SCHOOL-AGE
REGISTRATION PACKET

THIS INSTITUTION IS AN EQUAL OPPORTUNITY EMPLOYER

NEW DREAM FAMILY CENTER

SCHOOL-AGE ENROLLMENT FORMS

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School-Age Child Enrollment Form

Oregon Department of Early Learning and Care

Child's Name (Last, First)		Child Nickname
Date of Birth	**Date Entered Care**	**Age at Entry**

ALLERGY ALERT **Does your child have allergies?** ☐ YES* ☐ NO *If yes, please complete an allergy care plan.

Parent or Guardian Contact Information

Name (First, Last)			Relationship
Home Address (Street, City, Zip)			
Home Phone	Cell Phone	Email Address	
Employer and Work Hours	Work Address (Street, City, Zip)		Work Phone
Name (First, Last)			Relationship
Home Address (Street, City, Zip)			
Home Phone	Cell Phone	Email Address	
Employer and Work Hours	Work Address (Street, City, Zip)		Work Phone

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 Contact Information

Insurance Provider and Policy Information (if applicable)	
Child's medical provider(s) or emergency care facility	Phone

Parent or Guardian Authorizations (not all of these authorizations are required in family child care)

Please list any restrictions to permission of the following:

My child may be taken on neighborhood walks. ☐ Yes ☐ No Note: A signed permission slip is required for all field trips out of the neighborhood.

My child may use sunscreen ☐ Yes ☐ No My child may apply their own sunscreen under adult supervision. ☐ Yes ☐ No

My child may be photographed and/or recorded for publicity or news purposes: ☐ Yes ☐ No This applies to: ☐ On-site ☐ Off-site photography and video.

CC/SC: my child may participate in religious or cultural events described in center policy, including special occasions where food is being served. ☐ Yes ☐ No

I have reviewed a copy of this child care facility's current license certificate. ☐ Yes ☐ No

I have received a written copy of the program's child care policies. ☐ Yes ☐ No

In an emergency, the child care facility has my permission to call an ambulance or transport my child to any available physician or hospital at my expense to obtain medical treatment. In most 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 must be notified as soon as possible.

Parent/Guardian Signature	**Date**

Has your child previously been in child care? ☐ Yes ☐ No If yes, what type of care and for how long?

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

General likes and dislikes

Eating habits and schedule

Sleeping habits and schedule

Developmental and health history that could affect the child's participation in child care

Interactions with other children

How does your child like to be comforted?

Child's home language

Are there family cultural backgrounds, traditions, beliefs, or interests that you would like to share with us?

Does your child have any special needs (IFSP, IEP etc.)? ☐ **Yes*** ☐ No **If yes, please complete a written care plan.**

Child Medical Information

Does your child have any chronic health issues or specific care needs (such as previous serious illnesses or injuries)? ☐ **Yes*** ☐ No
If yes, please complete a written care plan.

Does your child regularly need medication, or have medications prescribed for continuous, long-term use? ☐ Yes ☐ No If yes, why?

Other Children in the Home

Name	Age	School or other information you want to share:
Name	Age	School or other information you want to share:
Name	Age	School or other information you want to share:
Name	Age	School or other information you want to share:

Enrollment form annual review or update(s). A center must have the parent or guardian review, update, and sign or initial the enrollment form at least annually. Please date and initial below anytime the enrollment information is reviewed and/or updated.

Date: _____ Parent initials: _____

Date: _____ Parent initials: _____

Date: _____ Parent initials: _____

New Dream Family Center
TIME SLOT FORM

2024 - 2025	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
FULL TIME: 7:30 AM –5:00 PM	☐	☐	☐	☐	☐
OR	*OR*	*OR*	*OR*	*OR*	*OR*
FULL TIME: 8:00 AM – 5:30 PM	☐	☐	☐	☐	☐
ESTIMATED DROP OFF TIME					
ESTIMATED PICKUP TIME					

If your child is enrolled in the after school program, they are automatically enrolled on the 8:00-5:30 schedule.

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 availability and approval 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** 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 Dream, 1295 W 18th Ave, Eugene, OR 97402.**

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: **N/A.**

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

New Dream Family Center

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.	Enter the **time** your child usually *leaves* each day.	**Normal Meals and Normal Days in Care**
Last:			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**Normal Days of the Week in Attendance** Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last			**Normal Meals While In Care** Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First	Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	**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 Kirkland with Iron (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 _____

2024-2025 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 <u>below</u> 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 ***<u>Enrolled</u>*** 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)

<u>Mark one ethnic identity:</u>
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

<u>Mark one or more racial identities</u>:
- ☐ 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:_____

<u>Centers</u>
Eligibility : ☐Free ☐Reduced Price ☐Above Scale

<u>FDCH</u>
☐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-	27,861	2,322	1,161	1,072	536
-2-	37,814	3,152	1,576	1,455	728
-3-	47,767	3,981	1,991	1,838	919
-4-	57,720	4,810	2,405	2,220	1,110
-5-	67,673	5,640	2,820	2,630	1,302
-6-	77,626	6,469	3,235	2,986	1,493
-7-	87,579	7,299	3,650	3,369	1,685
-8-	97,532	8,128	4,064	3,752	1,876
For each additional family member add	9,953	830	415	383	192

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

New Dream Family Center

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 New Dream Family Center

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 New Dream Family Center Use Only

Accommodation(s) Made: _____

_____

Sponsor Signature: _____ Date: _____

This institution is an equal opportunity provider.

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

Child Nutrition Programs
(503) 947-5894

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).

This institution is an equal opportunity provider.