
**Family Door Code: _____**

## CHILD INFORMATION

**Child's Name: _____ Registration Date: _____**

**☐ Male ☐ Female Date of Birth: _____ Age: _____**

**Home Address: _____ City: _____ State: _____ Zip Code: _____**

**Allergies or Medical Conditions or Dietary Restrictions: _____**

**_____**

**Pediatrician Name: _____ Phone Number: (_____)_____**

## GUARDIAN INFORMATION

**Primary Contact Name: _____ Phone Number: (_____)_____**

**Relationship: _____**

**Secondary Contact Name: _____ Phone Number: (_____)_____**

**Relationship: _____**

**Primary Email address: _____@_____._____**

## EMERGENCY CONTACTS AND AUTHORIZED PICK-UPS

***PARENTS/GUARDIANS WILL BE CONTACTED FIRST. THE FOLLOWING PEOPLE WILL BE CONTACTED ONLY IF THE PARENTS/GUARDIANS CANNOT BE REACHED. EVERYONE LISTED WILL BE REQUIRED TO HAVE A PHOTO ID ON FILE.***

1. **Name: _____ Phone Number: (_____)_____**

   **Relationship: _____**

2. **Name: _____ Phone Number: (_____)_____**

   **Relationship: _____**

3. **Name: _____ Phone Number: (_____)_____**

   **Relationship: _____**

4. **Name: _____ Phone Number: (_____)_____**

   **Relationship: _____**

5. **Name: _____ Phone Number: (_____)_____**

   **Relationship: _____**

**Anyone NOT allowed to pick your child up: _____**

***If you have a custody agreement or other legal documentation regarding your child, we will need a copy of that for their file.***

**Primary Guardian Signature: _____**

## PERMISSIONS

***Please read and place a check mark in the box for each item you give Lotti's Learning Academy for.***

- □ I give permission for Lotti's Learning Academy to provide transportation for emergency medical purposes.
- □ I give permission for Lotti's Learning Academy to photograph or video my child for purposes of learning, classroom display or special occasions.
- □ I give permission for Lotti's Learning Academy to post photos or videos containing my child to our school Facebook page.
- □ I give permission for Lotti's Learning Academy to apply sunscreen or bug spray to my child.
- □ I understand that my child may be subject to interviews by licensing staff, child maltreatment investigators and/or law enforcement.
- □ I have been given information on Shaken Baby Syndrome for my child ***(will be given with handbook).***
- □ I have been given information on Kindergarten Readiness Skills Calendar & Checklist ***(will be given with handbook).***
- □ I have been informed that DHS licensing compliance forms are available upon request.
- □ I give permission to Lotti's Learning Academy to administer minor medications such as triple antibiotic ointment, bandages, ice packs etc..

**Primary Guardian Signature: _____**

## MEDICATION & WELLNESS POLICY

*****PLEASE NOTE THAT WE ARE NOT ALLOWED TO GIVE MEDICATIONS UNLESS IT IS FOR EMERGENCY ONLY, ACCOMPANIED BY A DOCTOR'S NOTE*****

*****ALL MEDICATIONS OR MEDICAL TREATMENT MUST BE ACCOMPANIED BY A DOCTOR'S NOTE AND WILL EXPIRE AFTER 1 YEAR. A NEW NOTE WILL NEED TO BE OBTAINED*****

I understand that should my child have one of the following, they will be sent home and cannot return for a minimum of 24 hours WITHOUT MEDICATION:

- □ A fever of 101; 2 or more vomiting episodes
- □ 3 or more diarrhea episodes ( A doctor's note WILL BE REQUIRED if your child is on antibiotics, as we know diarrhea can happen while on antibiotics.)
- □ Rash accompanied with or without fever
- □ Head lice (we are a nit free facility)

**Primary Guardian Signature: _____**

**Date: _____ This will expire 1 year from this date.**

# FINANCIAL AGREEMENT

***Please read and place a check mark in the box for each item.***

- □ I wish to enroll my child in Lotti's Learning Academy.
- □ I acknowledge that tuition is due every Monday at drop-off.
- □ Tuition must be paid in cash or check, payable to Lotti's Learning Academy.
- □ Late tuition incurs a $20 per day late fee starting Tuesday.
- □ LLA reserves the right to turn delinquent accounts over for collection.
- □ A $30 fee will be charged for any returned checks, payable immediately. After the 2nd returned check, cash payments are required.
- □ Absent days require payment for the entire week to secure my child's place.
- □ Full tuition applies to weeks LLA is closed for holidays, inclement weather, or unforeseen closings.
- □ Full tuition applies to weeks LLA remains open during winter and spring breaks, regardless of attendance.
- □ Withdrawals require a 2-week notice.
- □ Late pick-up fees apply ($5 per minute, doubling after the 3rd late pick-up). Police and DHS may be contacted for repeated late pickups.
- □ Childcare is limited to a maximum of 10 hours per day; I will pick up my child within that timeframe.
- □ Any changes to pick-up lists, custody agreements, or other child-related matters will be promptly communicated to the director.

I have read and agree to the above terms and conditions regarding my financial responsibility to Lotti's Learning Academy.

**Primary Guardian Signature:** _____

**CLASSROOM CHILD INFORMATION SHEET:**

**This form will be kept in your child's classroom.**

**Child's Name:** _____

Prefers to be Called: _____

Siblings? ☐ **Yes** ☐ **No** _____

Has your child been in daycare or in-home care before? ☐ **Yes** ☐ **No**

**Where:** _____

Does your child have a regular bedtime schedule? ☐ **Yes** ☐ **No** Please list below:

**Time:** _____ **How long does your child sleep?** _____

How does your child go down for nap? _____

Is your child potty-trained? ☐ **Yes** ☐ **No** ☐ **N/A** ☐ **Begun/Working on it**

****ALL CHILDREN MUST BE POTTY TRAINED BY AGE 3****

**Tell us about your child's interests (if any):**

Favorite color: _____ Favorite character(s)_____

Music/Songs: _____

Food: _____

Allergies, Medical Conditions or Dietary Conditions:

_____

Favorite way to be comforted: _____

What time will your child normally be picked up? _____

By who: _____

**For infants under 12 months old only:**

On baby food: ☐ **Yes** ☐ **No** ☐ **N/A** ☐ **Formula** ☐ **Breastmilk**

**Breastfed at home:** ☐ **Yes** ☐ **No** ☐ **N/A**

**Feeding Schedule:**_____

**CHILD CARE FOOD PROGRAM**
**ENROLLEMENT FORM**

Provider's Initials: _____

Date: _____

To be completed by Parent or Guardian

You have chosen a daycare that participates on the USDA Child and Adult Care Food Program (CACFP). It is our goal to assist in providing your child with nutritious meals/snacks. This enrollment information must be verified. The mealtime patterns and the daily menus should always be posted and available for parents. If you have questions, comments, or would like to learn more about the Child and Adult Care Food Program, contact our office at (505) 682-8869.

| ELITE LEARNING ACADEMY | | 479-646-5350 | |
|---|---|---|---|
| Name of Day Care Facility | | Telephone # | |
| 2415 S 57TH ST | FT SMITH | AR | 72903 |
| Address | City | State | Zip Code |

**The following information is required by USDA Federal Regulation CFR 226.15(e)(2).**

I wish to enroll my child(ren), whose names and enrollment information are specified below, in the USDA Child and Adult Care Food Program. I understand this program reimburses day care facilities for serving nutritious and well-balanced meals/snacks to day care children.

**My Child(ren) will be served the following meals**:

Breakfast: ☑ AM Snack: ☐ Lunch: ☑ PM Snack: ☑ Supper: ☐ Late Snack: ☐

| **Please Print Child(ren)'s Information** | | | | | | |
|---|---|---|---|---|---|---|
| First Name | Last Name | Age | Birthdate | Hours of Care | Days of Week | Gender |
| | | | | From: 6AM<br>To: 6 PM | Sat. ☐ Tue. ☑ Fri. ☑<br>Sun. ☐ Wed. ☑<br>Mon. ☑ Thur. ☑ | |
| | | | | From: 6AM<br>To: 6PM | Sat. ☐ Tue. ☑ Fri. ☑<br>Sun. ☐ Wed. ☑<br>Mon. ☑ Thur. ☑ | |
| | | | | From: 6AM<br>To: 6PM | Sat. ☐ Tue. ☑ Fri. ☑<br>Sun. ☐ Wed. ☑<br>Mon. ☑ Thur. ☑ | |
| | | | | From: 6AM<br>To: 6PM | Sat. ☐ Tue. ☑ Fri. ☑<br>Sun. ☐ Wed. ☑<br>Mon. ☑ Thur. ☑ | |

Please identify any fool allergies or special needs your child(ren) require:

Doctor's Name: _____ Doctor's Telephone: _____



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Racial and Ethnic data is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program as administered in a nondiscriminatory manner.

***OPTIONAL* Participant's ethnic and racial identities** **Please select all that apply**

| Name of Enrolled Child(ren) | Age | Foster Child? | Hispanic or Latino | American Indian or Alaskan Native | Asian | Black or African American | Hawaiian Native or Other Pacific Islander | White |
|---|---|---|---|---|---|---|---|---|
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex (including gender identity and sexual orientation), or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

## EMERGENCY CONTACT INFORMATION:

Home Telephone #: _____ Work Telephone #: _____

_____

Parent's Address City State Zip Code

Parent's Signature: _____ Date: _____

*Form expires one (1) year from this date



Revised 07/2022

# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Facility Name** ELITE LEARNING ACADEMY



## PART 1. NAME OF ENROLLED CHILDREN

***OPTIONAL – Participant's ethnic and racial data**

**Racial and Ethnic data** is optional and is collected in accordance with FNS Instruction 113-1 Section XII (a)(2). This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

| NAME OF ENROLLED CHILDREN | AGE | DATE OF BIRTH | FOSTER CHILD? | HISPANIC OR LATINO Yes | HISPANIC OR LATINO No | American Indian or Alaskan Native | Asian | Black or African American | Hawaiian Native or Other Pacific Islander | White |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | | | | | |
| | | | | ☐ | ☐ | | | | | |
| | | | | ☐ | ☐ | | | | | |
| | | | | ☐ | ☐ | | | | | |

**ADDITIONAL HOUSEHOLD CHILDREN** _____ **TOTAL NUMBER OF CHILDREN AND ADULTS IN HOUSEHOLD:** _____

**PART 2. Benefits:** If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

| Name: | Case Number | |
|---|---|---|
| 1. _____ | _____ | **NOTE: A Case number is not the number found on the EBT card or an individual's Social Security number.** |
| 2. _____ | _____ | |
| 3. _____ | _____ | |

**PART 3.** If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Your School, Homeless Liaison, or Migrant Coordinator

☐ Homeless ☐ Migrant ☐ Runaway

## PART 4. TOTAL HOUSEHOLD GROSS INCOME: Please identify your income.

**PLEASE CIRCLE WHICH ONE YOU ARE REPORTING:**

*** Weekly / Every 2 Weeks / Twice a Month / Monthly / Annual ***

| Names of all Household Members, except children listed above | Earnings from work before deductions | Welfare, Child Support, Alimony | Pensions, SSI, VA Benefits, Social Security, Retirement | All other income | Check here if No Income |
|---|---|---|---|---|---|
| | $_____ | $_____ | $_____ | $_____ | |
| | $_____ | $_____ | $_____ | $_____ | |
| | $_____ | $_____ | $_____ | $_____ | |
| | $_____ | $_____ | $_____ | $_____ | |

## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

**Facility Name** ELITE LEARNING ACADEMY 

**PART 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**

An adult household member must sign this form. **If Part 3 is completed, 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.** (See Statement on the back of this page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: _____ Print name: _____

Date: _____ (form valid for one (1) year from this date)

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

**Last four digits of Social Security Number:** _*_*_*-_*_*-____ ☐ **I do not have a Social Security Number**

**(required)**

**Don't fill out this part. This is for official use only.**

**Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12**

Total Income_____ ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year Household Size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

If applicable, Sponsor Signature:_____ Date:_____

**Refer to the current USDA Income Eligibility Guidelines for making determinations of 'Free', 'Reduced', or 'Paid".**

HNP Representative Initials/Date (for use during CACFP Reviews)

_____

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.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired 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."