

On or before your child's first day of attendance we will need:

___ Enrollment Application

___ Completed emergency contact information form

___ Financial Agreement and Payment Policy
Form (signed by both parents if applicable)

___ Family Handbook Agreement

___ Signed Permission Forms

___ General Health Appraisal Form signed by physician

___ Current records of immunization

___ Allergy, Asthma, and Special Health Conditions

___ Health Care Plan, if required

___ USDA Income Eligibility Form

___ Door Access Badge completed and turned into Susan

___ COVID Agreement

Your \$50.00 registration fee and tuition for the first month/remainder of the month, paid by credit card (preferred method) on the website:

<https://commerce.cashnet.com/rrcccdcpay;>

check made to "The Children's Center" and dropped in the locked payment box outside the Center office or Cash must be taken directly to RRCC cashier department and a payment confirmation slip returned to Center payment box.

APPLICATION FOR ENROLLMENT

Date of Enrollment _____ Date of termination _____

Child's Name _____ Nickname _____

Birth Date _____ Place of Birth _____ Gender _____

Phone _____ Child lives with _____

Relationship to child _____

Address _____ City _____ State _____ Zip _____

Does your child have medical insurance? _____ Documented vision screening? _____ Documented hearing screening? _____ Documented dental screening? _____ Do you need resources on how to obtain medical insurance? _____

Name and phone of child's primary care provider _____

Family Member #1 _____ Relationship to child _____

____Parent____Step Parent____Legal Guardian____Temporary

Guardian____Other____Joint Custody____Not Joint Custody

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cellular _____

Pager _____ email _____

Social Security # _____ Driver's license # _____

Employer _____ Occupation _____

Address _____

If we cannot immediately contact you at work, who could find you:

Name _____ Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Family Member #2 _____ Relationship to Child _____

____Parent____Step Parent____Legal Guardian____Temporary

Guardian____Other____Joint Custody____Not Joint Custody

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Pager _____ email _____

Social Security # _____ Drivers License # _____

Employer _____ Occupation _____

Address _____

If we cannot immediately contact you at work, who could find you:

Name _____ Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Are there legal restrictions on who can have contact with your child? ____No

____Yes

If yes, please list and submit legal papers.

Persons Name _____ Relationship to child _____

Photo on file? ____No ____Yes

Other's living in home:

First & Last Names _____ Age _____ Relationship to child _____

First & Last Names _____ Age ___ Relationship to child _____
First & Last Names _____ Age ___ Relationship to child _____
First & Last Names _____ Age ___ Relationship to child _____
Ethnic Information for use in writing grant proposals:

What language is spoken in the home? _____

Check one: ___ Alaskan Native/American Indian ___ Asian/Pacific
Islander ___ Black, not Hispanic ___ Hispanic ___ White

People who may be called in an emergency and who are authorized to take your child from our Center. We cannot release your child to anyone NOT on the list, other than parents/guardians. Please indicate who to call first in an emergency.

Name #1 _____ Relationship to Child _____
Address _____ Phone # _____

Name #2 _____ Relationship to Child _____
Address _____ Phone # _____

Name # 3 _____ Relationship to child _____
Address _____ Phone # _____

Health Care Practitioner Name _____ Phone _____

Dentist's Name _____ Phone _____

Preferred hospital _____

Address _____ Phone _____

We understand it is our responsibility to inform the Children's Center @ Red Rocks Community College any time the above information changes. We also understand that the center will attempt to reach one of the people on this form, trying to reach us as parents/guardians first, if there is an emergency, before any action is taken. In the event that we cannot be reached, the staff has our permission to use discretion in securing medical aid. We give permission for emergency medical or hospital personnel to perform the necessary care needed for our child during an emergency. We further understand that the Children's Center @ RRCC, the staff at the Children's Center @RRCC, Red Rocks Community College, the staff at Red Rocks Community College and/or any person responsible for obtaining medical aid for our child will not be responsible for any expense incurred by our family due to medical aid being given to our child.

Parent/Guardian #1 Signature _____

Date _____

Parent/Guardian #2 Signature _____

Date _____

A \$50.00 non-refundable registration fee is due with this application.

CHILDREN'S CENTER @RED ROCKS --EMERGENCY INFORMATION

Child's Name: _____ Birthdate: _____

Legal Guardian # 1 Name: _____

Telephone Numbers: Home _____ Work _____

Legal Guardian #2 Name: _____

Telephone Number Home: _____ Work _____

Emergency Contacts (to whom child may be released if legal guardian is unavailable)

Name # 1 _____

Address: _____

Telephone Numbers: Home _____ Work _____

Name # 2 _____

Address: _____

Telephone Numbers: Home _____ Work _____

Child's Usual Source of Medical Care

Name _____

Address: _____

Telephone Number _____

Child's Usual Source of Dental Care

Name: _____

Address: _____

Telephone Number _____

Child's Health Insurance

Name of Insurance Plan: _____ ID # _____

Subscriber's Name (on insurance card): _____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations

Transport Arrangements in an Emergency Situation

Ambulance service _____ Child will be taken to: _____
(Parents/guardians are responsible for all emergency transportation charges)

Parents/Legal Guardian Consent and Agreement for Emergencies

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed to **act on my behalf** until I am available I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: _____ Parent/Legal Guardian's Signature # 1 _____

Date: _____ Parent/Legal Guardian's Signature #2 _____

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name: _____ **Birthdate:** _____

Allergies: None or Describe _____
Type of Reaction _____

Diet: Breast Fed Formula _____ Age Appropriate
 Special Diet _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.

I, _____ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: _____ DATE: _____

Parent/Guardian Signature _____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ **Weight @ Exam:** _____

Physical Exam: Normal Abnormal (Specify any physical abnormalities) _____

Allergies: None or Describe _____ Type of Reaction _____

Significant Health Concerns: Severe Allergies Reactive Airway Disease Asthma Seizures Diabetes Hospitalizations
 Developmental Delays Behavior Concerns Vision Hearing Dental Nutrition Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: None or Describe _____

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

OR Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: Up-to-Date See attached immunization record Administered today: _____

Health Care Provider: Complete if Appropriate

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam _____ ** B/P _____ **Head Circumference (up to 12 months) _____ ****

**** HCT/HGB _____ ** Lead Level Not at risk or Level _____**

****TB Not at risk or Test Results Normal Abnormal**

****Screenings Performed: Vision: Normal Abnormal Hearing: Normal Abnormal Dental: Normal Abnormal-**

Recommended Follow-up _____

Provider Signature

Next Well Visit: Per AAP guidelines* or Age _____

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp

Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

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COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com



COLORADO
Department of Public
Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____

Date of birth: _____

Parent/guardian: _____

Required vaccines

Immunization date(s) MM/DD/YY

Titer date*
MM/DD/YY

Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib <i>Haemophilus influenzae</i> type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		Varicella - positive screen date	
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*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

Immunization date(s) MM/DD/YY

HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____

Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____

Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____



Dear parents/guardians of students in Colorado kindergarten - 12th grade schools for the 2020-21 school year:

We know you're thinking of all the things you need to do to make sure your student is ready for school. Getting vaccinated is an important part of their school readiness and keeps children from catching and spreading diseases that can make them sick. We wish you and your student a healthy school year!

Required and recommended vaccines

- Colorado law requires students who attend a public, private, or parochial kindergarten - 12th grade school to be vaccinated against many of the diseases vaccines can prevent, unless an exemption is filed. For more information, visit colorado.gov/cdphe/schoolrequiredvaccines (or cdphe.colorado.gov/schoolrequiredvaccines). Your student must be vaccinated against:
 - diphtheria, tetanus & pertussis (DTaP, DTP, Tdap)
 - polio (IPV)
 - measles, mumps, rubella (MMR)
 - hepatitis B (HepB)
 - varicella (chickenpox)
- Colorado follows recommendations set by the Advisory Committee on Immunization Practices. Students entering kindergarten must receive their final doses of DTaP, IPV, MMR and varicella. Students entering 6th grade must receive one dose of Tdap vaccine, even if they are under 11 years of age. You can view recommended vaccine schedules for children 0 - 6 years of age at cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf and preteens/teens 7 - 18 years of age at cdc.gov/vaccines/schedules/downloads/teen/parent-version-schedule-7-18yrs.pdf.
- Vaccines are recommended for hepatitis A, influenza, meningococcal disease and human papillomavirus, but are not required.

Exclusion from school

- Your student may be excluded from school if your school does not have an up-to-date vaccine record, exemption, or in-process plan for your student on file.
- If someone gets sick with a vaccine-preventable disease or there is an outbreak at your student's school and your student has not received the vaccine for that disease, they may be excluded from school activities. That could mean lost learning time for them and lost work and wages for you. For example, if your student has not received a measles-mumps-rubella (MMR) vaccine, they may be excluded from school for 21 days after someone gets sick with measles.

Have questions?

- You may want to talk to a healthcare provider licensed to give vaccines or your local public health agency about which vaccines your student needs or if you have questions. You can read about the safety and importance of vaccines at SpreadTheVaxFacts.com, ImmunizeForGood.com, and colorado.gov/cdphe/immunization-education (or cdphe.colorado.gov/immunization-education).

Paying for vaccinations

- If you need help finding free or low-cost vaccines and providers who give them, go to COVax4Kids.org, contact your local public health agency, or call the state health department's Family Health Line at 1-303-692-2229 or 1-800-688-7777. You can find your local public health agency at colorado.gov/cdphe/find-your-local-public-health-agency (or cdphe.colorado.gov/find-your-local-public-health-agency).

Vaccination records

- Please take your student's updated vaccine record to school every time they receive a vaccine.
- Need to find your student's vaccine record? It may be available from the Colorado Immunization Information System. Visit COVaxRecords.org for more information.

Exemptions

- If your student cannot get vaccines because of medical reasons, you must submit an official *Immunization Medical Exemption Form* to your school, signed by a health care provider licensed to give vaccines. You only need to submit this form once, unless your student's information or school changes. You can get the form at colorado.gov/vaccineexemption (or cdphe.colorado.gov/vaccineexemption).
- If you choose not to have your student vaccinated according to the current recommended schedule because of personal belief or religious reasons, you must submit a non-medical exemption to your school. Non-medical exemptions must be submitted annually at every new school year (July 1st through June 30th of the following year). The easiest way to file a personal or religious exemption is by using our online or downloadable non-medical exemption form available at colorado.gov/vaccineexemption (or cdphe.colorado.gov/vaccineexemption).

How's your school doing on vaccinations?

- Some parents, especially those with students who have weakened immune systems, may want to know which schools have the highest percent of vaccinated students. Schools must report immunization and exemption numbers (but not student names or birth dates) to the state health department annually. Immunization and exemption rates can be found at COVaxRates.org.

Please share Page 2 of this letter with your student's health care provider as it provides helpful information about vaccines required for school entry, per Colorado law.



COLORADO

Department of Public
Health & Environment

Advancing Colorado's health and protecting the places we live, learn, work and play

Dear Colorado health care provider:

Colorado School Entry Immunization Law (25-4-901 et seq, C.R.S) and Colorado Board of Health rule (6 CCR 1009-2) require students who attend a public, private or parochial K - 12 school, licensed child care, preschool, or Head Start program to be vaccinated against many of the diseases vaccines can prevent, or have an exemption on file. For more information, visit, colorado.gov/pacific/cdphe/schoolrequiredvaccines (or cdphe.colorado.gov/schoolrequiredvaccines). Students must be vaccinated against:

- diphtheria, tetanus and pertussis (DTaP, DTP, Tdap)
- polio (IPV)
- measles, mumps, rubella (MMR)
- hepatitis B (HepB)
- haemophilus influenzae type b (Hib)
- pneumococcal (PCV13)
- varicella (chickenpox)

The number, timing and spacing of the required vaccine doses is set by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP). To be considered valid, a dose of vaccine must meet both the **minimum age and minimum intervals** as defined by ACIP. You can view the current ACIP vaccine schedule for persons 0 - 18 years of age at cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf. Vaccines are recommended for rotavirus, hepatitis A, influenza, meningococcal disease and human papillomavirus, but are not required for school attendance.

Colorado schools are required to review immunization records for school entry and can only accept valid doses of vaccine. Your patients may receive notification of noncompliance if a dose of vaccine does not meet the minimum age or minimum interval requirements, per the ACIP schedule. There are three ways a student can meet the compliance requirements established by Colorado law:

- 1) A student is considered fully immunized if he or she has received all doses of school-required vaccines according to the current ACIP schedule. Note: students are required to receive their final doses of DTaP, IPV, MMR and varicella by kindergarten entry and their Tdap by 6th grade entry, even if the student is under 11 years of age.
- 2) A student is in the process of becoming up-to-date on required vaccines and has a written plan from the parent/guardian on file with the school.
- 3) The student's health care provider (medical doctor, doctor of osteopathic medicine, advanced practice nurse or delegated physician assistant) has signed an official *Immunization Medical Exemption Form* because of a condition that precludes the student from receiving vaccine(s), or the student (emancipated or 18 years of age or older) or student's parent/guardian has submitted a signed non-medical exemption (religious or personal belief).

If students do not meet at least one of the compliance criteria, they are not permitted to attend school. If you have questions about the student's school immunization requirement, please communicate with the student's school nurse or school representative.

If you have questions about the ACIP immunization schedule, vaccines marked as invalid in your patient's immunization record, or about Colorado School Entry Immunization Law, please contact us at 303-692-2700 or cdphe.dcdimmunization@state.co.us. If you have questions about the Colorado Immunization Information System (CIIS), please contact us at 303-692-2437 (press 2), 1-888-611-9918 (press 1) or cdphe.ciis@state.co.us.

Other reliable clinical resources include:

- CDC Vaccines & Immunizations - cdc.gov/vaccines/default.htm
- CDC's *Epidemiology & Prevention of Vaccine-Preventable Diseases* - cdc.gov/vaccines/ed/webinar-epv/index.html
- The Immunization Action Coalition: Ask the Experts - immunize.org/askexperts/
- CDC Experts at the National Immunization Program - nipinfo@cdc.gov or 1-800-CDC-Info (1-800-232-4636)



Immunization Medical Exemption Form

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, Head Start programs. Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of disease and the circumstances of the outbreak.

Please complete all required fields below. Incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	(optional) Middle Name:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:	
Address:		
City:	State:	Zip Code:
Email Address:	County:	
Phone Number:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	

Parent/Guardian Completing This Form: Check if an emancipated student or student over 18 years old

Last Name:	First Name:	(optional) Middle Name:
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian		
Address:		
City:	State:	Zip Code:
Email Address:	County:	
Phone Number:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:	<input type="checkbox"/> Check if Not Applicable	
Address:		
City:	State:	Zip Code:
Phone Number:	Grade of Student:	

Required Vaccines for Entering School: (Check each vaccine declined)	List medical contraindication(s) for each vaccine declined
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Diphtheria, tetanus, pertussis (DTaP, Tdap)	
<input type="checkbox"/> Haemophilus influenzae type b (Hib)	
<input type="checkbox"/> Inactivated poliovirus (IPV)	
<input type="checkbox"/> Pneumococcal conjugate (PCV13)	
<input type="checkbox"/> Measles-mumps-rubella (MMR)	
<input type="checkbox"/> Varicella (chickenpox)	

The physical condition of the above named student is such that vaccination would endanger his/her life or health or is medically contraindicated due to other medical conditions.

Signature: _____ Date: _____

Physician (MD, DO), Advanced Practice Nurse (APN), or delegated Physician Assistant (PA)

Under Colorado law, you have the option to exclude your child's/your information from CIIS. To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child's/your immunization records to ensure school compliance.



Immunization

Non-Medical Exemption Form (Religious and Personal Belief)

Vaccines are one of the greatest public health achievements of the past century and save an estimated 3 million children's lives every year. The Colorado Department of Public Health and Environment strongly supports vaccination as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. For nearly all children, the benefits of preventing disease with a vaccine far outweigh the risks. Declining to follow the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) immunization schedule for number, space and timing of doses, may endanger an unvaccinated child's health and others who come into contact with him/her. Some vaccine-preventable diseases are common in other countries and unvaccinated children could easily get one of these diseases while traveling or from a traveler.

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. Prior to kindergarten, a non-medical exemption must be filed each time a student is due for vaccines according to the schedule developed by the ACIP.^{1,2} From kindergarten through 12th grade, a non-medical exemption must be filed every year during the student's school enrollment/registration process.¹ Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Please complete all required fields below; incomplete forms will not be accepted. *All fields are required unless noted optional.*

Type of Non-Medical Exemption Claimed: Personal Belief Religious

Student Information:

Last Name:	First Name:	(optional) Middle Name:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:	
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box:	
City:	State:	Zip Code:
Email Address:	County:	
Phone Number:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	

Parent/Guardian Completing This Form: Check if an emancipated student or student over 18 years old

Last Name:	First Name:	(optional) Middle Name:
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian		
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box:	
City:	State:	Zip Code:
Email Address:	County:	
Phone Number:	<input type="checkbox"/> Home <input type="checkbox"/> Cell	

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:	<input type="checkbox"/> Check if Not Applicable	
Address:		
City:	State:	Zip Code:
Phone Number:	Grade of Student:	

¹ Colorado Board of Health rule 6 CCR 1009-2: <https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7698&fileName=6%20CCR%201009-2>.

² 2018 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a non-medical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

Vaccine Preventable Disease Information

The information provided below is to ensure parents/guardians/students are informed about the risks of not vaccinating.

Diphtheria, tetanus, pertussis (DTaP, Tdap) - Unvaccinated children may be at increased risk of developing diphtheria, tetanus and/or pertussis if exposed to these diseases. Serious symptoms and effects of diphtheria include heart failure, paralysis, breathing problems, coma, and death. Serious symptoms and effects of tetanus include "locking" of the jaw, difficulty swallowing and breathing, seizures, painful tightening of muscles in the head and neck, and death. Serious symptoms and effects of pertussis (whooping cough) include severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures, brain damage, and death. For more information: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/dtap.pdf> and <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.pdf>

Haemophilus influenzae type b (Hib) - Unvaccinated children may be at increased risk of developing invasive Hib disease if exposed to this disease. Serious symptoms and effects include bacterial meningitis, pneumonia, severe swelling in the throat, brain damage, deafness, infections of the blood, joints, bones, and covering of the heart, and death. For more information: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hib.pdf>

Hepatitis B - Unvaccinated children may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects include jaundice, life-long liver problems such as liver damage, scarring, liver cancer, and death. For more information: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf>

Inactivated poliovirus (IPV) - Unvaccinated children may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects include paralysis of muscles that control breathing, meningitis, permanent disability, and death. For more information: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ipv.pdf>

Measles, mumps, rubella (MMR) - Unvaccinated children may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include pneumonia, seizures, brain damage, and death. Serious symptoms and effects of mumps include meningitis, painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include rash, arthritis, and muscle or joint pain. If a pregnant woman gets rubella, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. For more information: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmr.pdf>

Pneumococcal conjugate (PCV13) - Unvaccinated children may be at increased risk of developing pneumococcal disease if exposed to this disease. Serious symptoms and effects include pneumonia, lung infections, blood infections, meningitis and death. For more information: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/pcv13.pdf>.

Varicella (chickenpox) - Unvaccinated children may be at increased risk of developing varicella if exposed to this disease. Serious symptoms and effects include severe skin infections, pneumonia, brain damage, and death. For more information: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.pdf>

Required Vaccines for School Entry - Place an "X" next to each vaccine you are declining.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diphtheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenzae type b (Hib)		Pneumococcal conjugate (PCV13)
	Hepatitis B		Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student himself/herself (emancipated or over 18 years of age) and am declining the vaccine(s) indicated above due to a religious or personal belief that is opposed to vaccines. The information I have provided on this form is complete and accurate.

- I may change my mind at any time and accept vaccination(s) for my child/myself in the future.
- I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, or www.ImmunizeforGood.com for additional information on the benefits and risks of vaccines and the diseases they prevent.
- I can contact the Colorado Immunization Information System (CIIS) at www.ColoradoIIS.com or my health care provider to locate my child's/my immunization record.³

I acknowledge that I have read this document in its entirety.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

³ Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

ATTENTION PARENTS/GUARDIANS

This letter is to ensure that your child has his/her proper medical forms which will support our program in providing a healthy and safe environment for your child.

- Children needing any medication during program hours require **medication authorization(s)** that are signed by your health care provider.
 - Children with **severe allergies** requiring medication are required to have a completed health care plan that is signed by your health care provider.
 - Children with **asthma** that regularly require asthma medication during program hours are required to have a completed asthma health care plan that is signed by your health care provider.
 - Children with **special health conditions** are required to have a completed health care plan signed by your health care provider. This plan will be individually designed for your child; as delegated by the program's nurse consultant, the program staff and the child's guardian(s).
-

To Be Completed and Returned By Parent/Guardian

- Does your child have any food exclusions due to an allergic reaction to the food? YES NO
if yes, please list food and your child's reaction to exposure:
Food Reaction Medication

_____ _____ _____
_____ _____ _____
- Does your child have any other allergies requiring medications or special attention? YES NO
- Does your child have a special health condition (such as seizures, diabetes, feeding tube, oxygen, etc.) that requires special attention by center staff?

If yes to any of the above, please circle the appropriate response below:

- I will provide a Health Care Plan signed by my child's health care provider.
- I understand that the nurse consultant will review the health care plan and is available to assist in this process.
- I do not want a HCP for my child at this time.
- Please do not serve these foods to my child at this time.

Child's Name _____ Birthdate _____

Parent's Signature _____ Date _____

The Children's Center @ RRCC Permission Requests

Topical Preparations (Preventive)

Please check all of the permissions that you agree to. If you do not wish to grant permission for any of the permissions below, please indicate NO and discuss with the director.

Child's Name _____

Sunscreen: I give permission for the staff of The Children's Center @ RRCC to apply sunscreen to my child's exposed skin. I understand that it is my responsibility to apply sunscreen to my child in the morning prior to or upon arrival. The staff will reapply sunscreen in the afternoon.

_____ I will provide sunscreen for my child, labeled with first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

_____ I authorize the use of SPF RX, Mineral Sunscreen SPF 40 on my child.

Lotion/Lip Balm

_____ I will provide a fragrance-free lotion and/or lip balm, labeled with my child's first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

_____ I authorize the staff to use fragrance-free moisturizing lotion on my child.

Diaper Ointment/Cream

_____ I authorize the staff of The Children's Center @ RRCC to apply diaper rash ointment/cream to my child, in the original container, labeled with my child's full name and with the noted expiration date and I will replace prior to expiration. I understand that I may only provide diaper rash ointment/cream, free of antibiotic, antifungal or anti-inflammatory components **without a written prescription from my doctor.**

I agree to the use of the products mentioned above and understand that I must check the ingredients of all products to ensure that my child is not allergic to them. I understand that skin lotion/cream/balm will not be applied to broken skin or if a skin reaction has been observed. Parent will be informed of skin reaction promptly.

Parent Signature

Date

The Children's Center @ RRCC Permission Requests

Child's Name _____

College students working with children The Children's Center is a lab site for students. Students may do observations and activities with children in The Children's Center for educational/training purposes. These students have completed background checks and are always supervised by staff.

_____ I give permission for my child to be observed and participate in activities with the Early Childhood Education students at the college.

Photo/Video Use Photos/videos taken of children in the classroom are often appropriate for staff and training in Early Childhood Education classes, as well as other classes such as Psychology. Videos and photos will never be used for commercial purposes.

_____ I give permission for my child's picture to be used for the above purposes.

Walks on college campus Children may take walks with the staff on the college campus, both indoors and out. If children were to cross streets, the walk would be considered a field trip and a special permission form would be requested, prior to the walk.

_____ I give permission for my child to take walks with the staff on college campus indoors and outdoors.

Media Use On rare occasions, a teacher may select a video to enhance topics that the children are investigating.

_____ I give permission for the staff to use video to enhance a topic the children are learning about.

Use of Cots For Rest Permission must be granted for children under the age of two to rest on a cot.

_____ I give permission for my child to lay on a cot during rest time.

Parent Signature

Date

FAMILY HANDBOOK AGREEMENT

I HAVE READ AND UNDERSTAND THAT OUR FAMILY WILL FOLLOW THE PRACTICES AND POLICIES SET FORTH IN THE MOST CURRENT FAMILY HANDBOOK FOR THE CHILDREN'S CENTER AT RED ROCKS COMMUNITY COLLEGE. I KNOW IF I HAVE QUESTIONS THAT I AM TO CONTACT THE DIRECTOR OF THE CENTER FOR ANSWERS TO MY QUESTIONS.

Parent/Guardian #1 _____ Date _____

Parent/Guardian #2 _____ Date _____

FINANCIAL AGREEMENT AND PAYMENT POLICIES

- **Payment is due for the month of care of the first of each month. A late fee of \$25.00 will be assessed on the 10th of the month if tuition has not been paid.**
- **Check:** Make checks payable to The Children's Center.
- **Credit Card:** All credit card payments (preferred method) are made on line at <https://commerce.cashnet.com/rcccdcpay>. Responsible party must log in **the first attendance day of each month to make payment.**
- **Cash:** Cash payment must be made at college cashiers dept. Please pick up a Miscellaneous Deposit Form to take with your payment.
- Tuition is based on contracted days, not on actual days of attendance.
- **Payment is due for enrolled days whether child attends or not. We cannot substitute attendance days if your child does not attend on his/her scheduled days of attendance.**
- There is a non-refundable \$50.00 registration fee per child due at time of registration and each August. A portion of this fee pays for the on line assessment program used to track each child's development. Families who enroll after May 31 will not be charged the annual fee until the following year.
- Holidays and in-service days are fee days. Families are not charged for 1 week of closure in Aug. and 1 week of closure in Dec. Tuition is calculated multiplying weekly rate x 50 weeks /12 months and rate is consistent each month.
- Childcare may be denied for any child for whom tuition is more than 2 weeks late.
- Accounts are subject to a \$25.00 processing fee for returned check or denied card.
- Late pick up fee is \$1.00 per minute after 6pm. Consideration is made for weather conditions and circumstances.
- Vacations-full payment is due for 2 consecutive weeks of vacation, and 50% for additional consecutive weeks, if written notice of vacation is provided.
- Parent fees for families receiving CCCAP assistance must be paid in full on the first attendance day of each month.

I understand the monthly fee for my child is _____ and I have read and agree to the financial policies outlined in the Family Handbook and above.

Signature _____ Date _____

Signature _____ Date _____



IMPORTANT INFORMATION REGARDING HANDBOOK

Please bring this form to your family interview to be reviewed with the Director.

College Training Site, pg. 3: Children are **never** left alone with practicum students at any time. Background checks are completed on all work study students and staff. ECE students come to us with a completed background check.

Drop off/pick up, pg. 4: We ask that all children be here from 8:45am-3:15pm. Chronic late arrival (after 9:30) will be discussed with family.

Cell Phone: So that you can give your children the attention they deserve, cell phone use is not permitted in our Center.

Attendance Days: Preference is given to typical attendance patterns: Full time, MWF, TTH. We cannot offer substitute days if your child is not able to attend on their enrolled day. If we have space, you may **add** a day at the full rate.

Admission & Registration, pg. 6: Record of immunization and health status form must be completed and delivered at drop off on the first day of attendance, and resubmitted annually. New Families-Registration is due when offered spot, and first month payment on child's first day of attendance. All tuition payments are due at the beginning of month of care. There is a \$25.00 returned check fee.

Extended absences are billed as follows: 2 consecutive weeks at full tuition, additional consecutive days at 50%. Slots are not held through summer without payment for care.

Parent/Guardian agrees to notify director prior to enrollment if child has special needs, ILP, IEP or other support.

Curriculum:

We integrate elements of High Scope, Reggio Emilia and Montessori philosophies into our child-directed learning curriculum.

Celebrations: Because we respect all cultures and all family practices & beliefs and because we do not believe some celebrations are developmentally appropriate for young children, our celebrations always emerge from our curriculum. Please read handbook carefully.

I have discussed the above information with Center staff and understand and agree to it.

Parent/Guardian Signatures

Date

Dear Parent or Guardian,

Congratulations! You have chosen a childcare provider that participates in the Child and Adult Care Food Program (CACFP). The CACFP makes healthy food a regular part of your child's day care. Participating in the CACFP means that the center cares about good nutrition for children, will introduce and serve a variety of nutritious foods for your child to eat, and will serve foods appropriate for your child's nutritional needs.

Please complete, sign and return this **Income Eligibility Form (IEF)** to the center as soon as possible. Completing this form allows your child care center to provide healthy meals and snacks to your child while in care. The CACFP ensures that this form is confidential and the information you provide will not be used elsewhere.

The provider you have chosen cannot charge a separate fee for meals, nor ask you to provide food for your child for meals claimed for reimbursement from the CACFP, except in some special cases. Depending upon the hours in care, your provider will be serving your child breakfast, morning snack, lunch, afternoon snack, supper and/or late snack.

If any person in your household receives benefits from the Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), income reporting and the disclosure of the last four digits of the Social Security Number (SSN) in Step 3 is not required.

If no person in your household receives benefits from Temporary Assistance For Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), also known as Food Stamps, or the Food Distribution Program on Indian Reservations (FDPIR), or is not the beneficiary of the Other Source Categorical Eligibility programs, please list your household's total gross income from the current month, the amount projected for the first month the application is made for, or the month prior to the application. The U.S. Department of Agriculture, which funds the CACFP, defines a household as a group of related or unrelated individuals who are living as one economic unit and who share housing and all significant income and expenses.

If no person in your household receives benefits from Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), or the Food Distribution Program on Indian Reservations (FDPIR), you must provide the last four digits of your Social Security Number according to regulations. The disclosure of the Social Security Number is voluntary; however, the last four digits of the Social Security Number, or an indication of "none," is required for the approval of this form.

If any of the children living in the household are beneficiaries of the Other Source Categorical Eligible programs (Foster, Head Start/Early Head Start or Even Start Program, Homeless, Migrant or Runaway), the children are eligible for free meals and there is no need to complete an application - mark the box next to the program that applies. The institution collecting the form will need to verify the child's participation in the program by requesting documentation from the placement office if the child is a foster child, from the Even Start or Head Start official if the child or the pregnant mother is enrolled Head Start or Early Head Start or the child is an Event Start participant, and from the Migrant, Homeless or Runaway program officials. For Even Start, documentation from the Even Start official confirming that the child has not yet entered Kindergarten.

Household Income Chart

If your household's income is less than or the same as the amounts indicated for your household's size on the chart below, the center will receive more meal reimbursement from the Child and Adult Care Food Program (CACFP) to help provide the best meals possible for the children in car

Household Size	1	2	3	4	5	6	7	8	For each additional person add:
Yearly	23,606	31,894	40,182	48,470	56,758	65,046	73,334	81,622	+8,288
Monthly	1,968	2,658	3,349	4,040	4,730	5,421	6,112	6,802	+691
Weekly	454	614	773	933	1,092	1,251	1,411	1,570	+160

This chart is not to be used for determining eligibility by center staff, but is a guide for families completing the form.



Child Meal Patterns

Child & Adult Care Food Program

Breakfast (Select all three components for a reimbursable meal)				
Food Components and Food Items	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18 <small>(At-risk, afterschool programs and emergency shelters)</small>
Fluid Milk	4 ounces	6 ounces	8 ounces	8 ounces
Vegetables, fruits, or portions of both	¼ cup	½ cup	½ cup	½ cup
Grains*				
Whole grain-rich or enriched bread	½ slice	½ slice	1 slice	1 slice
Whole grain-rich or enriched bread product, such as biscuit, roll or muffin	½ serving	½ serving	1 serving	1 serving
Whole grain-rich, enriched or fortified cooked breakfast cereal, cereal grain and/or pasta	¼ cup	¼ cup	½ cup	½ cup
Whole grain-rich, enriched or fortified ready-to-eat breakfast cereal (dry, cold)				
Flakes or rounds	½ cup	½ cup	1 cup	1 cup
Puffed cereal	¾ cup	¾ cup	1 ¼ cup	1 ¼ cup
Granola	½ cup	½ cup	¾ cup	¾ cup
Grains substituted with a meat/meat alternate* (May be used to meet the entire grain requirement a maximum of three times per week.)	½ ounce	½ ounce	1 ounce	1 ounce
Lunch and Supper (Select all five components for a reimbursable meal)				
Food Components and Food Items	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18
Fluid Milk	4 ounces	6 ounces	8 ounces	8 ounces
Meat/meat alternates				
Lean meat, poultry, or fish	1 ounce	1 ½ ounce	2 ounces	2 ounces
Tofu, soy product, or alternate protein products	1 ounce	1 ½ ounce	2 ounces	2 ounces
Cheese	1 ounce	1 ½ ounce	2 ounces	2 ounces
Large egg	½	¾	1	1
Cooked dry beans or peas	¼ cup	¾ cup	½ cup	½ cup
Peanut/soy/nut or seed butters	2 TBSP	3 TBSP	4TBSP	4 TBSP
Yogurt, plain or flavored unsweetened or sweetened	4 ounces/ ½ cup	6 ounces/ ¾ cup	8 ounces/ 1 cup	8 ounces/ 1 cup
The following may be used to meet no more than 50% of the requirement: Peanuts, soy nuts, tree nuts, or seeds as listed in program guidance, or an equivalent quantity of any combination of the above meat/meat alternates	½ ounce= 50%	¾ ounce = 50%	1 ounce = 50%	1 ounce = 50%
Vegetables	½ cup	¼ cup	½ cup	½ cup
Fruits	½ cup	¼ cup	¼ cup	¼ cup
Grains				
Whole grain-rich or enriched bread	½ slice	½ slice	1 slice	1 slice
Whole grain-rich or enriched bread product, such as biscuit, roll or muffin	½ serving	½ serving	1 serving	1 serving
Whole grain-rich, enriched or fortified cooked breakfast cereal, cereal grain and/or pasta	¼ cup	¼ cup	½ cup	½ cup
Snack (Select two of the five components for a reimbursable snack)				
Food Components and Food Items	Ages 1-2	Ages 3-5	Ages 6-12	Ages 13-18
Fluid Milk	4 ounces	4 ounces	8 ounces	8 ounces
Meat/meat alternates				
Lean meat, poultry, or fish	½ ounce	½ ounce	1 ounce	1 ounce
Tofu, soy product, or alternate protein products	½ ounce	½ ounce	1 ounce	1 ounce
Cheese	½ ounce	½ ounce	1 ounce	1 ounce
Large egg	½	½	½	½
Cooked dry beans or peas	¼ cup	¼ cup	¼ cup	¼ cup
Peanut/soy/nut or seed butters	1 TBSP	1 TBSP	2 TSBP	2 TSBP
Yogurt, plain or flavored unsweetened or sweetened	2 ounces or ¼ cup	2 ounces or ¼ cup	4 ounces or ½ cup	4 ounces or ½ cup
Peanuts, soy nuts, tree nuts or seeds	½ ounce	½ ounce	1 ounce	1 ounce
Vegetables	½ cup	½ cup	¾ cup	¾ cup
Fruits	½ cup	½ cup	¾ cup	¾ cup
Grains				
Whole grain-rich or enriched bread	½ slice	½ slice	1 slice	1 slice
Whole grain-rich or enriched bread product, such as biscuit, roll or muffin	½ serving	½ serving	1 serving	1 serving
Whole grain-rich, enriched or fortified cooked breakfast cereal, cereal grain and/or pasta	¼ cup	¼ cup	½ cup	½ cup
Whole grain-rich, enriched or fortified ready-to-eat breakfast cereal (dry, cold)				
Flakes or rounds	½ cup	½ cup	1 cup	1 cup
Puffed cereal	¾ cup	¾ cup	1 ¼ cup	1 ¼ cup
Granola	½ cup	½ cup	¾ cup	¾ cup

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, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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 Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

2020-2021 Income Eligibility Form (IEF) for Child Care

STEP 1: List ALL children in day care

Children in Foster care or Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Addition documentation is required to verify their eligibility status. Review the Dear Parent Letter for more details. If more than three children, please complete an additional form.

Child's First Name	Child's Last Name	Age	Check all that apply				
			Foster Child	Migrant	Runaway	Homeless	Head Start

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

IF YES → Write the case number here & proceed to STEP 4 (Do not complete STEP 3) **CASE NUMBER:** _____ (Write only one case number in this space.)

IF NO → Go to STEP 3

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

Flip the page for information on sources of income for child income and Household Members.

A. Child Income

Sometimes children in the household earn or receive income.

Please include the TOTAL income received by any children listed in STEP 1.

Child Income:		Circle one:
		Yearly Monthly Bi-weekly Weekly

B. All other Household Members (including yourself)

List other household members not listed in STEP 1 (including yourself) even if they do not receive income. For each household member listed, if they do not receive income, report total gross income (before taxes) for each source in whole dollars (no cents). **If they do not receive income from any source, write '0'. If you enter '0', you are certifying that there is no income to report.**

Name of other Household Members (First and Last Names)	Earnings from Work	How Often?	Welfare/ Child Support/ Alimony	How Often?	Pensions/ Retirement/ Social Security/SSI/VA Benefits	How Often?
		Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)		Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)		Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)
	\$		\$		\$	
	\$		\$		\$	
	\$		\$		\$	
Total household Members (Children and Adults)		Last Four Digits of Social Security Number (SSN) of primary wage earner or other adult household member.			XXX-XX-	Check if no SSN

STEP 4: Contact Information and Adult Signature

"I certify 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 that 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

2020-2021 Income Eligibility Form (IEF) for Child Care

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 <ul style="list-style-type: none"> • 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 or 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

STEP 5: Children's Ethnic and Racial Identities

We are required to ask for information about your children's race and ethnicity. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care. Check all boxes that apply to the child(ren) in your care. If this information is left blank, the institution MUST complete it based on visual identification.

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: White (Includes Hispanic and Latino) Black or African American Asian Native Hawaiian or Other Pacific Islander American Indian or Alaskan Native

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, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. 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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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, Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider.

DO NOT FILL OUT: For center staff use only

Annual Income Conversion: Weekly x 52, Biweekly x 26, Monthly x 12

Household Last Name:

Total Income	\$	How Often? (Circle One)	Yearly	Monthly	Household size:	Eligibility	Free	Reduced	Paid
			Bi-Weekly	Weekly					

Determining Official's Signature

Month/Year

Expiration Date* (Month/Year)

Today's Date

*This form expires 12 months after the month in which the institution makes the determination

Example: If the determination is July 2020, the form is valid from July 1, 2020 through July 31, 2021. The institution may use the date the participant/guardian signs the Income Eligibility Form OR the date the institution's official make the determination and signs the Income Eligibility Form. The same approval method selected must be used for all forms approved by the institution.

SPECIAL DIET STATEMENT

(Colorado Department of Public Health and Environment, Child and Adult Care Food Program)

Nutrition is an important part of good health and a good childcare program. Children need well-balanced meals to meet their daily energy needs and help build strong bodies and minds. Through the Child and Adult Care Food Program (CACFP), you can be assured that your child is getting balanced nutritious meals. All of the meals claimed must follow patterns set by the U.S. Department of Agriculture. As participants in the CACFP, your child care center can claim a maximum of one meal and two snacks or two meals and one snack daily per child unless they are approved to claim a fourth meal. Your childcare center receives a reimbursement for claiming these meals as well as information on nutritious meals for children.

If your child is unable to consume the foods that are required in the meal pattern, then substitutions may be made if authorized by a recognized medical authority. See reverse side of this page.

Below are the minimum Child and Adult Care Food Program meal requirements for children 1 through 12 years old:	
BREAKFAST	EXAMPLE
<ol style="list-style-type: none"> 1) Fluid milk 2) Fruit, vegetable or juice 3) Bread/bread alternate 	<ul style="list-style-type: none"> • Milk • Sliced apples • Corn flakes
LUNCH/SUPPER	EXAMPLE
<ol style="list-style-type: none"> 1) Fluid milk 2) Meat/meat alternate 3a) Fruit, vegetable or juice 3b) Fruit or vegetable 4) Bread/bread alternate 	<ul style="list-style-type: none"> • Milk • Chicken • Green beans • Sliced peaches • Dinner roll
SNACK - Serve 2 of the following 4 foods:	EXAMPLE
<ol style="list-style-type: none"> 1) Fluid milk 2) Meat/meat alternate 3) Fruit, vegetable or juice 4) Bread/bread alternate 	<ul style="list-style-type: none"> • Pineapple juice • Wheat Crackers

USDA forbids discrimination because of race, color, national origin, age, sex, or disability. Any person who believes he or she has been discriminated against in any USDA-related activity should write immediately to the Secretary of Agriculture, Washington, D.C. 20250.

SPECIAL DIET STATEMENT

The child listed below participates in the USDA Child and Adult Care Food Program. Through this program, licensed childcare centers serve meals that meet the USDA meal pattern requirements (see reverse side of this form). Substitutions in the regular meal pattern may be made based on the authorization of a recognized medical authority, i.e., Physician, Physician's Assistant, Nurse/Practitioner, Child Health Associate or Registered Dietitian.

Child's Name: _____ Age: _____ Date*: _____

Child Care Center: _____ Substitution Effective Through*: _____

Reason for Substitution: _____

Substitutions are needed for the following food group (Please Check All That Apply)	Specific Foods to Avoid	Specific Food Substitutions	Key Nutrients that need to be Provided by Substitution
Iron Fortified Infant Formula			Iron, Calcium, Zinc, Protein, Calories
Fluid Milk			Calcium, Protein
Meat/Cheese/Eggs			Protein, Iron, B ₁₂
Fruits			Vitamin A, C, Fiber
Vegetables			Vitamin A, C, Fiber
Bread/Grains			B-complex, Fiber
Others - please specify _____ _____ _____			

Signature of Medical Authority: _____

Parent's Signature: _____

Please Print or Type Name: _____

Please Print or Type Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

This form must be updated every 6 months.

Follow Up Letter if Special Diet Statement Needs Clarification

Dear Medical Authority:

We have recently received a Special Diet Statement for _____.

The Diet Statement indicates _____

should be substituted for _____.

This substitution may not provide the child with sufficient _____

_____.

Unless you let me know of a change in the Special Diet Statement, I will assume that you are monitoring the child's nutritional status and making the necessary dietary additions.

Sincerely,

cc: _____

Parent

RRCC Children's Center Door Access Badge Parent Contact Information

Child's Name 1: _____

Child's Name 2: _____

Parent 1 Name: _____

Phone Number: _____ Work Number: _____

Email Address: _____

Parent 2 Name: _____

Phone Number: _____ Work Number: _____

Email Address: _____

Other Authorized Adult: _____

Phone Number: _____

Email Address: _____

Parents/Other Adults are responsible for keeping track of their access badges. If you lose your badge, please contact Campus Police immediately at 303-914-6394 so that we can deactivate your badge and schedule a time to get you a new one. The initial cost for your first badge is \$10/badge. The cost to replace a lost badge is \$10.00. The fees can be paid at the cashier's

RRCC Emergency Alert Messaging

In the event of a campus closure due to weather or an emergency due to an imminent threat, you will be notified immediately. In order to OPT IN to RRCC Emergency Alert text message notifications please check the box below and provide the mobile number(s) that you would like the text messages to be sent to. If you need to update your phone number or OPT OUT please contact the Police Services Manager via email at loretta.talfoya@rrcc.edu

OPT IN to Text Messaging Emergency Alert Notifications

Mobile Number(s): _____

You will automatically be subscribed to email and voice call alerts with the email address and phone number(s) that we have on file.

Parent 1 Signature: _____ Date: _____

Parent 2 Signature: _____ Date: _____

Other Adult Signature: _____ Date: _____

CC Director Signature: _____ Date: _____

VP Signature Approval: _____ Date: _____

Internal Use Only

Initials of Person Processing Badge: _____ Time: _____ Date Processed: _____

Signature of PSM: _____ Date Received by PSM: _____

Children’s Center at Red Rocks Community College

- The Children’s Center will be open limited hours 7:30-5:00.
- Care will only be offered 5 days per week Monday-Wednesday-Friday or Tuesday Thursday.
- Any children who are exhibiting any signs of illness will be sent home. Any child who is ill will be taken out of the classroom to the lobby area as we wait for their parent to pick them up. *Children will need to be symptom free for at least 72 hours without the help of medication before returning to care.*

I understand the following guidelines will be in place until further written notice: *Please review and initial on each line.*

_____ I will drop my child off between 7:30 and 9:00 a.m.

_____ I will not bring any toys etc. from home toys.

_____ I understand the symptoms of COVID-19 fever, dry cough, fatigue, vomiting, and difficulty breathing and affirm that if anyone in my household has COVID-19 symptoms or is diagnosed with COVID-19 my child will be excluded from care until the household member is fever free for at least 72 hours without the help of medication, and 10 days have passed since their first symptoms unless they have a clear alternative diagnosis from a medical provider.

Curbside drop off and pick up for families:

_____ I will be required to wear face coverings for drop off and pick up.

_____ I will walk my child to the east entrance for their daily temperature and health check.

_____ I will make sure that child has sunblock applied before they arrive at school.

_____ I will help my child/children who are over 3 get their mask on each morning the masks will be provided by the Center so that we can make sure that they are properly cleaned every day.

_____ I will support my child during the drop off transition by saying good bye.

_____ I understand a teacher will help my child get their hands washed using soapy water and clear water in spray bottles before entering the classroom and accompany my child to the classroom.

_____ I give my permission for staff to physically sign my child in and out each day.

_____ I understand children will enter their classroom via the playground so that Sunlight children are not going through the River Rock Room.

_____ I will pick up my child at the side yard gate and agree to call and notify the Center if I am going to pick my child up before 4:00 p.m. so that someone can meet me at the gate.

I have read, understand, and agree to comply with the expectations.

Signature Date Signature Date