State of Florida
Department of Children and Families

CHILD CARE APPLICATION FOR ENROLLMENT

Student Information: Date of Birth:_____ Sex:_____

Date of Enrollment_____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

Primary Hours of Care: From _____ To _____

Days of the Week in Care: M T W Th F Sa Su

Meals Typically Served While in Care: Br AM Snack Lunch PM Snack Sup Eve Snack

Family Information: Child Lives With: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Work Phone: _____/Cell: _____ Work Phone: _____/Cell: _____

Custody: Mother _____ Father _____ Both _____ Other _____

Medical Information:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor:_____Address:_____Phone:_____

Doctor:_____Address:_____Phone:_____

Dentist:_____Address:_____Phone:_____

Hospital Preference_____

Please list allergies, special medical or dietary needs, or other areas of concern:_____

_____

_____

Contacts:

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent or legal guardian cannot be reached:

Name	Address	Work#	Home#
Name	Address	Work#	Home#
Name	Address	Work#	Home#
Name	Address	Work#	Home#

Helpful Information About Child:

Section 65C-22.006(2), F.A.C., requires a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.

Section 402.3125(5), F.S., requires that parents receive a copy of the Child Care Facility Brochure, "Know Your Child Care Facility" (CF/PI 175-24), **or**

Section 65C-20.11(2)(c)(1), F.A.C., requires that parents(s) receive a copy of the family day care home brochure, "Selecting a Family Day Care Home Provider" (CF/PI 175-28).

Section 65C-22.006(3)(c)2., F.A.C., requires that parents are notified in writing of the disciplinary practices used by the child care facility, **or**

Section 65C-20.010(6)(c), F.A.C., requires that a written copy of the family day care provider's discipline policy be available for review by the parent(s).

Your signature below indicates that you have received the above items and that all information on this enrollment form is complete and accurate.
Please sign top line for this school year.
Other lines will be used for the following years.

Signature of Parent/Guardian — Date

Signature of Parent/Guardian — Updated Date

Signature of Parent/Guardian — Updated Date

Signature of Parent/Guardian — Updated Date

Signature of Parent/Guardian — Updated Date

Florida Department of Health

Child Care Food Program

Child Participation Form

Name of Child: _____ Name of Facility: _____

Dear Parent:
Please fill out the following information so that your child may participate in the Child Care Food Program, which reimburses child care providers for serving nutritious, well-balanced meals to children in child care.

If child care hours are the same every day, please complete this chart.		
Day	Normal Hours in Care	Meals Normally Received While in Care
Mon – Fri	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐

OR

If child care hours are <u>not</u> the same every day, please complete this chart.		
Monday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Tuesday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Wednesday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Thursday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Friday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Saturday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Sunday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐

☐ **Check here if your child has no regularly scheduled hours of care**

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Phone Number: _____

FLORIDA DEPARTMENT OF HEALTH

CHILD CARE FOOD PROGRAM
FREE AND REDUCED-PRICE MEAL APPLICATION

To apply for free and reduced price meals for your child, read the instructions and complete this form. Sign your name, date and return the application to _____. If you need assistance filling out this form, call this number:_____.

PART 1 – INFORMATION ON CHILD: **NAME AND ADDRESS OF CCC/OSHCC:**

Child's Name: _____ _____ _____ _____
Last Name First Name Date of Birth

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE PROGRAM OR TANF BENEFITS: Complete this part and Part 4.

Food Assistance Program Case Number: | | | | | | | | | | TANF Case Number: | | | | | | | | | |

PART 3 – ALL OTHER HOUSEHOLDS: If you gave a Food Assistance Program or TANF number, then skip to Part 4. Otherwise, complete this part and Part 4.

HOUSEHOLD MEMBERS		INCOME AMOUNT & FREQUENCY List pay frequency (i.e., annually, monthly, twice a month, biweekly, or weekly) after each amount.				
List the Names of Everyone in Your Household (include child listed in Part 1 above)	Check Box if Foster Child	Gross Earnings (Before Deductions) If self-employed, list net income	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security	All Other Income (including personal use income of a foster child)	Check Box if Person has NO INCOME
Last Name, First Name	☐	*$ Amt./Frequency*	*$ Amt./Frequency*	*$ Amt./Frequency*	*$ Amt./Frequency*	☐
1. _____	☐	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____	☐
2. _____	☐	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____	☐
3. _____	☐	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____	☐
4. _____	☐	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____	☐
5. _____	☐	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____	☐
6. _____	☐	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____	☐

PART 4 – SIGNATURE AND SSN: An adult household member must sign the application before it can be approved.

_____ _____ Home Phone # _____
Signature of Adult Household Member **Date Signed**

Home Address _____ Work Phone # _____
Street Address, City, State, Zip Code

Last Four Digits of Social Security Number |___|___|___|___| Write **NONE** if you don't have a Social Security Number

PENALTIES FOR MISREPRESENTATION: I certify that all information on this application is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

PART 5 (Optional) - RACIAL IDENTITY OF CHILD

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

ETHNIC IDENTITY OF CHILD

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Privacy Act Statement: Section 9 of the National School Lunch Act requires that, unless you list a current Food Assistance Program or TANF case number or are applying for a foster child, you must include the last four digits of the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. Provision of the last four digits of a social security number is not mandatory, but if this information is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. The last four digits of the social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Food Assistance Program or welfare office to determine current certification for receipt of Food Assistance Program or TANF benefits, contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. 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.

For Contractor Use Only:

☐ Food Assistance Program/TANF household Total Household Size:_____ Total Household Income: $_____

☐ Foster Child Income Frequency: Weekly / Biweekly / Twice a Month / Monthly / Annual **(circle one)**

Note: If different income frequencies are listed, convert all income to an annual amount. Annual Income Conversion: Weekly x 52, Biweekly x 26, Twice a Month x 24, Monthly x 12

Eligibility Determination: ☐ Free ☐ Reduced ☐ Non-needy

Reason for Non-needy Status: ☐ Income too High ☐ Incomplete Application ☐ Other (Reason)_____

Signature of Determining Official:_____ Date Signed:_____