

Ohio Department of Job and Family Services  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE**

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code	Home Telephone Number		
Parent/Guardian Name			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number		Parent's Work/School Name			
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
<b>Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.</b>					
Name		Name			
City		State	City		State
Telephone Number		Relationship to Child		Telephone Number	
				Relationship to Child	
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

**Allergies, Special Health or Medical Conditions, and Food Supplements**

Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? *(check all that apply)*

- No  
 Yes - check all that apply     Food     Medication     Environmental    Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? *(check one)*

- No  
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? *(check one)*

- No  
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? *(check one)*

- No  
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? *(check one)*

- No  
 Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

- No  
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.  
 N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? *(check one)*

- No  
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No  
 Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."  
 N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

**Diapering Statement**

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following)
The program's policy is to check diapers every <u>  2  </u> hours. Please indicate if you want your child's diaper checked according to the program's policy or another:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

**Emergency Transportation Authorization**

<b>Give <u>Permission</u> to Transport</b>	<b>OR</b>	<b>Do Not Give <u>Permission</u> to Transport</b>
Program or Home Name		Program or Home Name
has <b>permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.	Do not sign both	<b>does not have permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature		Parent's Signature
Date		Date

<b>Acknowledgement of Policies and Procedures</b>
I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.	
Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.			
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

# Glenwood Center for Early Childhood

2833 Valleyview Dr.  
Columbus, OH 43204  
614-274-0283

## Authorized Pick up List

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The following people have permission to pick up my child. I understand my child can only be released to individuals that are authorized by the parent/guardian and the individuals must be 18 years or older.**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_



# Photo Release

**Glenwood Center for Early Childhood  
2833 Valleyview Drive  
Columbus, Ohio 43204**

We like to use photos of children who are attending for promotional materials such as brochures or fliers, we also like to post pictures on Facebook and our website to let everyone know about the exciting things happening at Glenwood.

Please initial next to the statement that is your preference.

\_\_\_\_\_ I give Glenwood Center staff permission to take pictures of my child. I understand any pictures may be used in the center and on the center's website, [www.glenwoodcenter.net](http://www.glenwoodcenter.net), promotional materials and Facebook. I understand that my child's name will not be included with any pictures that are used, children are referred to by their class names or by age groups.

\_\_\_\_\_ I give Glenwood Center staff permission to take pictures of my child. However, I only want my child's pictures used in the center, not on the center's website, brochures, Facebook or other promotional materials.

\_\_\_\_\_ I DO NOT give permission to Glenwood Center to take pictures of my child.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# Developmental Screenings

**Glenwood Center for Early Childhood**  
**2833 Valleyview Drive**  
**Columbus, Ohio 43204**

*The Glenwood Center strives to make sure our children are ready for Kindergarten when it is time for them to take that next step in their lives. In order to reach that milestone periodically we screen the children to learn about where they are developmentally. Children enrolled in our Head Start program automatically receive developmental and kindergarten readiness screenings. We believe screenings are important and want all the children to have this opportunity.*

*The developmental screenings we utilize include the Brigance and the Ages and Stages Developmental Tool.*

*The Ages and Stages Developmental Tool (ASQ): Administered to our Non-Head start preschool room, Toddler and Infant Rooms, 45 days within enrollment, and/or September, January and May. Teachers will ask parents to fill out one of the screenings annually.*

*Brigance: Administered to all children in the Head Start Partnership classrooms, 45 days within enrollment, and/or September and May.*

*We provide opportunities for parent teacher conferences between caregivers and teachers to discuss children's progress and create goals together. We will inform you of conference dates as they are set, you may request a conference at any time.*

*Please fill out the form below indicating your preference regarding Glenwood staff screening your child.*

*Child's name:* \_\_\_\_\_

- I give Glenwood permission to screen my child.*
- I do not give permission for Glenwood to screen my child.*

*Parent Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_



# Chapel Consent

**Glenwood Center for Early Childhood  
2833 Valleyview Drive  
Columbus, Ohio 43204**

The Glenwood Center is an outreach of the Glenwood United Methodist Church. We are a Christian based center; we try to instill healthy morals and values in the children we serve. One of the ways we do that is by providing Chapel to all the children two years old and up. Chapel time consists of music, singing, a children's Bible story and prayer. Chapel is a weekly activity and usually lasts approximately 15 minutes. The children have a great time during Chapel and love singing the songs!

The classes that attend Chapel walk to the north end of the building where the Chapel is located. When the Pastor/leader of Chapel is unavailable the children are provided with activities in their classroom.

Please check the box of the statement you feel comfortable with and sign below.

Child's name: \_\_\_\_\_

I give permission for my child to participate in the weekly routine trip to the Glenwood Chapel located in the north wing of the building.

I do not give my permission for my child to attend Chapel. I understand my child will have to go to another class or go to the office while their class is participating in Chapel.

Signature of Parent/Guardian: \_\_\_\_\_

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

# Family Information

(use this form in place of SUTQ JFS 01511)

Child's First Name	Child's Last Name	Nickname (if any)
<b>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</b>		
<b>Who is in the child's immediate family?</b>		
<b>Who lives at home with your child?</b>		
<b>What is the primary language spoken in your child's home?</b>		
<b>Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional details?</b>		
<b>Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)</b>		
<b>My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice, <input type="checkbox"/> water. (Check all that apply) How much and how often?</b>		
<b>Does your child have any favorite foods?</b>		
<b>Does your child dislike any foods?</b>		



Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

What routines/actions or items do you use to comfort your child?

Please check **all** the words that best describe your child's personality and behavior.

- active  adventurous  affectionate  anxious  bossy  bright  busy  calm  cautious  
 cheerful  content  creative  curious  easily angered  emotional  energetic  excitable  
 friendly  gives in easily  happy  hesitant  insecure  jealous  likes structure/routines  
 loud  loving  mellow  outgoing  prefers adult attention  quiet  sensitive  serious  shares well  
 social  spontaneous  stubborn  tentative

Are there other additional personality and behavior characteristics that would be useful to know about your child?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

Is there any other information that would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date

# **Parent Handbook Acknowledgement Form**

*After reading the handbook, please sign and return this page with your enrollment paperwork. Please feel free to ask if you have any questions about any of the policies in the handbook.*

*I acknowledge that I have received a copy of the parent handbook for Glenwood Center. I agree to follow all policies within.*

-----  
*Signature of Parent/Guardian*

-----  
*Date*

-----  
*Signature of Parent/Guardian*

-----  
*Date*

# Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

## Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups)
Milk	Milk	Milk
Fruit or Vegetable	Meat/meat alternate	Meat/meat alternate
Grain	Grain	Grain
Meat/meat alternate (may be substituted for the grain up to 3 times per week)	Vegetable (two different vegetables can be substituted for a fruit)	Vegetable
	Fruit	Fruit

## Participating

**Facilities** Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes:** Licensed private homes.
- **After School Care Programs:** Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters:** Programs providing meals to homeless children.

**Eligibility** State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

**Contact Information** If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Ohio Department of Education

**Glenwood Center**  
2833 Valleyview Drive  
Columbus, OH 43204

CACFP Program Specialist  
25 S. Front Street, MS 303  
Columbus, OH 43215-4183  
Phone: 614-466-2945  
Toll Free: 1-800-808-6235

## Nondiscrimination

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

Ohio Department of Education - Office for Child Nutrition  
**CHILD AND ADULT CARE FOOD PROGRAM**  
**ENROLLMENT FORM**

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

**Instructions for Completion**

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be completed annually and signed by the child's parent or guardian.

CENTER NAME <b>Glennwood Center for Early Childhood</b>		
CHILD'S NAME <small>(please print)</small>	AGE	BIRTHDATE <small>month / day / year</small>

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE  
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule

SIGNATURE OF PARENT/GUARDIAN	DATE	DAY PHONE NUMBER
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MAILING ADDRESS:		
STREET /APT.	CITY	ZIP CODE

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:  
 (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;  
 (2) Fax: (202) 690-7442; or  
 (3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

**HOUSEHOLD LETTER - Dear Parent or Guardian**

Please help us comply with the requirements of the United States Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. The completion of the income eligibility application is optional. Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits. An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced-price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226.23(e)(2)(iv). If you have questions regarding the completion of this application, contact the child care center.

**PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART (\*denotes required info)**

- Print the name of the child(ren) enrolled at the child care center. All children (including foster children) can be listed on the same application.
- List the enrolled child's age and birth date.
- Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.

**PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 – If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits.**

Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

- List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

**SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2.**

**PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.**

- a) Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.
- b) Check the box for any person listed as a household member (including children) that has no income.
- c) For each household member, list each type of income received during the last month and list how often the money was received.
  1. Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually). Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and 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.
  2. List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.
  3. List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received.
  4. List all other income sources. Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

**PART 4 – SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (\* denotes required info)**

- a) \* All applications must have the signature of an adult household member.
- b) \* The adult signing the application must also date the form.
- c) \* Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number." If you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

**PART 5 – RACIAL/ETHNIC IDENTITY – OPTIONAL**

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

**NON-DISCRIMINATION STATEMENT:** In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [How to File a Complaint](#), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 832-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

**REDUCED INCOME ELIGIBILITY GUIDELINES**

Guidelines to be effective from July 1, 2019 through June 30, 2020

Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	23,107	1,928	963	889	445
2	31,284	2,607	1,304	1,204	602
3	39,461	3,289	1,645	1,518	759
4	47,638	3,970	1,985	1,833	917
5	55,815	4,652	2,326	2,147	1,074
6	63,992	5,333	2,667	2,462	1,231
7	72,169	6,015	3,008	2,776	1,388
8	80,346	6,696	3,348	3,091	1,546
For each additional family member, add	+8,177	+682	+314	+315	+158

**CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT**  
**INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2019-2020**

**INSTRUCTIONS:** To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if *Part 3* is completed. *Part 5* is optional. \* Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

<b>CENTER NAME</b>	Glenwood Center for Early Childhood			<b>CHECK IF A FOSTER CHILD</b> (The legal responsibility of a welfare agency or court)	<b>PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 digits.</b>		
<b>PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER</b>					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Check type of benefit: <input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)	
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE				CASE NO.	
1.						CASE NO.	
2.						CASE NO.	
3.				CASE NO.			
4.				CASE NO.			

**PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED:** List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ 200 / weekly	\$ 150 / twice month	\$ 100 / monthly	\$ _____ / _____
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER:** Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

<b>* SIGNATURE OF ADULT HOUSEHOLD MEMBER</b>	<b>* DATE</b>	* If Part 3 is completed, insert last 4 digits of Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> (Check if applicable) I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

**PART 5: RACIAL/ETHNIC IDENTITY (Optional):** Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one ethnic identity:  Hispanic or Latino  Not Hispanic or Latino

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.  
 State Distribution: 7/13/2019

**THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.**

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion: Weekly x 52, Every 2 Weeks (bi-weekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12	Application Certified/Categorized as: <input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household size and income <input type="checkbox"/> Foster Child <input type="checkbox"/> REDUCED, based on Household size and income
Total Household Size: _____ Total Household Income: \$ _____ Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year	<input type="checkbox"/> PAID, based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date	Expiration Date
Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.		(From the first of month of date signed)	(Valid until last day of month in which form was signed one year earlier)



## What Do I Bring to My First Visit?

- ♥ Proof of income (current pay stubs, approval letter for Healthy Start, Ohio Works First, Food Stamps or current Medicaid card)
- ♥ Proof of address (utility or credit bill, or Ohio driver's license)
- ♥ Proof of identity for you and any other applicants (birth certificate, driver's license, Medicaid card, crib card or shot record)
- ♥ All family members applying for WIC services
- ♥ If pregnant, a doctor's statement showing due date
- ♥ Children's shot records



Women,  
Infants &  
Children



Eat Smart,  
Play Hard



Ohio WIC



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This institution is an equal opportunity provider.

Healthy  Ohio  
The State of Living Well.



The mission of the WIC program is to improve the health status and prevent health problems among Ohio's at-risk women, infants and children.

Visit our Web site: <http://www.odh.ohio.gov>

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## What is WIC?

WIC is a nutrition education program. WIC provides nutritious foods that promote good health for pregnant women, women who just had a baby, breastfeeding moms, infants and children up to age 5.



## What Does WIC Provide?

- ♥ Nutrition education and support
- ♥ Breastfeeding education and support
- ♥ Referral for health care
- ♥ Immunization screening and referral



## Who is Eligible For WIC?



Women who are pregnant, breastfeeding or have a baby less than 6 months old, and infants and children up to 5 years old are eligible to apply for WIC. Fathers are welcome to apply for WIC for their children up to age 5.

### To qualify for services you must:

- ♥ Live in Ohio
- ♥ Meet WIC income guidelines
- ♥ Have certain nutritional or health risks

## How Do I Apply?

### Make an appointment

Call your local clinic to schedule an appointment to meet with a WIC staff member or call **1-800-755-GROW (4769)** for locations and more information.

### See if you qualify

All it takes is a visit to your local WIC clinic to see if you qualify for services.



### Receive WIC coupons

If you are eligible, you will receive coupons to buy healthy foods at local WIC-approved grocery stores.

### Supplemental foods such as:

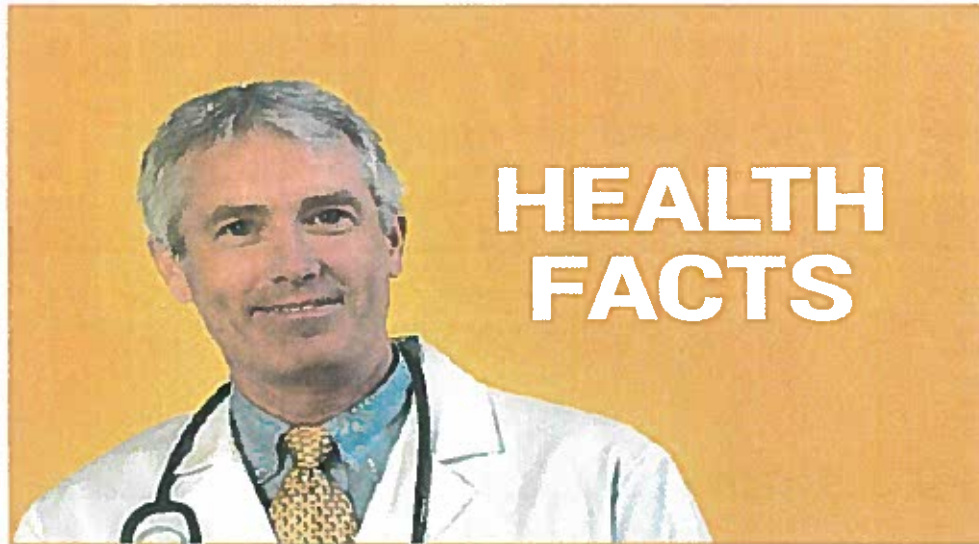
- Cereal
- Eggs
- Milk
- Whole-grain foods
- Fruits and Vegetables
- Infant formula





# Children: Health Screening For Children

Reviewed By Margaret A. Walsh, MD on 8/1/2017



## Health Screening For Children

Health screening benefits the overall health of the child. It is through checkups and tests that physicians can identify potential health problems. Many childhood health problems can be corrected before they become a health problem that the child carries into adulthood. Through health screening, healthy eating and regular physical activity you can help your child learn healthy living habits which can last a lifetime.

### **Blood Pressure**

Your child should have [blood pressure](#) measurements regularly, starting at around 3 years of age. High blood pressure in children needs medical attention. It may be a sign of underlying disease. If not treated it may lead to serious illness. Check with your child's physician care about blood pressure measurements.

## **Lead**

Lead can harm your child, slowing physical and mental growth and damaging many parts of the body. The most common way children get lead poisoning is by being around old house paint that is chipping or peeling. Some authorities recommend lead tests at 1 and 2 years of age. If you can answer "yes" to any of the questions below, your child may need lead tests earlier and more often than other children. Has your child:

- Lived in or regularly visited a house built before 1950? (This could include a day care center, preschool, the home of a babysitter or relative, etc.)
- Lived in or regularly visited a house built before 1978 (the year lead-based paint was banned for residential use) with recent, ongoing, or planned renovation or remodeling?
- Had a brother or sister, housemate, or playmate followed or treated for lead poisoning?

## **Vision and Hearing**

Your child's vision should be tested before starting school, at about 3 or 4 years of age. Your child may need vision tests as he or she grows. Some authorities recommend hearing testing beginning at 3 to 4 years of age. If at any age your child has any of the vision or hearing warning signs listed below, be sure to talk with your health care provider.

### **Vision Warning Signs**

- Eyes turning inward (crossing) or outward
- Squinting
- [Headaches](#)
- Not doing as well in school work as before
- Blurred or double vision

### **Hearing Warning Signs**

- Poor response to noise or voice
- Slow language and speech development
- Abnormal sounding speech

**Special Warning:** Listening to very loud music, especially with earphones, can permanently damage your child's hearing.

### **Additional Tests**

Your child may need other tests to prevent health problems. Some common tests are:

- Anemia (Blood) Test- Anemia is having less than the normal number of red blood cells or less hemoglobin than normal in the blood. Your child may need to be tested for anemia when he or she is still a baby (usually around the first birthday). Children may need this test as they get older.
- Cholesterol (Blood) Test- Children (2 years and older) may need this test especially if they have a parent with high cholesterol or a parent or grandparent with heart disease before age 55. If a family history is not available, testing may be needed if your child is obese or has [high blood pressure](#).
- Tuberculosis (TB) Skin Test- Children may need this test if they have had close contact with a person who has TB, live in an area where TB is more common than average (such as a Native American reservation, a homeless shelter or an institution) or have recently moved from Asia, Africa, Central America, South America, the Caribbean, or the Pacific Islands.

### Sources:

*WebMD does not provide medical advice, diagnosis or treatment. [See additional information](#)*

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[https://www.onhealth.com/content/1/health\\_screening\\_for\\_children](https://www.onhealth.com/content/1/health_screening_for_children)