Welcome!
We are so excited to have your family here at Birdie's Nest! Please read through this document as well as the parent handbook and email us with any questions.
NaRhea (owner) birdiesnestccc@gmail.com
Justice (center director) justice.birdiesnest@gmail.com

Please fill out this entire packet. Some common areas that are missed are the insurance policy ID#, dentist, and hospital preference. We cannot accept your packet without all sections completed.

Older Children
Two extra outfits

Water bottle

Blanket for nap time (ages 1-3)

Diapers and wipes (if needed)

Diaper rash cream (if needed)

Pacifier (if needed)- paci clips are NOT allowed

Tylenol/Motrin/Ibuprofen (if needed)- we must have a doctor's note in order to use medication. We recommend requesting the following wording on the note "to be used for pain/discomfort until the age of 2" as well as the correct dosage for their weight. Children over the age of 2 do not need a doctor's note. We will always ask before giving medication.

Sunscreen- summer months

Please let us know if you have any questions! We can't wait for you to get started with us.
Birdie's Nest Team

Welcome!
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Please fill out this entire packet. Some common areas that are missed are the insurance policy ID#, dentist, and hospital preference. We cannot accept your packet without all sections completed.

Infants

Bottles must be premade and ready to warm. Breast milk must be brought in bottles and not in storage bags. All bottles and bottle lids must be labeled. Amazon has some really great sticker labels that will hold up in the bottle warmer as well. If bottles are not labeled, we will add them for a $5 fee per bottle.

Two extra outfits

Diapers and wipes

Pacifier- paci clips are NOT allowed

Blanket and sleep sack- swaddles and weighted sleep sacks are NOT allowed

Diaper rash cream

Infant's Tylenol/Motrin/Ibuprofen (if needed)- we must have a doctor's note in order to use medication. We recommend requesting the following wording on the note "to be used for pain/discomfort until the age of 2" as well as the correct dosage for their weight. We will always ask before giving medication.

Sunscreen- over the age of 6 months, summer months

Please let us know if you have any questions! We can't wait for you to get started with us.
Birdie's Nest Team

Child's name: _____

My child has the following allergies:

_____

*Please provide a doctor's note or physical examination form that includes these allergies.

Does your child use an EpiPen or medication for their allergy? Yes No

Does your child have an allergy action plan? Yes No

We serve 100% juice with our snack for children over the age of one. Would you like your child to have juice? Yes No
If not, you will be required to provide a fruit replacement. Examples include: applesauce pouches, fruit cups, dried fruit, fresh fruit

Does your child have any food sensitivities? If so, please explain below:

_____

If a doctor's note is provided for food sensitivities, we can replace that item during meals. Without a doctor's note, families are required to provide that replacement

Parent Signature_____ Date_____

Director/Supervisor
Signature_____Date_____

* Must also bring child's physical + immunizations on 1st day of care.

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

CHILD'S NAME:		**BIRTH DATE:**
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACT PERSON(S)		
1. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER
3. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER

PERSONS AUTHORIZED TO PICK UP CHILD	ADDRESS	PHONE NUMBER
1.		
2.		
3.		

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

Name	Name

Fill out all lines! ↓ ↓ Must have a dentist on file!

PHYSICIAN NAME	**DENTIST NAME**
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
KNOWN ALLERGIES	DATE OF LAST TETANUS
PRESENT MEDICATION	
INSURANCE COMPANY	POLICY HOLDER ID

This consent will be in effect beginning (date) _____ **and be updated annually by the parent/legal guardian.**

SIGNATURE OF PARENT OR GUARDIAN	**DATE**	**SIGNATURE OF PARENT OR GUARDIAN**	**DATE**
UPDATE	**DATE**	**UPDATE**	**DATE**
UPDATE	**DATE**	**UPDATE**	**DATE**

Parent #1 Email _____

Parent #2 Email _____

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Infant, Toddler, Preschool Age (including Kindergarten entry)
Child Health Form

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI – starting at age 24 mo.: _____

Head Circumference @ age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr.: _____

Hgb or Hct @ 12 mo.: _____

Lead Risk Assessment: _____

Blood Lead Level @ 1 yr. & 2 yr.: date_____ results_____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe
Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____
Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

☐ TB testing completed (only for high-risk child)

Health provider authorizes the child may receive the following at child care: (include *over-the-counter medications)*

	Name	Dosage
☐ Diaper cream/ointment:		
☐ Fever or Pain reliever:		
☐ Sunscreen:		
☐ Other		

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/hcci/products

Additional Referrals made:

☐ _____
☐ _____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(Please complete and give to parent for child care templates at https://hhs.iowa.gov/hcci/products)

Comments:

May use stamp

Signature _____
Circle Provider Type: MD DO PA ARNP Chiropractor

Address: Telephone:

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767288.1525543973.1674849857-346854326.1661880588

PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

☐ **Growth** - I am concerned about my child's growth.

☐ **Appetite** - I am concerned about my child's eating/feeding habits or appetite.

☐ **Rest** - I am concerned about the amount of sleep my child needs.

☐ **Illness/Surgery/Injury** - My child had a serious illness, injury, or surgery.

Please describe:

☐ **Physical Activity** - My child must restrict physical activity.

Please describe:

☐ **Development and Learning** - I am concerned about my child's behavior, development, or learning.

Please describe:

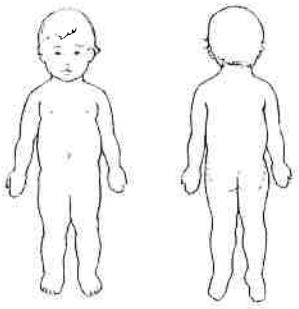
☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has skin problems, birthmarks, Mongolian spots, etc.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aids or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Nervous System, headaches, seizures
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Needs special equipment.

List equipment:

☐ **Medication**[1] - My child takes medication.

Medication Name	Time Given	Reason for Medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at https://hhs.iowa.gov/hcci/products

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature (required) _____ Date: _____

[1] Please review the child care program's policies about the use of medication at child care.

INTAKE SHEET

I. Child's Identification Information

Name	Nickname:

Sex:	Birthdate	Name of school, if attending:

II. Family Information: Parents or Guardians

Name Address Place of Employment Work Phone

_____

_____

_____ Single _____Married _____Divorced _____Separated _____Foster Parent

Names and ages of other children in the home:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

III. Emergency Contact

Name Address Place of Employment Work Phone

_____

_____

IV. Play and Sociability

- How does your child get along with other children? _____
  _____
- His/Her usual playmates are _____girls _____boys _____older _____younger
- What is the usual size of your child's neighborhood playgroup?
- Previous group experience other than school: _____Preschool _____Playgroup _____Sunday School
- _____Other (Specify) _____

V. Personality and Emotional Development

- Is your child affectionate? _____ To whom? _____
- Does she/he accept new people easily? _____ YES _____ NO
- What are your child's fears? _____
- Is your child usually happy? _____ YES _____ NO
- What nervous habits does your child have? _____

VI. Discipline

INTAKE SHEET

- When you find it necessary to discipline your child, which parent usually does this and how? _____

_____

_____

VII. Infants and Toddlers

- Has your baby had any feeding problems? _____ YES _____ NO
  If yes, please explain _____
- Have you noticed any allergies or sensitivities to particular foods? _____
- Is your baby: Breast fed? _____ Bottle fed? _____
- What food is your baby eating now?

Fruits	_____	Juices	_____
Vegetables	_____	Meats	_____
Cereals	_____	Milk (Formula)	_____

- Sleep habits during the day: _____
- Does your child have a "fussy" time? When? _____
- How do you handle this "fussy" time? _____
- Do you have special ways of helping your baby go to sleep? If yes, how. _____

_____

- Does your child use a pacifier or suck thumb/fingers? _____
- Has toilet training been attempted? Yes No What is used at home? _____
- Is baby's skin highly sensitive? Yes No What is used at home? _____

- How does you child relate to strangers?
- Is your child frightened by anything? _____

VIII. Other Information: Please list some of your child's favorite:

Snacks & Drinks: _____

Games: _____

Other Activities: _____

Give any other information you believe will be helpful to us in understanding your child. _____

_____

_____

_____

Child's name: _____

Please request to join our private Facebook group "Birdie's Nest Parents Group". We post pictures, reminders, and upcoming events. There are a few membership questions that you will need to answer before being approved.

I do_____/do not_____, give consent for Birdie's Nest Child Care Center & Preschool to take photos and videos of the above named child and I consent that they may use the photos/videos of our child in promoting the purpose of the center on public social media pages. I understand that no financial benefits from the use of the photos/videos are obligated to be paid to us.

By enrolling your child at Birdie's Nest, you are agreeing to photos being taken and posted on our ProCare app and our private Facebook group. Sometimes group photos may be taken and posted. Birdie's Nest is not responsible for how those photos are shared by individual families and parents. For our older children that attend field trips, we can not control how those entities and businesses photograph while we are there. It is possible that they may take pictures of our groups and post them on their social media sites.

Parent Signature_____ Date_____

Director/Supervisor
Signature_____Date_____

Parent's/Guardian's Permission To Apply Sunscreen To Child

(Name of Child) _____

As the parent or guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at:

(Child Care Business) _____

to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- ❑ I do not know of any allergies my child has to sunscreen.
- ❑ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.
- ❑ I have provided the following brand/type of sunscreen for use on my child:

  _____

- ❑ My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

  _____

  _____

- ❑ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

  _____

Parent/Guardian full name (print): _____

Parent/Guardian signature: _____ Date: _____

Child's name: _____

I do_____/do not_____ give consent for the above named child to participate in field trips with Birdie's Nest. I understand that I will be notified before each field trip via ProCare. I understand that I will need to provide a car seat the day of a field trip if needed. By signing this document, I am giving permission for my child to attend all field trips.

Parent Signature_____ Date_____

The below form is only for children in our school age program.

Child's name: _____

I understand that my child will be transported in a center-owned vehicle from (name of school) _____. This includes days in which there is early release at the school. I affirm that my child's participation in the transportation program is entirely my choice, with the understanding of risk or accidental injuries that may be involved in any transportation program in the center.

Parent Signature_____ Date_____

The following two pages are how we receive reimbursement from our food program.

Iowa Eligibility Application

Please fill out parts 1-6. If you receive food stamps, you can list your case number in part 2 and then skip part 5. If you do not receive food stamps, all parts 1-6 must be completed.

Child Care Enrollment Form

List your child's name, birthdate, a rough estimate of their arrival and departure times, and mark off which days your child will be in care. You can also check off the boxes under "meals served during care" for breakfast, lunch, and PM snack. If you have an infant that is still receiving bottles, please also fill out the bottom portion. As a reminder, bottles must be premade each day. Once your child starts baby food, we also provide Gerber baby food for them here.

Iowa Eligibility Application

FFY 18-19

Complete one application per household. Fiscal Year 2018-2019

Part 1. Check all applicable boxes:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home(HP) Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.
Name of household member with Case Number _____ **List Case Number** _ _ _ _ _ _ _ _ _ _

Part 4. Children enrolled: REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino
Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White
If ethnicity & race are not completed, the form will be completed based on visual observation

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income: DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3.
Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	Gross Income: Report income by how often the household member is paid. Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.										
2.			☐							
3.			☐							
4.			☐							
5.			☐							
			☐							

Last four digits of my Social Security Number: **X XX - X X -** _ _ _ _ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form _____

Signature of Adult Completing Form | Printed Name of Adult Completing Form | Date Signed

Address of Adult Completing Form | Town | ZIP Code | Work Phone | Home Phone | Cell Phone

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.
Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $ _____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _____

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)

Eligibility Determination:
☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk

Application Denied:
☐ Incomplete ☐ Over income limits

☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature | **Effective Date**

CHILD & ADULT CARE FOOD PROGRAM

Your child is enrolled in a center that participates in the Child and Adult Ca[illegible]od Program (CACFP). By participating in this Program, the center follows federal meal pattern requirements and receives reimbursement to a[illegible]t with food costs. The CACFP requires parents to provide specific enrollment information on an annual basis. This form will be placed in center files and treated as confidential information. Complete one form for all of your children who are enrolled at the center.

May 2019

Iowa Child and Adult Care Food Program
Child Care Enrollment Form

Last Name, First Name	Birthdate	Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/Race*	
		Arrival	Departure	M	T	W	Th	F	S	S	B	AM Sn	Lu	PM Sn	D	E Sn	Ethnicity	Race

*Ethnicity (Select one and enter in the chart above): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (Select one or more and enter in the chart above): W=White, B=Black or African American, I=American Indian or Alaska Native, A=Asian, and P=Native Hawaiian or Other Pacific Islander This information is requested by the Federal Government in order to monitor compliance with Civil Rights law. You are not required to furnish this information, but are encouraged to do so. The law requires that organizations may not discriminate on the basis of this information nor on whether you choose to furnish it. However, if you choose not to furnish it, the center's Program representative is required to note race/ethnicity on the basis of visual observation.

Infants only (0 to 12 months): ☐ I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to children of all ages: you are not required to provide infant food or formula. Infant feeding is based on Academy of Pediatrics nutrition guidelines. Infant foods served are appropriate for the age and developmental readiness of your infant. Mark (X) to indicate your choice(s) below:

☐ I will provide breastmilk for my infant. ☐ Yes ☐ No Center formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

☐ I would like to breastfeed on site, if this option is available[1]. ☐ Yes ☐ No If yes, time(s)_____

☐ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): _____

☐ I accept the center's formula for my infant. Name of iron-fortified formula: _____

☐ I will submit a Diet Modification Request Form for non-reimbursable formula. Name of formula: _____

☐ I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.

☐ I will provide solid foods for my infant[2]. The center may supplement with additional solid foods when my infant needs them: ☐ Yes ☐ No

Parent Signature_____ Date:_____

Parent Signature_____ Date:_____(Make any needed changes above, sign and date)

Parent Signature_____ Date:_____(Make any needed changes above, sign and date)

[1]Ask your center if you can breastfeed on-site.

[2]The parent may provide no more than one required meal component in order for the center to claim reimbursement for the meal. DHS licensed centers must follow CACFP infant meal pattern requirements regardless of who supplies the food. Your center can provide a copy of the CACFP infant meal pattern and a list of reimbursable foods upon request.

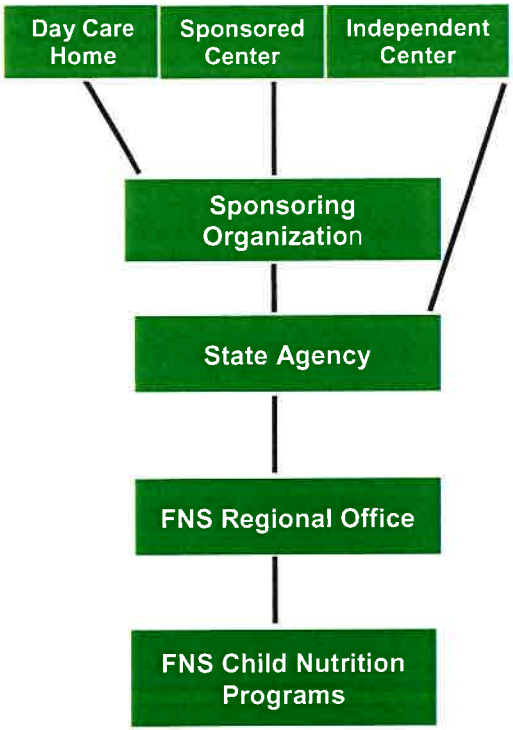
How does CACFP work?

Day care homes and centers receive money for serving nutritious meals. The Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture (USDA) oversees CACFP.

States approve sponsors and centers to operate the program. States also monitor and provide training and guidance to make sure CACFP runs right.

Sponsoring organizations support day care homes and centers with training and monitoring. All day care homes participate in CACFP through a sponsor.

CACFP Partners



Contacts

If you are interested in CACFP or have questions about CACFP, State agencies can help. Our website has State contact information.

http://www.fns.usda.gov/cacfp

USDA

FNS-319
October 2018

Building for The Future

In the Child and Adult Care Food Program (CACFP)

Building for the Future in the CACFP

What is CACFP?

CACFP is the Child and Adult Care Food Program. It is a Federal program that pays for healthy meals and snacks for children and adults in day care.

CACFP improves the quality of day care. It makes the cost of day care cheaper for many low-income families.

Besides providing meals in day care, CACFP makes afterschool programs more appealing to at-risk children and youth. Serving afterschool meals and snacks attracts students to learning activities that are safe and fun.

Children and youth who are homeless can also receive meals at shelters that participate in CACFP.

Who is eligible for CACFP meals?

- Children under age 13,
- Migrant children under age 16,
- Children and youth under age 19 in afterschool programs in low-income areas,
- Children and youth under age 19 who live in homeless shelters, and
- Adults who are impaired or over age 60 and enrolled in adult day care

What kinds of meals are served?

CACFP meals follow USDA nutrition standards.

- Breakfast consists of milk, fruits or vegetables, and grains.
- Lunch and Supper require milk, grains, meat or other proteins, fruits, and vegetables.
- Snacks include two different servings from the five components: milk, fruits, vegetables, grains, or meat or other proteins.

Where are CACFP meals served?

Many types of facilities participate in CACFP.

Child Care Centers:
Licensed child care centers and Head Start programs provide day care with meals and snacks to large numbers of children.

Outside-School-Hours Care Centers:
Licensed centers offer before or afterschool care with meals and snacks to large numbers of school-aged children.

Family Day Care Homes:
Licensed providers offer family child care with free meals and snacks to small groups of children in private homes.

"At-Risk" Afterschool Care Programs:
Centers in low-income areas provide learning activities with free meals and snacks to school-age children and youth.

Emergency Shelters:
Homeless, domestic violence, and runaway youth shelters provide places to live with free meals for children and youth.

Adult Day Care Centers:
Licensed centers provide day care with meals and snacks to enrolled adults.

Tuition® Express

Automated Payment Processing Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) Birdie's Nest CCC to initiate credit card charges to the below-referenced credit card account (**Section A**) OR, initiate debit entries to my (our) checking or savings account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

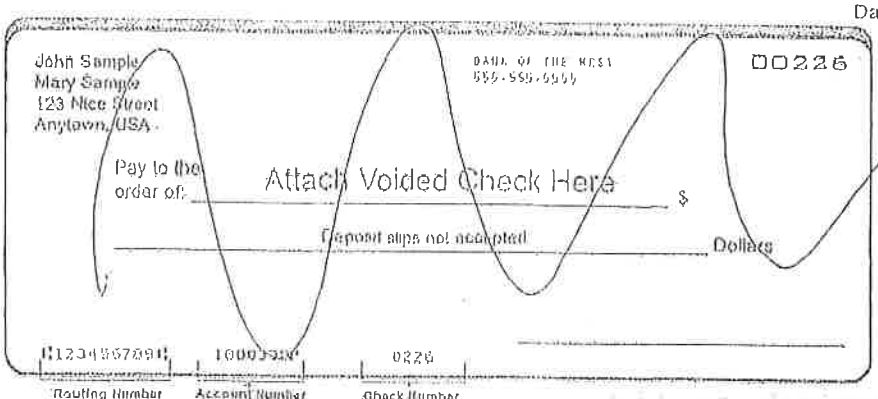
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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Birdie's Nest Child Care Policies Agreement

- Center policies may change without notice.
- By signing this policy, I understand that accidents and injuries can and will occur. All of my children in care will have their own health insurance policy. As their parent or guardian I will be responsible for all medical co-pays, office visit fees, ER bills, convenient care payments, or any and all other medical expenses that have incurred from any accidents or injuries while in care.
- By signing this policy, I have been given a handbook, I have asked all clarifying questions, and I fully understand what is expected of me and my family while in care at Birdie's Nest.
- I understand that we have paid holiday closures, paid staff training days, and may close with pay during unsafe weather or other power outages or instances where we can not operate in a safe manner. We may also have to delay opening or close early due to any manner in which we cannot operate safely.
- I understand that all tuition and fees paid are non-refundable
- I understand that any tuition returned as non sufficient funds will be charged a $30 fee.
- By signing this policy handbook, you indicate that you have read the policies and agree to follow them. You also agree to follow any new policies that are made in the future.
- By signing this page, you indicate that you have read all policies and agree to follow them. We reserve the right to make changes to policies without notice.
- If your tuition declines, your child cannot be in care until tuition is paid in full. If your tuition declines more than once, we can remove your child from care.
- I understand that my child can and will be potentially exposed to contagious illnesses. I understand that I am liable for all costs associated with medical care and treatment and or loss of wages due to taking time off to care for any sick children.
- I understand that biting is a developmentally normal behavior for a child aged 3 and under to do. I will make my best efforts to talk to my child about not biting and how to respond if they are bit.
- I understand that my expectation if I have an issue or a problem will be to communicate in a respectful manner to my child's lead teacher first. If there is no resolve, then I will email the center director, if no resolve from that, then I will email the center owner. I will remain professional and respectful in all communications and understand if I do not follow those rules, my child can be removed from care with no notice.
- I understand that I will have yearly curriculum fees due. The cost is $50 per family.

- I understand that all fees and tuition will be pulled automatically.

- I understand that social media messages to staff members are not appropriate. I will use ProCare and email for my written communication with staff.

Parent or legal guardian's signature (Please print name also) Date of signature

Parent or legal guardian's signature (Please print name also) Date of signature

Director/Supervisor legal signature (Please print name also) Date of signature