Robins Nest
learning center

CHILD
INFORMATION PACKET

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Dear Parent,

Congratulations!

You have selected Robin's Nest Learning Center, an early learning program that has achieved the Gold Circle of Quality through ExceleRate Illinois, the state's new quality rating and improvement system for early learning and development programs. ExceleRate Illinois recognizes a program's commitment to quality beyond the basic state licensing requirements (which cover seven broad areas including staffing, programming, health, safety and hygiene). The Gold Circle of Quality shows that your child's program has gone the extra mile to make sure your child receives the enhanced learning and care experience.

What does this ExceleRate Illinois Circle of Quality mean to you and your child? Regardless of the specific Circle of Quality, recognition by ExceleRate Illinois shows that your child's program has met specific standards of quality and is helping to give your child a good start in learning and in life.

About ExceleRate Illinois

ExceleRate Illinois focuses on four areas: 1. Teaching and Learning, 2. Family and Community Engagement, 3. Leadership and Management and 4. Qualifications and Continuing Education.

The **Gold Circle of Quality** recognizes programs which have demonstrated quality on all 15 standards, as validated by an independent assessor. Gold Circle programs meet or exceed specific quality benchmarks on learning environment, instructional quality, and all program administrative standards; group size and staff/child ratios; staff qualifications; and professional development.

For more information on ExceleRate Illinois, please visit: www.excelerateillinois.com.

Thank you for recognizing the importance of quality early learning programs for your family. We encourage you to take a moment to congratulate your program's director and staff on their achievement.

Sincerely,

Theresa Hawley, Executive Director, Governor's Office of Early Childhood Development

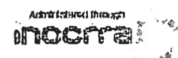
Linda Saterfield, Associate Director, Office of Early Childhood, Division of Family and Community Services, Illinois Department of Human Services

Cynthia Zumwalt, Early Childhood Division Administrator, Illinois State Board of Education

Denice Murray, Deputy Director, Division of Regulation and Monitoring Illinois Department of Children and Family Services

1226 Towanda Plaza | Bloomington, IL 61701 | p. 866.697.8278 | f. 309.828.1808 | www.excelerateillinois.com

ExceleRate™ Illinois is administered through INCCRRA under the joint direction of the Governor's Office of Early Childhood Development, the Illinois Department of Human Services, and the Illinois State Board of Education.



Robin's Nest Parent Check List

I need these things the day you start at RN

Please take the time to go over this check list & check off the items you turned in to RN at the time of enrollment.

___ $50 Registration Fee to hold slot. **Without this fee the slot is not guaranteed.**

___ Contract agreement: ***Fill in accurate times & days. We schedule based on this form!***

___Signed rate sheet.

___ Deposit for 1 week's tuition: *Can divide over 5 weeks if need to.* ***Check here for that option*** _____

___ Read over & sign contract Email Address ________________________

___ Tuition Express ____ **Not using automatic billing $ 3.00 weekly fee**

___ Orientation check list

___ Enrollment record Cell Phone Carrier _________________

___ Two-week notice form

___ Drop off policy

___ DCFS Verification form

___ Parent Consents Form (DCFS)

___Authorization to pick up form.

___ Sick policy

___ Family photo to be displayed in classroom

___ Emergency Medical consent form

___ Health form: on state form. ___Shot records: a copy will be fine

___ Birth Certificate

____Food paperwork ____Infant feeding agreement

____CCAP **paperwork w/ pay stubs & school schedule to drop off on first day.**

I understand by signing this form that I will provide the above needed paperwork within 30 days of the date of this form to avoid the **35.00 per month administration fee.** These are forms required by the state for compliance.

Parent Signature: ______________________________ Date ____________________

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) ___Robin's Nest___ 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 $3.00 Service Charge

SECTION A (Credit Card)

Cardholder Name ____________________ Phone # ____________________

Cardholder Address ____________________ City ____________________ State ____ Zip ____

Account Number ____________________ Expiration Date ____________________

Cardholder Signature ____________________ Date ____________________

SECTION B (Bank Account) NO Service Charge

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

____

A service of

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myprocare®

Dear parent/guardian,

Robin's Nest Learning Center is pleased to offer **MyProcare**, a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.

Log In today!

1. Go to MyProcare.com.

2. Enter your email address (the email you have on file with Robin's Nest Learning and choose ***Go***. *It is very imporant the contact information is up to date.*

3. Enter the confirmation code sent to your email, choose a password, and press ***Go***.

4. Then you may:
    a. View your child's schedule, time card, immunizations and more.
    b. Use the ***Pay*** button to make a payment with your card.

Thank you!

Robin Moore and MyProcare

Robins Nest
Learning Center

PARENT ORIENTATION CHECKLIST

Welcome to Robin's Nest! Please look over the following check list and ask questions as we go through the following procedures. Child's Name ______________________________________

1. RN director has walked me through the center and introduced me to my child's teachers. My child will be in ________________ and the lead teacher is _______________
2. RN offers the extra time needed for you and your child to spend in the classroom and get to know the classroom, teachers and new friends. We have an open door policy for you and your family to visit anytime!
3. RN director has gone over all needed paperwork and provided a check list of needed items to complete by child's file. An overview of the contract was provided and signed off on at the time of enrollment.
4.
5. RN director has asked what my expectations are of RN and the needs of my child.
6. RN director has showed me where my child's classroom lesson plans are posted, the class schedule & the "Coty Bug sign" on each classroom door.
7. RN director has provided me a file folder for my child to collect art work, file information needed and monthly updates. These folders are filed by classroom and child's first name. I understand it is important to check file folder daily in the event there might be an accident form.
8. RN director has showed me where to sign in medications that needed to be given and I understand that I need a doctor's note for RN to give medications. I agree to give first dose of any medication at home.
9. RN director showed me where the parent resource binder is and location of monthly informational sheets located by the front office door.
10. RN director has offered interpreter services as needed in home language or ASL.
11. RN director has showed me where to put important paperwork and tuition checks (if not using tuition express there is a 2.00 service fee per check)
12. RN director has provided me with a list of items I need for my child's file and I agree to get these items to the school within 30 days to avoid the incomplete file fee of 35.00. Upon turning in paperwork there is a 35.00 registration/technology fee required to accept paperwork.
13. RN director has explained there is no refunds on deposit.

14. RN director has explained tuition express, the card reader and I agree to pay child care on Mondays to avoid late fees.
15. RN is not responsible for any cash dropped in tuition box or given to a child for an activity.
16. RN has a quiet time from 11-2. I agree not to drop off my child during these hours.
17. RN director explained the importance of NOT bringing any outside food into the center. We have children with death allergies. Please do not allow children to carry in left over breakfast or uneaten snacks.
18. RN has meal times and menus posted and has showed me the lunch room for all pre-school age children.
19. RN director has explained our cloth potty training policy and the $5.00 per week potty fee associated with changing potty accidents. If your child is potty trained and they start having multiple accidents, the potty fee many be reinstated/charged.
20. RN director explained that I need 1 set of clothing labeled in a Ziplock bag with my child's name on it if my child is potty trained. If my child is potty training we need 5 sets of pants and underwear.
21. RN director showed me where to pick up soiled clothing, lost and found toys and coats. Both are located by the front door.
22. RN director explained we are fully trained on emergency procedures and in the event we ever needed to relocate, the address and phone number are on the front door of the school.
23. RN director has invited me to participate in parent/teacher conferences in May, Nov or anytime that I feel I need to meet.
24. RN director has explained there is an annual review of the school and I agree to provide information that is important to me, my family and the raising of our child in your program.
25. RN has given me a copy of their discipline policy. I agree if my child ever hits or hurts a child or teacher before a field trip, the director can take my child off that activity.
26. RN takes ANY concern very seriously and we will follow up in writing or with a call. Please check file folder for that document. If you feel your concern was not handled properly, please call Robin any time: 618-922-8445.
27. RN was explained that a two week notice is required to change days, change contract, request vacation or end contract. RN does everything Monday to Monday. Email is the preferred way to communicate these contract changes. A written notice can be put in the tuition. box. The tuition box is opened on Monday nights only.
28. RN director has explained the 5.00 per month per child supply fee. The receipts are posted on the bulletin board in the follow for parental view.

29. RN director has explained CCAP procedures with me. I will pay my co-pay the first of the month, or divide into 4 weeks due on Monday nights. If I leave mid-month, the whole co-pay is due.
30. If I am applying for CCAP, I understand that I will pay 25.00 per week for the first 2 weeks until approval is obtained. After the 3rd week of no approval, I agree to pay private pay rates as outlined on rate sheet.
31. I understand all CCAP paperwork needs to be turned in to RN to be logged and accounted for. If CCAP paperwork is late, childcare can be terminated by the state resulting in private pay rates.
32. I understand that I am required to notify CCAP of any changes: change of job, marital status, pregnancy, pay raise, loss of job, school schedule etc… within 48 hours of the change. If this is not done, CCAP will terminate payment and I will be required to pay private pay rates.
33. School age building is open in the afternoon when school is in session or after 9:00 during summer/out of school days. I will drop off and sign in & out in the main building.
34. There is a large sign in the parking lot telling parent where to pick up school age children. When the sign is covered, I know to go to school age building.
35. RN director has explained school age procedures, drop off, meals etc… to me.
36. RN director has explained the summer camp calendars, field trips fees, out of school days (how to sign up for them).
37. RN director has given me information on the RN FB page to stay on top of activities, deadlines. and what we are doing on a daily basis.
38. RN has been given an email to send me updates, reminders, invoices and monthly calendar. I agree to read brightly colored signs that are posted on doors to provided additional information.

Parent Signature ____ Date ____________________

Director who went over these procedures ____

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD ______________________________

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES.

Parent(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes ______________________________
to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. ______________________________
is the preferred doctor/clinic/hospital.

See Robin's NEST separate FORM

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize ______________________________ to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

ADMINISTER OVER-THE-COUNTER MEDICINE

(Administer only in accord with the appropriate standards for licensure)

I/we authorize ______________________________ to administer over-the-counter medicine to my/our child as specified in written instructions.

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

CHILD PICKUP

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize ____
Name Address Phone

and/or SEE ROBIN'S NEST FORM
Name Address Phone

and/or ____
Name Address Phone

to pick up my/our child when I am/we are unavailable.

Date ______________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ______________________ ______________________________
Signature of parent/guardian

____
Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

I/we authorize ______________________________ to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above-named person(s). I/we understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date ______________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ______________________ ______________________________
Signature of parent/guardian

____
Relationship to child

SWIMMING

I/we consent to my/our child using the swimming pool of Robin's NEST - Splash Pad
Name of Provider

at ____.
Address

Date ______________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ______________________ ______________________________
Signature of parent/guardian

____
Relationship to child

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian		Telephone # Home	Work

IMMUNIZATIONS : To be completed by health care provider. The mo/da/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				Comments:		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED	Vaccine / Dose					
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature Title Date

Signature Title Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease Signature Title

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps** ☐Rubella ☐Varicella Attach copy of lab result.
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: ____________________
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes No	List:

Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. Parent /Guardian Signature Date		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI BMI PERCENTILE B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI >85% age/sex Yes☐ No☐ And any two of the following: Family History Yes☐ No ☐ Ethnic Minority Yes☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ At Risk Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed☐ Test performed ☐ Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm__________

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting | DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

PARENT LETTER
FOR CHILD CARE CENTERS

July 1, 2022 Through June 30, 2023

Parent or Guardian:

This child care center participates in the USDA Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information you provide on the attached Household Eligibility Application. Part of the USDA requirement is to ask you to complete the application. If your income is equal to or less than the income listed in the chart below for your household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. We cannot approve an application that is not complete. Please return the completed application back to our center as soon as possible.

If a member of your family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits; or you care for a foster child that is the legal responsibility of the State through DCFS or the court, these children are eligible for meal benefits regardless of your household income.

If your income(s) is over the income guidelines listed below, you are not required to complete this application; however, it would be helpful if you would write your child's name on the application and return it to our center. Please notify us, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the income eligibiy standards.

Income Eligibility Guidelines
Effective from July 1, 2022 to June 30, 2023

Reduced-Price Meals
185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	25,142	2,096	1,048	967	484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
For each additional family member, add	8,732	728	364	336	168

The information you provide on the application will be used to determine your child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

By signing the section on the application for the Illinois All Kids Health Insurance, you are stating you do not want your information shared with the Illinois Department of Healthcare and Family Services. If you agree to disclose the application information, it may be used to identify your child(ren) for the health insurance program. If you would like more information on All Kids, call toll-free (866) 255-5437 or (877) 204-1012 (TTY).

If you have any questions or need help, please contact our center.

The USDA Household Income Eligibility Guidelines are listed for families who do not receive TANF or SNAP benefits. If a household's income falls within or below the listed guidelines, they should contact their child care center or day care home provider for the benefits of the program. They may be required to complete an application and provide income, TANF, or SNAP information.

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/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, 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
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **email: program.intake@usda.gov**

This institution is an equal opportunity provider.

INSTRUCTIONS FOR APPLYING - COMPLETE ONE APPLICATION PER HOUSEHOLD

Follow These Instructions and Return the Completed form to your Center. Once approved for meal benefits, a child's Household Eligibility Application is effective for 12 months.

FOSTER CHILD(REN)

A foster child remains the legal responsibility of the state through a foster care agency or the court. If you submit documentation from the state or local agency that the child is in foster care, that documentation replaces completing a Household Eligibility Application.

1) If all children in your household (who attend this center) are foster children that are the legal responsibility of a foster care agency or court, provide the following:
   - Part 1 — List the name(s) and age(s) of your foster child(ren) attending this center.
   - Part 2 — Check the box(es) indicating a foster child(ren).
   - Part 3 — 5 Skip
   - Part 6 — Provide a signature of an adult household member and date the application.
   - Parts 7-9 — (OPTIONAL)

2) If you have some foster children that are the legal responsibility of a foster care agency or court along with other children attending this center, please provide the following:
   - Part 1 — List ALL household members, including the foster child(ren), and the age(s) of the child(ren) attending the center.
   - Part 2 — Check the box(es) identifying the foster child(ren).
   - Part 3 — Record a valid SNAP/TANF case number if applicable
   - Part 4 — Skip
   - Complete Parts 5 and 6 if applicable. See the instructions for **INCOME–HOUSEHOLDS REPORTING** section.
   - Parts 7-9 — (OPTIONAL)

SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING

If any member (child or adult) of your household receives SNAP or TANF benefits, provide the following:
- Part 1 — List ALL people in your household (including grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the center.
- Part 2 — Skip
- Part 3 — Record a valid SNAP or TANF case number for any member (child or adult) of this household. You will find your SNAP or TANF case number on your letter of eligibility for benefits.
- Part 4 — 5 Skip
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

HOMELESS, MIGRANT, RUNAWAY, OR HEAD START

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant, a runaway, or head start, follow these instructions.
- Part 1 — List ALL household members, and the age(s) of the child(ren) attending the center.
- Part 2 — 3 Skip
- Part 4 — If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your local school.
- Part 5 — Complete only if a child in your household isn't eligible under Part 4. See instructions for **INCOME – HOUSEHOLDS REPORTING** section below and complete Parts 5 and 6.
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

INCOME - HOUSEHOLDS REPORTING

If no one in your household receives SNAP or TANF benefits, please report all household income. The Household Eligibility Application must include the following information:
- Part 1 — List the names of ALL household members and the age(s) of the child(ren) attending the child care center.
- Part 2 — 4 Skip
- Part 5 — List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
  - o For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - o If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
  - o If you have no income, list zero in the earnings from work column.
- Part 6 — Provide a signature of an adult household member and date the application. Also, provide the last four digits of the Social Security Number for the adult signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a Social Security Number, mark the box, I do not have a Social Security Number.
- Parts 7-9 — (OPTIONAL)

PRIVACY AND DISCRIMINATION 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 your child 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 or other 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 Child and Adult Care Food Program. 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.

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 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. This institution is an equal opportunity provider.

Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

ILLINOIS STATE BOARD OF EDUCATION
Annual Enrollment Form
Child and Adult Care Food Program

This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.

This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.

Parents/Centers: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. If parent does not complete Section 5, center staff should complete to the best of their ability (by observation) and initial the section. The center will review completed enrollment form.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | **2** DAYS OF WEEK IN ATTENDANCE | **3** TIMES CHILD NORMALLY ATTENDS DURING WEEK | **4** MEALS RECEIVED

First Child

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No **I work multiple shifts and child(ren) may be in care different days/hours**

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Second Child

Name

Birth Date

Age

☐ ***Same Days as Above***

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

☐ ***Same Times as Child Above***

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No **I work multiple shifts and child(ren) may be in care different days/hours**

☐ ***Same Meals as Above***

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Third Child

Name

Birth Date

Age

☐ ***Same Days as Above***

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

☐ ***Same Times as Child Above***

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No **I work multiple shifts and child(ren) may be in care different days/hours**

☐ ***Same Meals as Above***

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Please answer both questions. This information is voluntary.

5 ETHNIC/RACIAL CATEGORIES—

A. Ethnic data of child(ren) — Mark only one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 SIGNATURE

I certify the information above is correct.

Signature of Parent or Guardian ____________ _Date_ ____________ _Telephone Number of Parent or Guardian_ ____________

CHILD CARE REPRESENTATIVE USE ONLY

Effective Date of this enrollment form: ____________

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which this form is received.

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
CHILD AND ADULT CARE FOOD PROGRAM

1. All Household Members		**2.**	**3.**
NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	**FOSTER CHILD** Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6	**SNAP OR TANF CASE NUMBER** Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

4. Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

Signature of Homeless Liason, Migrant Coordinator, or Head Start Director ______ Date ______

5. Total Household Gross Income (before deductions) You must tell us how much and how often.

GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "*I do not have a Social Security Number*" box.

X X X - X X - ___ ___ ___ ___ Social Security Number

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

I certify all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date ______ *Printed Name of Adult Household Member* ______ *Signature of Adult Household Member* ______

7. Contact Information (Optional)

Work Telephone Number (Include Area Code) ______ *Home Telephone Number (Include Area Code)* ______ *Home Address (Number, Street, City, State, ZIP Code)* ______

8. Children's Racial and Ethnic Identities (Optional)

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

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

9. Optional – Sharing Information With All Kids Insurance Program

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If ***yes***, do not sign below.
☐ No, I do not want my information from this application shared with the *All Kids Insurance Program*.

Date: ______ Sign here: ______

CHILD CARE REPRESENTATIVE USE ONLY

Eligibility Determination - Complete Sections A and B Below

SECTION A Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 — ***Convert income only if different frequencies of pay are reported.***

TOTAL INCOME $ ______ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** ______

☐ **Free based on:**
☐ foster child
☐ SNAP or TANF
☐ homeless
☐ migrant
☐ runaway
☐ household's income
☐ Head Start

☐ **Reduced based on:**
☐ household's income

☐ **Denied — Reason:**
☐ income too high
☐ incomplete application
☐ Non-qualifying SNAP/TANF

SECTION B Signature of Determining Official: ______ Date: ______

Robins Nest
Learning Center

Enrollment Record

Name of Child: ____

Birthdate: __________________________________ Sex: __________

Address: ____

Date Child Received: __________________ Date Child Left: __________________

Parent Or Other Person(s) Placing the Child

Name: ______________________________ Relation to child: ____________

Email: ____

Home Address: ____

Phone: ______________ Cell: ______________ Work Ph: ______________

Working hours: ____

Parent Or Other Person(s) Placing the Child

Name: ______________________________ Relation to child: ____________

Email: ____

Home Address: ____

Phone: ______________ Cell: ______________ Work Ph: ______________

Working hours: ____

Other Person To Notify If Person Placing the Child Cannot be Reach

Name ____

Address____

Phone: ____________ Work Ph: ____________ Relationship ________________

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name ____

Address____

Phone Number ______________ Hospital or Clinic ________________________

PROGRAM

Days per week __________________ Hour of care________________________

Rate of pay (optional) ____________________ ______________

______________________ ______________________ __________

Signature of parent or other person placing child Signature of caregiver Date

Completely filled in form must be kept by the licensee for each child not related to the licensee. Please have this form available all times to licensing representatives of the Department of Child and Family Services. Contact the Area Office for supplies this form.

Robins Nest
Learning Center

CLASSROOM INFORMATION

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

This information is for your child's teacher.
Please fill out completely for a nice first day transition.

Could you please provide us with a family picture so we can add your family to our classroom tree?

Child's Legal Name: ______________________________

Preferred Name (if different from above): ______________________________

Birthdate: ______________

Allergies: ______________________________

Any daily medications taken (frequency & dosage):

____

Any known fears of child's: ______________________________

Things to provide comfort to your child: ______________________________

Is your child potty trained? Yes ☐ No ☐

Does your child still have potty accidents? Yes ☐ No ☐

Can your child write their name? Yes ☐ No ☐

The name you would like your child to learn to write:

____

Best way to communicate? Text ☐ Email ☐

Cell Phone Carrier: ______________________________

Email: ______________________________

Facebook: Follow us on Robin's Nest Learning Center Page!

State of Illinois

Illinois Department of Children and Family Services

Verification of Receipt

I/We, ______________________________
Please Print Name(s)

parents of ______________________________, hereby certify that I/We have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

Signature of Parent: ______________________________ Date: ______________

Signature of Parent: ______________________________ Date: ______________

Robins Nest
Learning Center

AUTHORIZATION TO PICKUP

Please list any family member, friend, co-worker that may be picking up your child. If there is a parent or someone that is not allowed to pick up the child be sure to note that also.

Child's Name: ____

4 Digit Code for Parents: ____________

Parent/Guardian Name: ____

Parent/Guardian Name: ____

I authorize the following people to pick up my child/children:

They must sign in/out after presenting a valid ID when picking up child/children.

Please list Name, Relationship, Address, Phone Number & Work Phone

1) ________________________________ Relationship: ______________

Add: ____________________________ Ph: __________ Work Ph: __________

2) ________________________________ Relationship: ______________

Add: ____________________________ Ph: __________ Work Ph: __________

3) ________________________________ Relationship: ______________

Add: ____________________________ Ph: __________ Work Ph: __________

4) ________________________________ Relationship: ______________

Add: ____________________________ Ph: __________ Work Ph: __________

5) ________________________________ Relationship: ______________

Add: ____________________________ Ph: __________ Work Ph: __________

6) ________________________________ Relationship: ______________

Add: ____________________________ Ph: __________ Work Ph: __________

This person can pick up my child on certain days according to court ordered parenting time:

____

Times/days allowed

____

____

____

____

Robins Nest
Learning Center

EMERGENCY MEDICAL RELEASE

I,____ being the parent or legal guardian of________________________________ give my consent for emergency medical and surgical treatment of this minor by a licensed physician should his/her condition so require it in my absence. I understand that in such a case reasonable attempts would first be made to contact me, time & condition permitting.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards or medical practice for the particular type of injury or illness involved. I impose no specific limitations or prohibitions regarding treatment other than those that follow:

My child is allergic to these medications:

____

My child takes these medications on a regular basis:

____

Child's Birth date: ____________________

Parent/Guardian #1: ____

Home Address: ____

Phone: ________________ Cell:________________ Work Ph: __________________

Work Address: ____

Parent/Guardian #2: ____

Home Address: ____

Phone: ________________ Cell:________________ Work Ph: __________________

Work Address: ____

Other Emergency Contact Name: ____

Address: ____

Phone: ________________ Work Ph: _______________ Relation: _________________

I also understand children play & do sometimes get hurt by tripping, falling off play equipment & other various activities. I/we will not hold Robin's Nest responsible for medical attention needed in such a case unless the licensing finds the center negligent.

I do not have Medical Insurance: ☐

I have Medical Insurance: ☐

Please provide a copy of your card or print out insurance information.

Hospital Coverage information/choice: ______________________________________

Address: ____ Phone: ____________

Dentist Coverage information/choice: ______________________________________

Address: ____ Phone: ____________

Doctor coverage information/choice: ______________________________________

Address: ____ Phone: ____________

Parent/ Guardian Signature: ________________________________ Date: _______

FEEDING AGREEMENT & INFANT SCHEDULE

Health, Safety & Sanitation

At Robin's Nest hand washing is the most important way we keep illness down in our classroom. Please wash your child's hands when they enter our classrooms.

Please do not leave a diaper bag, car seat or anything that could hold medications or other dangerous items in the reach of children in our classrooms, hallway or office. If you need to leave something for someone picking up, there is a place in the gym. Ask the director.

Please provide us with a change of clothes in a zip lock bag with your child's name on it to leave in the bucket.

Diapering, Diapers & Wipes

Please provide diapers & wipes weekly and log those diapers in daily so you have a record of when you last dropped some off to us.
Please be sure your child's name is on everything you turn in.
In the event we do not have diapers for your child, we will provide diapers for $1.00 each and a box of wipes for $5.00.
We will diaper your child as an infant every other hour or as needed and every two hours as a toddler.
I agree with the above policy: ☐
OR I would like my child diapered as follows:
____
____

Food Program & Feeding Schedules

Robin's Nest participates in the state food program. Robin's Nest provides formula (milk-based/soy Good start) and all bottles, solid food, and cereals. There are no additional fees or requirements from the parents to participate in this program.

Robin's Nest is an extension of your family and will vary from this procedure to fit parents' needs for their children that meet the basic requirements for care in our facility based on DCFS rules and regulations and that of your physician.

I will be using the center's food program ☐
I will be bringing my own food & bottles ☐ (See below for requirements)
I am breastfeeding my child ☐
I will provide my own bottles ☐
I will be bring my own food and use the center's bottles ☐

If you want your child fed outside of the food program requirements outlined above, we need you to provide the needed items on a daily basis.

1. We need enough bottles to feed your child every 3 hours or as you have prescribed here in this form and DCFS.
    a. The bottles need to be labeled with your child's name on them.
    Lid, nipple & bottle if we wash them at the center.
    b. Be filled with formula or formula powder ready to serve.
    c. Will be sent home daily after we have rinsed them. We will not wash them at the center because we don't want to mix them up with the hundred bottles/nipples we have here.

2. If you want your child fed with a specific bottle, we will need you to provide 4 bottles prepared as outlined above.

3. We will need a can of the formula you are using to mix for cereal meals as needed.
When we have used it, we will send home the empty can so you know we need more. We encourage our parents to check your child's bucket daily for needed items. We are extremely busy so we may forget to mention it to you.

4. When you drop off bottles daily, please place on the counter in a zip lock bag and we will put in your child's feeding bucket.

5. When you pick up, we will place all used bottles in the zip lock bag and return to you each evening. Please replace the next day your child will be attending our school.

6. If you forget to bring formula/ food, we will call you and let you know. If we do not have what we need by the time your child needs to eat, we will feed your child what we serve based on the food program.

Please let us know in writing as your child's feedings change as they grow. There is a form in the classroom on the door to change feeding schedules and add new things to your child's diet. Drop that form in the tuition box and the director will follow up with the infant staff that following week to meet the upcoming changes.

Your Home Schedule

(Arrive at Center= A)(Get up = GU)(F= Food) (S=sleep) Depart (D)

On Demand Schedule:

6:00 am __________ 7:00 am _________ 8:00 am _________ 9:00 am _________ 10:00 am _________ 11:00 am _________
Noon _________ 1:00 pm _________ 2:00 pm _________ 3:00 pm __________ 4:00 pm _________ 5:00 pm _________
6:00 pm _________

Please update monthly until eating table food.

I understand the feeding requirements outlined in this agreement and would like my child to:

☐ Be fed based on the food program that the center offers.

☐ I will provide for my child daily as outline above and understand that if I do not provide the needed food, the center will use their food to meet the needs of my child.

☐ My child is breastfed

I would like my child fed the following times & amounts while in care at Robin's Nest:

☐ On demand __________ oz

☐ Other (see details below)

My child is eating: ____

My child likes: ____

My child has these food allergies (type of food & reaction type):

____

____

Parent signature: ______________________________________ Date: ________________

Director Signature: ____

Lead Staff: ____

Teacher: ____

Potty Training Agreement

Potty training agreement is attached to this form. Please look over and see how we do potty training in our school.

We will need a signed potty training agreement to do potty training in our classroom and there is a 5.00 per week potty fee. This pays for cleaning of carpets etc… for potty accidents that occur in a classroom.

We ask that you bring in 5 changes of underwear and easy pull up and down pants in a zip lock bag labeled with your child's name on it. When they have a potty accident we will place soiled clothing into the bag and you will pick up in our soiled clothing area nightly.

Please return clean clothes in a ziplock bag the next day so you don't have to rent clothes.

Please place clothing in a zip lock bag. This is a health department requirement. There is a 1.00 fee for providing a ziplock bag.

Robin's Nest does not use pull ups or diapers to potty train. Potty training is most successful when we are consistent at school and at home. We use pee pads for nap time on cots. There is no need for pull ups at nap.

Please call with questions and thank you!

Jana & Robin

Robins Nest
Learning Center

Potty Training Agreement

Potty training is an exciting time for you and your child. Please read over the article I have provided called "I have to Go Potty". This article will provide you some basic information about potty training and our philosophy.

When you are ready to start the process, we will need the following contract:

I would like my child ____ to start the potty training process. I understand there is a 5.00 per week potty fee that will be assessed to my account until my child goes two-weeks accident free at school. There will be a potty chart in the classroom noting potty accidents for the month.

The potty fee covers the frequent carpet cleaning, mycobacterium spray to clean carpets in potty training classrooms, washing of bedding and extra time required for staffing to change children out of soiled clothing while maintaining ratios inside the classroom.

We ask you to provide 1 complete set of clothing: Pants, shirt. Socks and underwear & 4 sets of pants and underwear each in a zip lock bag with your child's name on them. Your soled clothing will go back into the ziplock bag and will be located where the soiled clothing is stored by sign in & out door at entry.
Please pick up soiled clothing daily. Per health department regulations we cannot wash soiled clothing in our washing machine.

I understand that I am required to provide ziplock bags for soiled clothing as required by the health department to prevent cross contamination. If you do don't provide a zip lock bag, the center will provide a zip lock bag to maintain compliance and charge the account 1.00 per bag.

I understand that I am required to replenish soiled clothing daily to be sure my child has clothing to potty train with. If I do not have clothing on hand, the school is required to put a diaper on the child and stop potty training for the day.

Child's Name ____

Parent Signature ____

Date ______________________