



# Nehemiah C E N T E R

## Application Check List

Kindergarden- High School	Pre- Kindergarden
1) <input type="checkbox"/> Please attach a copy of your STAAR	1) <input type="checkbox"/> Completed Meal Application Form
2) <input type="checkbox"/> Last Report Card (Most Recent Copy)	2) <input type="checkbox"/> Copy of immunization Record
3) <input type="checkbox"/> Standford Scores	3) <input type="checkbox"/> Completed Medical Form
4) <input type="checkbox"/> Completed Meal Application Form	4) <input type="checkbox"/> <i>Residential Verification (Utility Bill w/current address</i>
5) <input type="checkbox"/> Copy of Immunization Record	5) <input type="checkbox"/> <i>1040 Income Verification or letter from the employer</i>
	6) <input type="checkbox"/> Birth Certificate

Name of Child: \_\_\_\_\_ Grade Level: \_\_\_\_\_  
(Please Print) School: \_\_\_\_\_

*Please return all completed admission forms to Mr. Perez or Mrs. Jordan*

*(Do not write below this line)*

Office Use Only

\_\_\_\_\_ Application Date

\_\_\_\_\_ Application Approval Date (all items are present)

\_\_\_\_\_ Enrollment Date

\_\_\_\_\_ Start Date (Billing Begins)



### Admission Information

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

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

#### General Information

Operation's Name		Director's Name <i>Tonia Labbé</i>	
Child's Full Name	Child's Date of Birth	Child Lives With <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian	
Child's Home Address		Date of Admission	Date of Withdrawal
Name of Parent or Guardian Completing Form	Address of Parent or Guardian (if different from the child's)		
List telephone numbers below where parents/guardian may be reached while child is in care.			
Parent 1 Telephone No.	Parent 2 Telephone No.	Guardian's Telephone No.	Custody Documents on File <input type="radio"/> Yes <input type="radio"/> No
Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached			Relationship
I authorize the child care operation <b>to release</b> my child to leave the child care operation <b>ONLY</b> with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.			
Name		Phone Number	
Name		Phone Number	
Name		Phone Number	

#### Consent Information

Check All That Apply:

**1. Transportation**

I give consent for my child to be transported and supervised by the operation's employees:

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

**2. Field Trips**

I give consent for my child to participate in field trips.

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

Comments

**3. Water Activities**

I give consent for my child to participate in the following water activities:

- water table play     sprinkler play     splashing/wading pools     swimming pools     aquatic playgrounds

**4. Receipt of Written Operational Policies (Check All that Apply)**

I acknowledge receipt of the facility's operational policies, including those for:

- |  |   |
|--|---|
| <input type="checkbox"/> Discipline and guidance                                       | <input type="checkbox"/> Procedures for release of children   |
| <input type="checkbox"/> Suspension and expulsion                                      | <input type="checkbox"/> Illness and exclusion criteria   |
| <input type="checkbox"/> Emergency plans   | <input type="checkbox"/> Procedures for dispensing medications  |
| <input type="checkbox"/> Procedures for conducting health checks                       | <input type="checkbox"/> Immunization requirements for children   |
| <input type="checkbox"/> Safe sleep  | <input type="checkbox"/> Meals and food service practices   |
| <input type="checkbox"/> Procedures for parents to discuss concerns with the director  | <input type="checkbox"/> Procedures to visit the center without securing prior approval   |
| <input type="checkbox"/> Procedures for parents to participate in operation activities | <input type="checkbox"/> Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website |

**5. Meals**

I understand that the following meals will be served to my child while in care:

- None     Breakfast     Morning snack     Lunch     Afternoon snack     Supper     Evening snack

**6. Days and Times in Care**

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

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

**Authorization For Emergency Medical Attention**

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

Name of Physician	Address	Phone Number
Name of Emergency Care Facility	Address	Phone Number

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

\_\_\_\_\_  
Signature — Parent or Legal Guardian

**Child's Additional Information Section**

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies?  Yes  No Plan Submitted on \_\_\_\_\_

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

**School Age Children**

My child attends the following school

School Phone Number

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

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

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

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

**Admission Requirement**

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

Check **only one** option:

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

\_\_\_\_\_  
Signature — Health Care Professional

\_\_\_\_\_  
Date Signed

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

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

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

Name

Address of Health Care Professional

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

### Requirements for Exclusion

- I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

### Vision Exam Results

Right Eye 20/      Left Eye 20/       Pass       Fail

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

### Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				<input type="radio"/> Pass <input type="radio"/> Fail
Left				<input type="radio"/> Pass <input type="radio"/> Fail

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

### Vaccine Information

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

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1-2 months (second dose)	
	6-18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15-18 months (fourth dose)	
	4-6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12-15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	

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

**Physician or Public Health Personnel Verification**

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

\_\_\_\_\_ Signature

\_\_\_\_\_ Date Signed

**Varicella (Chickenpox)**

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

\_\_\_\_\_ Signature

\_\_\_\_\_ Date Signed

**Additional Information Regarding Immunizations**

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

**TB Test (If Required)**

Positive  Negative Date: \_\_\_\_\_

**Gang Free Zone**

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

**Privacy Statement**

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

**Signatures**

\_\_\_\_\_

Child's Parent or Legal Guardian

\_\_\_\_\_

Date Signed

\_\_\_\_\_

Center Designee

\_\_\_\_\_

Date Signed



# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

## Part 1. All Household Members

Name of Enrolled Child(ren): \_\_\_\_\_

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

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

NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

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

Check here if no case number

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

A. Name (List only household members with income)	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
<i>(Example)</i> Jane Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-monthly
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____
	\$ ____/____	\$ ____/____	\$ ____/____	\$ ____/____

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

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

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

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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





# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

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

Mark one ethnic identity:

- Hispanic or Latino  
 Not Hispanic or Latino

Mark one or more racial identities:

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

**Part 7. Sharing Information With Other Programs: OPTIONAL**

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

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

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

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

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year Household size: \_\_\_\_\_  
 Categorical Eligibility: \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_ Reduced \_\_\_ Denied \_\_\_ Tier I \_\_\_ Tier II \_\_\_  
 Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

**PLACE  
 PICTURE  
 HERE**



Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 Allergy to: \_\_\_\_\_  
 Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

**THEREFORE:**  
 If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.  
 If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

**FOR ANY OF THE FOLLOWING:  
 SEVERE SYMPTOMS**

 <b>LUNG</b> Short of breath, wheezing, repetitive cough	 <b>HEART</b> Pale, blue, faint, weak pulse, dizzy	 <b>THROAT</b> Tight, hoarse, trouble breathing/swallowing	 <b>MOUTH</b> Significant swelling of the tongue and/or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	<b>OR A COMBINATION</b> of symptoms from different body areas.

- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

**MILD SYMPTOMS**

 <b>NOSE</b> Itchy/runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea/discomfort
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**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand or Generic: \_\_\_\_\_  
 Epinephrine Dose:  0.15 mg IM  0.3 mg IM  
 Antihistamine Brand or Generic: \_\_\_\_\_  
 Antihistamine Dose: \_\_\_\_\_  
 Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

**PARENT/GUARDIAN ACKNOWLEDGMENT FORM**

**Please write and sign your name at the bottom of the page to certify that you agree with the following statements regarding policies and/or expectations of the Nehemiah Center. Return signed copy to staff.**

A. I have read and understood the policies and expectations set forth in the Nehemiah Center, Inc. Parent Handbook. I agree to abide by the policies and will work towards remaining in good standing with the Center to ensure my child's enrollment privileges in the Center's programs.

B. I agree that the Nehemiah Center, Inc. shall not be responsible for any personal injuries or losses sustained by my child(ren) while on the Center's premises or in vehicles as a result of any Nehemiah sponsored activities. I further agree to indemnify and hold harmless the Nehemiah Center from any claims or demands arising out of any such injuries or losses.

C. I give authorization for my child to be photographed, videotaped, and or digitally recorded for all purposes toward the Center's daily operations. This includes, but is not limited to: **Annual Newsletters; Thank You Letters; Photo Albums; Off-Campus Activities; Family Services; Volunteer Program; College Prep Program; Fundraising & Development; Marketing & Advertising.**

D. I acknowledge that report cards and other standardized test scoring are to be received by the Director of Education from myself or my child **upon the day of the release of academic information** that is set by HISD. I understand that photocopies of academic grades and/or test scores will be kept in my child's individual academic file. In the event that academic reporting is not received within one week of release from the school, the Director of Education reserves the right to contact the school about my child's grades and overall conduct.

**Parent/Guardian Name** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_

**Names of Child(ren)** \_\_\_\_\_

**Date** \_\_\_\_\_

THE NEHEMIAH CENTER

**Parent Data**

Today's Date \_\_\_\_\_

Name of Mother \_\_\_\_\_ Number of years at Nehemiah \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced/Separated \_\_\_\_\_ **New** \_\_\_\_\_

Mother's Occupation/Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Home Address \_\_\_\_\_

**Education: Highest level of education completed?**

High School or less      Some College      Associate Degree      College Degree      Post-Graduate

**Annual Household Income** \_\_\_\_\_

Name of Father (or Guardian) \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced/Separated \_\_\_\_\_

Father's Occupation/Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Home Address (if different from mother's) \_\_\_\_\_

**Education: Highest level of education completed?**

High School or less      Some College      Associate Degree      College Degree      Post-Graduate

List everyone in your household and ages:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

7. \_\_\_\_\_ 8. \_\_\_\_\_



**Please acknowledge receipt of the “Parent’s Guide to Child Care by signing below.**

**Local Child-Care Licensing Office**

**P. O. Box 16017**

**Houston, TX 77222-6017**

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**Parent’s Signature**

**DATE**

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**Child(ren)Name**