REGISTRATION PACKET

THIS INSTITUTION IS AN EQUAL OPPORTUNITY EMPLOYER

NEW DREAM FAMILY CENTER

ENROLLMENT FORMS CHECKLIST

In the Registration Packet you will find the following forms:

- ☐ Pre-Registration Agreement
- ☐ New Dream Enrollment Form
- ☐ Time Slot Form
- ☐ CACFP Letter
- ☐ CACFP Child Enrollment Form
- ☐ Confidential Income Statement
- ☐ Oregon Health Authority Immunization Status
- ☐ Medical Statement for Accommodating Disabilities
- ☐ Permissions Forms
- ☐ Parent Acknowledgement of Handbook Policies

NEW DREAM FAMILY CENTER

Pre-Registration Agreement

Dear Pre-Registered New Dream Families,

Thank you so much for enrolling your child(ren) with us at the New Dream! We are excited to serve you and your children for as long as they are in care.

If you intend to enroll with a start date greater than two months in advance, a deposit of half a month of your expected tuition and enrollment fee will be due to secure your space. This 50% deposit will be applied to the first full month of enrollment. Please check with the enrollment coordinator about availability in each classroom.

To reiterate: the pre-registration policies are as follows:

1. You will need to work with the enrollment coordinator to determine that there is an opening in the classroom needed.
2. Schedule changes are never guaranteed and will be accommodated as ratios, staffing, and the best interest of the center permits. Be sure to contact the center as soon as possible if a change in your schedule is needed.
3. To guarantee a space in a room, we require a **50% NON-REFUNDABLE** deposit, and enrollment fee.
4. If enrollment begins mid-month, tuition will be pro-rated and due at the time of start. The 50% deposit will then be applied to the first full calendar month of attendance.
5. If you move your start date to a later time and want to keep your guaranteed spot, you will be responsible for the tuition in the intervening time.
6. Tuition is subject to change depending on increases, scheduling, registration fees, and supply fees.

You have Preregistered for:

_______________ _______________ _______________

Classroom Schedule Start Date Child's Name

_______________ _______________

Parent Signature *Date* *Parent Signature* *Date*

____

Administrative Signature *Date*

NEW DREAM FAMILY CENTER

ENROLLMENT FORM

Child's Last Name	**Date Entered Care**	
Child's First Name	**Age at Entry to Care**	
Child's Nickname	**Date of Birth**	
ALLERGY ALERT: Does child have allergies? Yes No If yes, list all allergies on back side of form		
Parent or Guardian Contact Information		
Name (first, last)	Relationship	
Home Address	City	Zip
Home Phone	Work Phone	
Personal Email	Work Email	
Employer and Work Hours	Cell Phone	
Work Address	City	Zip
Name (first, last)	Relationship	
Home Address	City	Zip
Home Phone	Work Phone	
Personal Email	Work Email	
Employer and Work Hours	Cell Phone	
Work Address	City	Zip
Required Emergency Contact Information – person other than parent or guardian that is authorized to pick up child		
Name (first, last)	Phone	Relationship
Name (first, last)	Phone	Relationship
Non-Emergency Contact Information – person other than parent or guardian that is authorized to pick up child		
Name (first, last)	Phone	Relationship
Name (first, last)	Phone	Relationship
Medical / Dental Contact Information		
Insurance Provider and Policy Information (if applicable)		
Primary Physician Name		
Dental Provider (if child is school-age. If none, list dental provider for child care facility)		

NEW DREAM FAMILY CENTER

ENROLLMENT FORM

Parent or Guardian Authorization

Please list any restriction to permission of the following:

My Child may be taken on field trips or excursions by bus or private motor vehicle, as well as on neighborhood walking excursions under required supervision (see special transportation arrangements section)

My Child may participate in swimming or other water activities under required supervision (CCD requires approved lifeguard).

My Child may be photographed for publicity (such as website, Facebook, advertising) or for use in the center (such as bulletin boards, newsletters) Publicity Center Use

My Child may be given prescribed or non-prescribed medicine in the original container as indicated on the container and provided by the parents. This may include sunscreen, pain reliever, antibacterial first aid cream, and diapering ointment, or teething products. Prescription medications must be current, in original container. A permission slip is required for each medication.

In an emergency, the child care facility has my permission to call 911. In medical emergencies, 911 is called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child will be notified immediately or as soon as possible.

Parent / Guardian Signature____**Date** _______________________

Child Information

Has your child previously been in child care?	If yes, what type of care and for how long?
Reason for requesting care	

Child General Information – please include all information that will assist us in providing quality care for your child

Likes and Dislikes
Eating Habits and Schedule
Sleeping Habits and Schedule

NEW DREAM FAMILY CENTER

ENROLLMENT FORM

Play
Fears
Special Words and their Meanings

Child Medical Information

Does your child have allergies? Yes No	Has your child had chickenpox? Yes No

List all allergies or other health problems, including instructions for providing best possible care in regard to stated conditions. Do any of the medical conditions restrict the child's activities?

Other Children in Home

Name (first, last)	Nickname	Age	Gender
Name (first, last)	Nickname	Age	Gender
Name (first, last)	Nickname	Age	Gender
Name (first, last)	Nickname	Age	Gender

Special Transportation Arrangements

CCD requires a written plan of the transportation arrangements between the child care facility and the parent or guardian of the child for extracurricular activities. The following indicates the child care facility's transportation plan:

______________________(Child) attends **The New Dream Family Center** (school). He/she will be transported/escorted between the child care facility and the school by (check applicable type):________school bus,_________head start bus, ________child care facility or________will arrive/depart unescorted with my permission. If my child is not at the designated pickup site, or does not arrive as planned, please contact (check applicable type):__________parent or guardian, or_________the school, in order to confirm the child's whereabouts, as well as devise a plan as needed to locate the child. My child also has permission to (**specify**, i.e.: work with teacher after school, attend an extracurricular class or meeting, depart for home at a specific time, etc.)

Parent / Guardian Signature____ **Date** _____________________

NEW DREAM FAMILY CENTER

ENROLLMENT FORM

Fee Agreement and Contract Terms (Some policies do not apply or may vary for DHS families)

1. An annual, non-refundable family Registration Fee is to be paid at the time of enrollment. Registration Fees are renewed in September 1st each year and must be paid in full by September 30th.
2. The Center is open from 8 AM to 5 PM Monday through Friday. A Late Pick-Up fee of $1 per minute per child will be charged when a child is left past the center's closing time, and must be paid at time of pickup.
3. Tuition is due in advance of services provided. Tuition payments must be received by the 5th of each month.
4. Accounts that are two weeks behind may result in immediate termination of service; however, once balance is paid, the child may return into care. (Subsidized families adhere to policies contracted with DHS regarding delinquent copays.)
5. Tuition fees are not pro-rated for illness, holidays, or emergency closures of the center.
6. 30-day written notice is required prior to withdrawing. All balances must be paid in full by last day of attendance. Any outstanding balance will be referred to a collection agency. All fees associated with collections or attorney charges will be added to the collection account.
7. The terms of this agreement, including tuition, fees and policies may be changed by New Dream with 30 day notice to families.

I certify that I have received and read the parent handbook, and understand and accept all the terms and conditions in the Fee Agreement and Contract Terms.

______________________________	______________________________
Parent / Guardian Signature	**Date**
______________________________	______________________________
Parent / Guardian Signature	**Date**
______________________________	______________________________
Center Director Signature	**Date**

New Dream Family Center is a nonprofit community-oriented business, and as such, we always look for ways to connect with the families whom we serve. We know that every person has gifts and skills to share, so we invite you to become more involved with the center as a volunteer, a board member, or as someone we can call for an expert opinion. If you'd like to be more involved with us, let us know a little bit about what your skills and interests are below: ____

____

____

THANK YOU!

New Dream Family Center

TIME SLOT FORM

2023 - 2024	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
FULL TIME: 7:30 AM – 5:30 PM	☐	☐	☐	☐	☐
OR	*OR*	*OR*	*OR*	*OR*	*OR*
PART TIME: 8:30 AM - 2:30 PM	☐	☐	☐	☐	☐
ESTIMATED DROP OFF TIME					
ESTIMATED PICKUP TIME					

Reminder: Please provide estimated drop off and pick up time

Childs Name:________________________________**Class:**______________________

Parent Signature:____________________________**Date:** ______________________

****In the event of a change to your schedule in the upcoming month please communicate with the Front desk for <u>availability</u> and <u>approval</u> before a permanent change is made. ****

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled at a child care center. **New Dream Family Centerr** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached Confidential Income Statement. In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced price meals.

1. **Do I need to fill out a Confidential Income Statement for each of my children in day care?** Complete and submit one CACFP Confidential Income Statement for all children in your household **only** if they are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: New Drea, 1295 W 18th Ave, Eugene, OR 97402 541-344-1905.**
2. **Who is eligible for free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) are eligible for free meals. Foster children and children enrolled in Head Start based on income are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.
3. **Who can get reduced price meals?** Your children can get low-cost meals if your household income is within the reduced price limits on the Federal Income Guidelines shown on this application. Children in households participating in WIC may be eligible for reduced price meals.
4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the center or the day care home.
5. **Who should I include as members of my household?** You must include all people in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.
6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Federal Income Guidelines, the family day care home or center will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility guidelines.
7. **What if my income is not always the same?** List the amount that you normally earn. For example, if you normally earn $1000 each month, but you missed some work last month and only earned $900, put down that you earn $1000 per month. If you normally earn overtime, include it, but not if you only earn it sometimes.
8. **What if I have foster child(ren)?** Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the confidential Income Statement, but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **1899 Willamette St, Eugene, OR 97401 541-686-7555.**
9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
10. **Centers charging for meals only (Pricing programs only). Will the information I provide be verified?** Maybe. We may ask you to send written proof to verify the information you submitted on the form. **What if I disagree with the decision about the information I complete on this form?** You should talk to your sponsoring organization. You may ask for a hearing by calling or writing to: **hearing official name, address, phone number.**

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call **541-344-1905.**

Sincerely,

New Dream Family Center

This institution is an equal opportunity provider.

OMER Roster Number ________

Child and Adult Care Food Program CHILD ENROLLMENT FORM

Child Care Centers/Head Start Programs

____

CACFP Sponsor Name/Site Name

TO BE COMPLETED BY PARENT/GUARDIAN ONLY

The CACFP reimburses centers for serving nutritious, well-balanced meals and snacks to children in care.
Complete the following chart for all children in care. Sign, date, and return to the center. Use additional forms, as needed.
Parents/guardians of all infants must complete the Infant Formula Selection section.

Children's Names	Normal Hours in Care: Enter the **time** your child usually *arrives* each day.	Normal Hours in Care: Enter the **time** your child usually *leaves* each day.	Normal Meals and Normal Days in Care
Last: First	______ Time ☐ AM ☐ PM	______ Time ☐ AM ☐ PM	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐ **Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last First	______ Time ☐ AM ☐ PM	______ Time ☐ AM ☐ PM	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐ **Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last First	______ Time ☐ AM ☐ PM	______ Time ☐ AM ☐ PM	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐ **Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last First	______ Time ☐ AM ☐ PM	______ Time ☐ AM ☐ PM	**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐ **Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

Parent/Guardian Print Name: ______________________________________ Date ____________

Parent/Guardian Signature: ______________________________________

INFANT FORMULA SELECTION: Complete if any child listed above is an infant under one year of age

This center provides ______________________________ (list brand) iron fortified infant formula.

Check one: ☐ I accept the center provided formula
☐ I decline the center provided formula
I understand that by declining the center provided formula, I agree to provide breast milk or formula for my child.
If I provide formula it must be on the approved formula list for the center to be reimbursed for the meal.

Updates: *(annual at a minimum)*	The parent/guardian signing this form certifies that the enrollment information is correct. If information has changed, the parent/guardian has written the appropriate changes on the form and initialed the change. *If there are many changes, please complete a new form.*	
First Update	*Parent/Guardian Signature*	*Date*
Second Update	*Parent/Guardian Signature*	*Date*
Third Update	*Parent/Guardian Signature*	*Date*
Fourth Update	*Parent/Guardian Signature*	*Date*

This institution is an equal opportunity provider.

OMER Roster Number _________

2023-2024 CONFIDENTIAL INCOME STATEMENT – Child Care Centers/Family Day Care Providers

INSTRUCTIONS:

- If your household received SNAP, TANF or FDPIR, complete parts 1-3, and 5; part 6 is optional.
- If you do not receive these benefits and your income is below the guidelines (back) complete parts 1, 2, 4, and 5; part 6 is optional.
- If you are applying for a FOSTER CHILD only, complete parts 1, 2, and 5; part 6 is optional.

Any income fields left blank will be counted as zeros. Please be careful that you meant to leave income fields blank.

1 HOUSEHOLD INFORMATION

Print name of person completing this application (Last name, First name)

____

Name **Print**

____

Mailing Address – Apt #

____

City State Zip

Home Phone or Cell Phone (Circle One)

____

Work Phone

____

➔ Number living in this household ______
(Write names of **all** household members on part 2 and/or part 4 of this form)

2 CHILD INFORMATION – (Names of Your Children *Enrolled* in Child Care)

	Child's Name (Legal Last name, First name)	Birth Date	Age	Check if Foster Child (placed by welfare agency or court) If only foster care child(ren) see instructions above
1.	______________	__________	_____	☐
2.	______________	__________	_____	☐
3.	______________	__________	_____	☐

3 PUBLIC BENEFITS

Indicate which **benefits** your household currently receives, and list case number, if any:

Name: ______________________________ Case Number: ______________________________

☐ SNAP (Supplemental Nutrition Assistance Program) (*Oregon Trail Card number not acceptable*)
☐ TANF (Temporary Assistance to Needy Families) (*Employment Related Day Care does not qualify*)
☐ FDPIR (Food Distribution on Indian Reservations)

4 HOUSEHOLD MEMBERS & GROSS MONTHLY INCOME – if not monthly, see back for conversions

	Column 1 List **all** household members, including children not attending school, and income. Do not include children listed in part 2, unless they receive regular income. (*Last name, first name*)	**Column 2** MONTHLY INCOME (Total earnings & wages before deductions)	**Column 3** MONTHLY CHILD SUPPORT, WELFARE, ALIMONY RECEIVED	**Column 4** MONTHLY PENSIONS, SOCIAL SEC., RETIREMENT, SSI, VA	**Column 5** OTHER MONTHLY INCOME -Including unemployment and workers comp.	**Column 6** Check if No Income
1.	__________	______	______	______	______	☐
2.	__________	______	______	______	______	☐
3.	__________	______	______	______	______	☐
4.	__________	______	______	______	______	☐
5.	__________	______	______	______	______	☐
6.	__________	______	______	______	______	☐
7.	__________	______	______	______	______	☐

5 SIGNATURE, DATE and Last four numbers of SOCIAL SECURITY NUMBER (Adult must sign)

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.

Signature of Adult Household Member

X______________________________

Date Signed

____
Month/day/year

Social Security Number
(See privacy statement on back)
XXX-XX -___ ___ ___ ___

☐ **I do not have a Social Security Number.**

6 RACIAL OR ETHNIC GROUP (OPTIONAL)

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ Asian
☐ American Indian & Alaskan Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ Other

SPONSOR USE ONLY - DO NOT WRITE BELOW THIS LINE

Total Income:_____________ Number in Household:__________

Centers
Eligibility : ☐Free ☐Reduced Price ☐Above Scale

FDCH
☐Tier 1 ☐Tier 2

Eligibility based on : ☐SNAP ☐TANF ☐ FDPIR ☐Household Income ☐ Foster Child

Notes: ____
____

Determining Official's Signature :____________________________ Date_____________
Second Check Signature: ____________________ Date_____________

SEE IMPORTANT INFORMATION ON REVERSE SIDE

DETERMINING MONTHLY INCOME FOR EARNINGS & WAGES

Monthly income for all household members must be reported in Section 4 of this application. Income means any money regularly received from work, child support, alimony, pensions, retirements, social security or any other source. Exclude student/school loans. Money received from a business or farm owned by you should be reported as "net income". *Net Income is defined as the total income left after business and farm operating expenses are subtracted from gross receipts.*

Homeless, migrant and runaway youth are categorically eligible for free meals.

Household members who are not paid monthly should change earnings into monthly income by doing the following:

Household members who are paid every week: Multiply total earnings and wages for one pay period, before deductions, by 52. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid every 2 weeks: Multiply total earnings and wages for one pay period, before deductions, by 26. Then divide by 12. The resulting amount is the total monthly income.

Household members who are paid twice a month: Multiply total earnings and wages for one pay period, before deductions, by 24 then divide by 12. The resulting amount is the total monthly income.

Household members who are seasonal workers or work less than 12 months: Project annual rate of income to accurately represent actual circumstances then divide by 12. The resulting amount is the projected monthly income.

FEDERAL INCOME GUIDELINES

Participants may qualify at least for reduced price meals if your household income falls within the limits of this chart.

	Reduced Price Meals				
Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
-1-	26,973	2,248	1,124	1,038	519
-2-	36,482	3,041	1,521	1,404	702
-3-	45.991	3,883	1,917	1,769	885
-4-	55,500	4,625	2,313	2,135	1,068
-5-	65,009	5,418	2,709	2,501	1,251
-6-	74,518	6,210	3,105	2,867	1,434
-7-	84,027	7,003	3,502	3,232	1,616
-8-	93,536	7,795	3,898	3,598	1,799
For each additional family member add	9,509	793	397	366	183

PRIVACY STATEMENT - SOCIAL SECURITY NUMBERS and OTHER INFORMATION

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information but if you do not, we cannot approve your child for free or reduced price meals. You must include the last 4 digits of the social security number of the adult household member who signs the application. The last 4 digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program case number or Food Distribution Program on Indian Reservations (FDPIR) identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals and for administration and enforcement of the lunch and breakfast programs. We **may** share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs; auditors for program reviews; and law enforcement officials to help them look into violations of program rules. We may share the information on this form with Medicaid, unless you tell us not to. The information, if disclosed, will only be used to identify eligible participants and seek to enroll them in Medicaid.

NON-DISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1. **mail:** U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or **fax:** (833) 256-1665 or (202) 690-7442; or **email:** program.intake@usda.gov. This institution is an equal opportunity provider.

Oregon Certificate of Immunization Status
Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Complete for all | Up-to-date | Medical | Non medical

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*
Mailing Address *Dirección*	City *Ciudad*	State *Estado*	Zip Code *Codigo Postal*
Parents' or Guardians' Names *Nombre de los padres o guardian*		Home Telephone Number *Número de Teléfono*	

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)					
Booster Dose Tdap					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] Check here if child has had chickenpox disease______________(mm/dd/yy)					
Measles/Mumps/Rubella (MMR)					
or Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

I certify that the above information is an accurate record of this child's immunization history.

Signature* ________________________________ Date

Update Signature ________________________________ Date

Update Signature ________________________________ Date

Update Signature ________________________________ Date

*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

For school/facility use only
School/facility Name
Student ID Number
Grade

Continued On Reverse Side

Oregon Certificate of Immunization Status, Page 2
Oregon Health Authority, Immunization Program

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*

Recommended Vaccines

Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Pneumococcal (PCV) (Only in children less than 5 years)					
Meningococcal (MCV4, MPSV4)					
Human Papilloma Virus (HPV) (9 years or older)					
Influenza (Flu)					
Other Vaccine Please specify:					
Other Vaccine Please specify:					

For medical exemptions:

Please submit a letter signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

For Immunity Documentation (history of disease or positive titer)**: Please submit a letter signed by a licensed physician stating:**

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

Nonmedical Exemption:

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

A health care practitioner

The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

Diphtheria/ Tetanus/Pertussis
Polio
Varicella
Measles/Mumps/Rubella
Hepatitis B
Hepatitis A
Hib

Signature of Parent or Guardian ____________ Date

Optional:
ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:
Religious belief   Philosophical belief   Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature ____________ Date

Update Signature ____________ Date

Update Signature ____________ Date

Update Signature ____________ Date

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

Medical Statement to Request Special Meals and/or Accommodations

Federal law and USDA regulation require Child Nutrition Programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal dietary preferences.

Site/Provider Name:	**Submit this form to:**

Part I To be completed by Parent/Guardian, Adult Participant, or

Name of Participant: ____________________

Parent/Guardian Name: ____________________ Phone #: __________

Part II To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law*. Complete questions 1-3.

1. **Describe** the major life activity or major bodily function(s) affected by the participant's physical or mental impairment that restricts the diet:
   ____
   ____
2. **Meal Accommodation Plan (Foods to omit or avoid):**
   ____
   ____
3. **Foods to be substituted and recommended alternatives (include modification and accommodation):**
   ____
   ____

Signature of State Licensed Health Care Professional:

____________________	____________________	__________
Printed Name	Signature	Date

Part III Use Only

Accommodation(s) Made: ____________________

____

Sponsor Signature: ____________________ Date: __________

Rev. 4/21

This institution is an equal opportunity provider.

Oregon Department of Education
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Child Nutrition Programs
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Instructions for completing the Meal Preference Request Form:

1. **Organization Name:** Include the name of the Sponsoring Organization that is providing the form
2. **Site/Provider Name:** Print the name of the site where meals will be served (e.g., ABC School, XYZ Child Care Center)
3. **Submit this form to:** Include the name and contact information for the organization staff who will be collecting the completed form
4. **Part I:** This section can be completed by the **Parent/Guardian, Adult Participant, or Organization**
    a. **Name of Participant:** Print the first and last name of the child or adult participant
    b. **Parent/Guardian Name:** Print the first and last name(s) of the parent or guardian. This is not required for adult participants.
    c. **Phone #:** Include a number for the parent/guardian in case of questions
5. **Part II:** This section must be completed by a **State licensed health care professional*:**
    a. In section 1 – **Describe:** The major life activity or major bodily function affected by the participant's physical or mental impairment that restricts the diet.
    b. In section 2 – **Meal Accomodation Plan:** Provide any foods to omit or avoid.
    c. In section 3 – **Foods to be substituted and recommended alternatives:** Provide the modification and accommodation.
6. **Part III**: This section must be completed by the Sponsoring Organization after Parts I and II are completed.
    a. **Accommodations Made**: The Sponsoring Organization staff will indicate what accommodations will be made for the requests made in Part II.
    b. **Sponsor Signature and Date**: The Sponsoring Organization staff will sign and date the form. This form will be considered incomplete if this section is not filled in.

This form is only for participants requiring a medical meal accommodation and should be filled out by a licensed medical professional*. Participants requesting a Non-Medical Meal Accommodation and/or a Milk Substitution will use the Meal Preference Request Form.

***State License Health Care Professions** include: Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD).

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New Dream Family Center

Permission Forms

SUNSCREEN PERMISSION

I_______________________________________, give New Dream Family Care Center permission to apply sunscreen to____(child name) as they feel it is needed for time outdoors.

Please check the appropriate choices below:

☐ I have provided a bottle of sunscreen to be used on the child listed above.

☐ I would not like New Dream to apply sunscreen to my child(ren).

☐ I have provided a hat for my child(ren).

WALK PERMISSION

I_______________________________________, give New Dream Family Care Center permission for my child(ren)_______________________________________to be taken on neighborhood walking excursions with at least two teachers supervising while outside of the Center.

☐ I allow my child to be taken on walks, and will provide my child with appropriate gear to wear while outside.

☐ I decline permission for my child to participate in walks.

PHOTO PERMISSION

We would appreciate it if parents completed this consent form in order to allow their child(ren) to be photographed during special events or normal day to day activities organized at New Dream Child Care. In order for a child to have their photograph taken, they must have a consent form on file at New Dream. If you do not want to have your child photographed, please do not hesitate to indicate this in the section below.

☐ I understand that my child(ren) whose name(s) are listed below may be photographed at New Dream during normal business hours field trips, or activities.

____

____

☐ I understand that these photographs may be used in within the classroom.

☐ I understand that these photographs may be shared in the private "ProCare Connect" app, or other classroom communications ie.: newsletters or emails.

New Dream Family Center

Permission Forms

☐ I give permission for my child(ren) to be photographed, or their images recorded to be used for media purposes (ie. Facebook, the New Dream website, newsletters, flyers)

☐ No, I do not wish to have my child(ren) photographed for any purposes.

PLEASE FILL OUT THEABOVE PERMISSIONSAND PRINT AND SIGN BELOW:

____
Parent Name (Printed)

____
Parent Signature

____
Date

NEW DREAM FAMILY CENTER

ACKNOWLEDGMENT OF POLICIES AND RECEIPT OF PARENT/GUARDIAN HANDBOOK

The rules and regulations of the New Dream Family Center are set forth in the Parent/Guardian Handbook. Our goal is to provide children a safe, fun, active, and healthy environment while they are here at our center.

Comprehensive program information and policies are found in the provided parent handbook. It is the responsibility of all parents to read and follow the policies, provisions, and procedures contained in the Parent Handbook.

As with any center, we are constantly striving for improvement. The contents of the Parent Handbook are subject to change and will be revised in accordance with changes to the rules and regulations of state and federal governing bodies, or at the discretion of the Board of Directors at New Dream Family Center. Any such revisions will supersede, modify, or eliminate the current contents of the handbook. Information on revisions and changes will be made available to families as soon as possible after adoption. Contact the Center Director for any questions about the contents of the Parent/Guardian Handbook.

By signing this form, you are confirming that you have received, read, fully understand, and are committed to following the policies of our program. You understand that failure to follow the above rules and regulations can lead to termination.

______________________________	___________	________________________________
Parent/Guardian Name (please print)	Date	Parent/Guardian Signature
______________________________	___________	________________________________
Parent/Guardian Name (please print)	Date	Parent/Guardian Signature
______________________________	___________	________________________________
Center Director Name (please print)	Date	Center Director Signature