Name: _____

Address: _____

I represent that I am the parent/guardian of the above minor.
I hereby consent and agree____ as a
parent/guardian to all terms and provisions above.

I do not agree_____ as a parent/guardian to all terms and provisions above. Please see the below restrictions.

I agree to the following restrictions that pertain to my child's work, photographs, moving pictures, videotapes, and recordings:

_____

Parent / Guardian Printed Name: _____

Signature: _____

Date: _____

Relationship _____

WASHINGTON HEALTH SYSTEM

CONSENT FOR: EMERGENCY TREATMENT, MEDICAL/SURGICAL CARE, and MINOR'S MEDICAL INFORMATION

I, _____ hereby grant consent for _____

☐ Mother ☐ Father ☐ Legal Guardian ☐Son ☐ Daughter

to receive such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, as may be deemed necessary in the professional judgment of authorized members of the hospital staff or their designees.

I understand that while the medical team will provide appropriate care and treatment for my child, no promises or guarantees can be made about the results or outcome

I have read this form and certify that I understand its content. I hereby give my consent to the staff

of Rainbow's End Learning Center
(name of person or agency)

who will be caring for my child _____
(name of child)

for the period _____ to PRESENT

to arrange for routine or emergency medical care and treatment necessary to preserve the health of our/my child.

We acknowledge that we/I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

Parent Name: _____

Child's Name: _____

Family Doctor / Pediatrician: _____

Child's Date of Birth: _____

Child's Allergies: _____

Home Address: _____

Current Medications: _____

Phone Number: _____

Health Insurance Company: _____

Group Number: _____

ID Number: _____

In case of emergency I can be reached at: _____

If I am unable to be reached, please contact: _____

Relationship: _____ Phone Number: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

Early Intervention / Intermediate Unit Permission Form for Information Sharing and Service Access

Child's Name: _____
Date of Birth: _____

Please read and indicate your consent by checking the appropriate boxes below:

☐ **I give permission for Rainbow's End Learning Center to obtain information from Early Intervention and/or the Intermediate Unit pertaining to my child,**

_____.
(Child's Name)

☐ **I give permission for Rainbow's End Learning Center to release my child to receive Early Intervention and/or Intermediate Unit services within the building.**

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____

Date: _____

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

Authorization for the release of Protected Health Information

to Rainbow's End Learning Center

I agree to provide & release the indicated information from the record of:

Child's Name: _____ **Date of Birth:** _____

To:

Rainbow's End Learning Center

655 Jefferson Avenue Washington
PA 15301

Ph: 724-225-5668 Fax: 724-225-4934

Information to be released for these dates: From: _____ **To:** Current

Assessment/ Evaluation Reports ( ) IFSP/IEP

Written Progress Notes: ( ) Verbal Progress Notes: ( ) Ongoing Contact ( )

Other: Anything Pertinent to Care of Child

I understand that the purpose for the release of these records is to facilitate the development and provision of services and supports to my child.

This consent shall be in effect from the date of signature and will remain effective until consent is revoked (see below) or the child is no longer enrolled at Rainbow's End Learning Center.

Information is disclosed with the prior written consent of the parent/guardian.

REVOKING CONSENT to Release Information:

I understand that t may revoke this consent at any time by notifying Lisa Flaus, Program Director IN WRITING that I do not wish any further information disclosed concerning my child.

(This does not apply to any release of records prior to the date consent was revoked)

I understand that I have the right to inspect and review all relevant records and receive copies of requested.

I have read and understand the above information.

Parent Signature: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

Suspension and Expulsion Policy

At Rainbow's End Learning Center, we understand it is essential for all children to have a positive educational experience from the start to build steps for lifelong learning. Suspending and/ or expelling a child from our Early Learning Program is not considered normal practice and prevention of suspension or expulsion from the program is essential to promote partnerships between our program and families. This supports healthy development, continuous quality improvement and supports children's social, emotional and behavioral health.

Policies and expectations within the center are discussed and agreed upon at enrollment to ensure all parties are working collaboratively together. Children are welcome with support staff into the program and behavioral plans are used as needed. Children will not be excluded from enrollment if a parent identifies the need for support staff and the center will follow any necessary plans to assist the family and support staff with the child. All families will be encouraged to participate in their child's care as much as they are able.

Rainbow's End supports developmentally appropriate practice in each classroom and provides children with a safe and interactive as well as stimulating learning environment. Staff are offered and must take professional development on age-appropriate behavior as well as partnering with parents. Classrooms are set up to avoid conflict as much as possible, and staff are encouraged to develop professional relationships with families and the children enrolled. Each child will be treated equally.

For all children, including anyone with an Individualized Education Program (IEP)/ Individualized Family Service Plan (IFSP), once a behavioral concern is identified - this refers to any behavior observed in a child that may fall outside typical developmental expectations, including but not limited to: hitting, kicking, spitting, harm to self or others, foul language, damaging property, eloping from classroom, etc.

1. If a child exhibits behavioral issues, staff will alert the director and document the behaviors as well as any relevant information such as, but not excluded to: time, date, antecedents, interactions, what redirection is used and amount of time from start to end of behavior.
2. Documentation will be shared with families, and we will collaborate with families to develop a behavioral support plan that best meets the child's needs.
3. Staff will share helpful resources with families and places they may go to for additional assistance.

4. Once a plan is established staff will document daily and share with families both positive and negative behaviors and how the plan of action is working.
5. Staff will provide the child with reasonable accommodations to assist the child. Some examples include, but are not limited to: need for a snack, fidget toy, extra time to prepare for transitions, signal cards, etc.
6. Staff will document daily and share documentation with parents as often as needed.
7. All children will be given positive reinforcement on a regular basis
8. All children will have lessons on social and emotional development with their classroom teachers.
9. If violent or unsafe behavior continues, a discussion with parent / guardian regarding the need for a suspension or expulsion will occur.

For the safety of the child, other children in the center and the staff, it may become necessary to suspend or expel a child from Rainbows End Learning Center. There may be instances based on the severity of an incident where the prior listed items may not all be followed prior to a suspension/expulsion.

Transition Process:

If an expulsion must occur, Rainbow's End will assist the family and child in transitioning to another program by identifying and engaging mental/behavioral health consultants and community resources to assist in determining the most appropriate placement for the child.

ACKNOWLEDGEMENT:

I, the parent/ guardian of _____

Acknowledge the Expulsion and Suspension Policy was explained to me, and I have read and received a copy of the Expulsion and Suspension Policy.

Parent / Guardian Signature: _____

Date: _____

Infant Getting to Know You

Child's Name:

BOTTLE SCHEDULE
NUMBER OF OZS
& HOW OFTEN

BABY FOOD PERMITTED (CIRCLE)

Any **Not Yet**

Some

(Please list approved foods)

TIPS TO HELP CALM YOUR BABY

ALLERGIES/FOODS THAT BOTHER BABY

NAP SCHEDULE

What else should we KNOW about your little one?

PARENT SIGNATURE:_____

DATE:_____

Getting to Know You!

CHILD'S NAME: _____

1. Does your child have a nickname? _____

2. Who does your child live with at home?

_____

3. Is there anything about your child's home life that you would like for us to know?

_____

_____

_____

_____

4. Does your child have any health concerns or allergies we should know about?

_____

_____

5. What are your child's favorite foods and snacks?

_____

_____

6. What are some things your child is interested in?

_____

_____

_____

7. What makes your child happy?

_____

_____

8. What upsets your child?

_____

_____

9. What are you hoping your child gains from his or her childcare experience the most?

_____

_____

_____

_____

Parent Signature: _____

Date: _____

RAINBOW'S END LEARNING CENTER

Dear Parent/Guardian,
Please review each item below and initial next to each statement to indicate your consent. Then, complete the requested contact information and sign at the bottom of the form.

Parent/Guardian Permissions

___ I would like to be added to ClassDojo to receive updates and communication.
Cell Phone Number for Texts: _____

Email for Billing (Required): _____

___ I give RELC permission to apply diaper cream, lotion, and/or chapstick to my child as needed.
(Parent must provide the product and give it directly to the teacher for safe storage.)

___ I give RELC permission to apply sunscreen to my child during the Spring through Fall months.
(Parent must provide the sunscreen.)

___ I understand that if I do not provide sunscreen, my child will go outside without it and may be at risk for sunburn.

___ I give permission for my child to participate in Water Day activities during the summer months.

Child's Name: _____

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

Date: _____

Rainbow's End Learning Center

Please initial and sign below to indicate whether you received a copy of the parent handbook.

Thank you,

Lisa Flaus

Lisa Flaus

Director of Rainbow's End Learning Center Washington

Yes, I received a copy of the parent handbook _____

No, I did not receive a copy of the parent handbook _____

Signature _____

Child's Name _____

Date _____

CACFP Meal Benefit Income Eligibility Form
Sharing Information with Medicaid and SCHIP
July 1, 2025-June 30, 2026

Children who get Child and Adult Care Food Program (CACFP) free or reduced-price meals may also qualify for low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP).

We may share your child's CACFP eligibility information with Medicaid or SCHIP, *unless you tell us not to*. Medicaid and SCHIP *only* use the information to find out if children are eligible for their programs. Their staff may contact you to offer to enroll your children in these health insurance programs.

If you **do not** want us to share your information with Medicaid or SCHIP, fill out this page. You should send this page with your *CACFP Meal Benefit Income Eligibility* form when you apply. Sending in this page will not change your child's eligibility for free or reduced-price meals.

☐ **No! I do not** want my child's CACFP eligibility information shared with Medicaid or SCHIP.

If you checked no, fill this out:

Child's Name:
_____

Child's Name:
_____

Child's Name:
_____

Child's Name:
_____

Today's Date:
_____

Print Your Name:
_____

Address:
_____

Signature of Parent or Guardian:
_____

If you have questions or need help, please contact **[Name]** at **[Phone Number]** or **[Email Address]**.

This institution is an equal opportunity provider.

We ask about your children's ethnicity and race to make sure we do our best to serve our community. Providing this information is not required. You won't be denied benefits based on your race, color, national origin, sex, age, or disability.

pennsylvania
DEPARTMENT OF EDUCATION

CACFP Infant Enrollment Form

Center/Provider Name: Rainbow's End Learning Center

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

Childcare centers/providers participating in the CACFP **are required** to offer at least one iron fortified infant formula for infants who are enrolled in care. You may decline the infant formula offered, and supply breast milk and/or your own CACFP approved iron-fortified formula.
(NOTE: A CACFP approved iron-fortified formula must have 1 mg of iron or more per 100 calories of formula when prepared using the label directions and must be regulated by the FDA.)

Additionally, when you determine, in consultation with your physician, that your infant is developmentally ready, the childcare center/provider will also be **required** to offer iron fortified infant cereal and other infant foods.

Infant's Name_____Infant's Date of Birth_____

Iron Fortified Formula offered by the Center/Provider: Similac Advance

Breast milk and/or Formula preference

Record date to indicate your preference (choose all that apply) *I understand that I may change my decision at any time with advance notice	**Birth -5 months Date & Initial**	**6 – 11 months Date & Initial**
I will provide expressed breast milk for my infant.		
I will breast feed my infant on site at the center/provider.		
I want the childcare center/provider to provide the infant formula it offers for my infant.		
I will provide the infant formula for my infant. (must be iron fortified) **Name of infant formula I will provide:** _____		
My infant has a special dietary need that requires a formula that does not meet the criteria for an approved iron fortified formula. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, and the recommended substitution. **Name of infant formula:** _____ ☐ Center will provide the formula. ☐ I will provide the formula.		

Preference regarding infant cereal and other foods

Record date to indicate your preference *I understand that I may change my decision at any time with advance notice	**6 – 11 months Date & Initial**
I want the childcare center/provider to provide the iron fortified infant cereal and other foods for my infant.	
I want the childcare center/provider to provide all food items with one exception. (This option is only applicable if center/provider is providing the iron-fortified infant formula) **One food item that I will provide (must be a creditable CACFP food item): _____**	
My infant has a special dietary need that requires modifications to the infant meal pattern requirements. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, the foods to avoid and the recommended substitutions	
I am aware and understand the all information provided on this form and my ability to have my infant participate in the CACFP; however, **I decline** the infant formula and food offered by the center/provider and elect to furnish ALL infant formula and food for my infant. **(Center/Provider may not claim meals for this infant)**	

Parent/Guardian **Date** **Center/Provider signature** **Date**

This supplemental infant form must be completed for all infants in care and must be maintained by center/provider and if applicable, a copy must be maintained by the Sponsoring organization.

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1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
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2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

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CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

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.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3) **CASE NUMBER:**

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Children listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. 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.

Name of Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. This form is not valid without signature and date of adult household member

"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 CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Revision 08/16/2021

Source of Income for Children

Sources of Child Income	Examples
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member regularly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults

Earnings from Work	Public Assistance/Alimony/ Child Support	Pensions/Retirement/ All other sources of income
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

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. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. 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), Temporary Assistance for Needy Families (TANF) Program 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 the meal reimbursement for your child care center/provider. 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.

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Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442;
EMAIL: or program.intake@usda.gov.

***Only use this address if you are filing a complaint of discrimination.**

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For Official CACFP Sponsor Use Only NOT VALID WITHOUT DETERMINING OFFICIAL'S SIGNATURE AND DATE

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

Total Income | How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○ | Household size | Categorial Eligibility ☐ | Eligibility Free ○ Reduced ○ Denied ○

Determining Official's Signature | Date | Confirming Official's Signature (second check) | Date | Follow-up Official's Signature (For Pricing Institutions - Verification Official) | Date

Effective Date: If the Institution is using the parent/guardian signature date as the effective date, the form must have been signed by the Institution representative within the same month the parent signed the form or the immediately following month.

Child and Adult Care Food Program
Child Enrollment Form

Sponsor/Center Name: Rainbow's End Learning Center
Agreement #: 300-63-930-0

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours									
BIRTH DATE	Other:									
AGE	**Enrollment Date:** **Withdrawal Date:**									
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours									
BIRTH DATE	Other:									
AGE	**Enrollment Date:** **Withdrawal Date:**									
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours									
BIRTH DATE	Other:									
AGE	**Enrollment Date:** **Withdrawal Date:**									

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

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