

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name: Learning Tree Day School - 1077706		Director's Name: Mr. Umang P. Shah	
Child's Full Name:	Child's Date of Birth:	Child Lives With? ☐ Both parents ☐ Mom ☐ Dad ☐ Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian <i>(if different from the child's)</i> :		
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ☐ Yes ☐ No
In case of an emergency, call:			
Name of Emergency Contact:	Relationship:	Area Code and Phone No.:	
Address:			
I authorize the child care operation to release my child to leave the child care operation ONLY with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	

Consent Information

1. Transportation:
I give consent for my child to be transported and supervised by the operation's employees (Check all that apply). ☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school
2. Field Trips:
☐ I give consent for my child to participate in field trips. ☐ I do not give consent for my child to participate in field trips.
Comments:
Parent Email:
Mother:
Father:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance: ☐ Yes ☐ No

If no, what type of assistance is needed: _____

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

- | | |
|--|---|
| ☐ Discipline and guidance | ☐ Procedures for release of children |
| ☐ Suspension and expulsion | ☐ Illness and exclusion criteria |
| ☐ Emergency plans | ☐ Procedures for dispensing medications |
| ☐ Procedures for conducting health checks | ☐ Immunization requirements for children |
| ☐ Safe sleep | ☐ Meals and food service practices |
| ☐ Procedures for parents to discuss concerns with the director | ☐ Procedures to visit the center without securing prior approval |
| ☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | ☐ Procedures for supporting inclusive services |
| ☐ Procedures for parents to participate in operation activities | ☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website |

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Child's Special Care Needs (check all that apply)

- | | |
|--|---|
| ☐ Environmental allergies | ☐ Limitations or restrictions on child's activities |
| ☐ Food intolerances | ☐ Reasonable accommodations or modifications |
| ☐ Existing illness | ☐ Adaptive equipment (<i>include instructions below</i>) |
| ☐ Previous serious illness | ☐ Symptoms or indications of complications |
| ☐ Injuries and hospitalizations (<i>past 12 months</i>) | ☐ Medications prescribed for continuous long-term use |
| ☐ Other: _____ | |

Explain any needs selected above:

Does your child have diagnosed food allergies? ☐ Yes ☐ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian _____

Date Signed _____

School Age Children

My child attends the following school:

School Area Code and Phone No.:

My child has permission to (*check all that apply*):

- ☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

- ☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian _____

Date Signed _____

Requirements for Exclusion from Compliance

- ☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.
- ☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ☐ Pass ☐ Fail

Signature _____ Date Signed _____

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				☐ Pass ☐ Fail
Left				☐ Pass ☐ Fail

Signature _____ Date Signed _____

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. *(Select **only one** option.)*

- ☐ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.
- ☐ A signed and dated copy of a health care professional's statement is attached.
- ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional _____ Date Signed _____

Signature — Parent or Legal Guardian _____ Date Signed _____

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	SHOT
	6 months (third dose)	RECORDS
	12–15 months (fourth dose)	ATTACHED
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature _____

Date Signed _____

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

☐ Positive ☐ Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>

Signatures

Child's Parent or Legal Guardian _____

Date Signed _____

Center Designee _____

Date Signed _____

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature _____

Date Signed _____

Parent Handbook Acknowledgment Page

Child's Name: _____

I have read the Learning Tree Day School Parent Handbook and agree to abide by the policies and procedures as outlined in the handbook. I further agree to communicate with the teachers, staff, and Director if I have questions, concerns, or need more information.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that Learning Tree Day School is not responsible for lost, stolen, or damaged Cell Phones, Tablets, Video Games, MP3 Players, or any other items of value. We encourage the student not to bring these items from home.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that two weeks' written notice is required if my child will not attend Learning Tree Day School. I acknowledge that if I do not give two weeks' written notice, I will be financially responsible for the tuition and Specialty fees.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that Learning Tree Day School reserves the right to modify or amend the policies at any time without prior notice.

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

I acknowledge that my child may be featured in Learning Tree Day School's social media content (including but not limited to photos, videos, and posts).

Signed: _____ **Date:** _____ (Parent or Legal Guardian)

This form serves as an acknowledgment by the parent or legal guardian regarding the understanding and acceptance of the policies outlined in the Learning Tree Day School Parent Handbook, including the potential use of the child in the school's social media content. Please sign and date each section to indicate your acknowledgment and agreement.

LEARNING TREE DAY SCHOOL

FINANCIAL POLICIES AGREEMENT

Name of child: _____

Tuition for your child's care is: _____ per month/bi-monthly

TUITION MUST BE PAID WHETHER OR NOT YOUR CHILD ATTENDS

A late payment charge of \$20 will be incurred if payment is not received after the fifth of the month.

Monthly Tuition Schedule:

Payment Obligation: Childcare fees are applicable whether or not your child attends daycare on the agreed-upon days/hours. There will be no substitution, exchange, or breaks in fees for days when your child is absent due to illness, vacation, or any other reason.

Billing Cycle: Daycare billing occurs twice per month on the 1st and 15th for enrolled schoolers.

Preschool Tuition: Tuition for preschool programs is payable weekly, bi-monthly, or monthly, as per the selected payment schedule at enrollment.

Insufficient Funds: In the event of a returned check due to insufficient funds, a \$30.00 fee will be assessed.

No Refunds or Prorated Tuition: There will be no refunds or prorated tuition for absences, whether they are excused or unexcused.

Enrollment Termination: Enrollment is subject to termination if payment is not received by the tenth of the month. Tuition is not prorated if a child withdraws for any reason before the end of the month.

I understand the above written policies and agree to follow them:

Parent Signature

Date

Operational Discipline and Guidance Policy

This form provides the required information per 26 Texas Administrative Code (TAC) minimum standards Sections 744.501(7), 746.501(a)(7), and 747.501(5).

Directions: Parents will review this policy upon enrolling their child. Employees, household members and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

Discipline and Guidance Policy

Discipline must be:

- 1) individualized and consistent for each child;
- 2) appropriate to the child's level of understanding; and
- 3) directed toward teaching the child acceptable behavior and self-control.

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control and self-direction, which include at least the following:

- 1) using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
- 2) reminding a child of behavior expectations daily by using clear, positive statements;
- 3) redirecting behavior using positive statements; and
- 4) using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:

- 1) corporal punishment or threats of corporal punishment;
- 2) punishment associated with food, naps or toilet training;
- 3) grabbing or pulling a child;
- 4) putting anything in or on a child's mouth;
- 5) humiliating, ridiculing, rejecting or yelling at a child;
- 6) subjecting a child to harsh, abusive or profane language;
- 7) placing a child in a locked or dark room, bathroom or closet;
- 8) placing a child in a restrictive device for time out;
- 9) withholding active play or keeping a child inside as a consequence for behavior, unless the child is exhibiting behavior during active play that requires a brief supervised separation or time out that is consistent with 746.2803(4)(D); and
- 10) requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Additional Discipline and Guidance Measures

(Only Applies to Before or After School Program (BAP)/School Age Program (SAP) that Operates under 26 TAC Chapter 744)

A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise or proficiency:

- ensure that the measures are considered commonly accepted teaching or training techniques;
- describe the training and disciplinary measures in writing to parents and employees and include the following information:
 - (A) the disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
 - (B) what behaviors would warrant the use of these measures; and
 - (C) the maximum amount of time the measures would be imposed;
- inform parents that they have the right to ask for additional information; and
- ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code Section 261.001 and TAC Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

Signature

This policy is effective on the following date: _____

Signed by: _____

Role: ☐ Parent ☐ Caregiver or Employee ☐ Household Member (CH. 747 only)

Minimum Standards Related to Discipline

- Title 26, Chapter 746 Subchapter L: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=746&sch=L&rl=Y)
- Title 26, Chapter 747 Subchapter L: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=747&sch=L&rl=Y)
- Title 26, Chapter 744 Subchapter G: [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=744&sch=G&rl=Y)

Parent's Rights

This form provides the required information per Chapter 42 of the Human Resource Code (HRC) Section 42.04271.

Directions: Parents will review these rights upon enrolling their child.

Rights of Parent or Guardian

A parent or guardian of a child at a child care facility has the right to:

- (1) enter and examine the child care facility during the facility's hours of operation without advanced notice;
- (2) review the child care facility's publicly accessible records;
- (3) receive inspection reports for the child care facility and information about how to access the facility's online compliance history;
- (4) obtain a copy of the child care facility's policies and procedures;
- (5) review, at the request of the parent or guardian, the facility's:
 - (A) staff training records; and
 - (B) any in-house staff training curriculum used by the facility;
- (6) review the child care facility's written records concerning the parent's or guardian's child;
- (7) inspect any video recordings of an alleged incident of abuse or neglect involving the parent's or guardian's child, provided that:
 - (A) video recordings of the alleged incident are available;
 - (B) the parent or guardian of the child does not retain any part of the video recording depicting a child that is not their own; and
 - (C) the parent or guardian of any other child captured in the video recording receives written notice from the facility before allowing a parent to inspect a recording;
- (8) have the child care facility comply with a court order preventing another parent or guardian from visiting or removing the parent's or guardian's child;
- (9) be provided the contact information for the child care facility's local Child Care Regulation office;
- (10) file a complaint against the child care facility by contacting the local Child Care Regulation office; and
- (11) be free from any retaliatory action by the child care facility for exercising any of the parent's or guardian's rights.

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

Signature of Parent or Guardian

Date

Resources

Facility Information and Online Compliance History: <http://txchildcaresearch.org>

Child Care Regulation Contact Information: <https://www.hhs.texas.gov/services/safety/child-care/contact-child-care-regulation>

Family Orientation Checklist & Acknowledgment Form

Learning Tree Day School - Family Orientation

Welcome to our program! To ensure a smooth transition and provide essential information, we conduct a Family Orientation Session. Please check each item after completion. Your participation is vital in understanding our program's policies, procedures, and resources.

Family Orientation Checklist:

1. ☐ **Tour of the Facility:**
 - Introduction to the premises, highlighting key areas and facilities.
2. ☐ **Introduction to Teaching Staff:**
 - Meet and greet with staff members, providing an overview of their roles.
3. ☐ **Visit with Classroom Teacher:**
 - Opportunity to connect with the child's classroom teacher.
4. ☐ **Overview of Parent Handbook:**
 - Distribution and discussion of the Parent Handbook's key policies and guidelines.
5. ☐ **Policy for Arrival & Late Arrival:**
 - Explanation of arrival procedures and importance of punctuality.
6. ☐ **Consistent Arrival Time:**
 - Emphasize the significance of regular and consistent arrival times for the child's routine.
7. ☐ **Explanation of Texas Rising Star Quality Certification:**
 - Information regarding the center's certification and its significance in maintaining quality standards.
8. ☐ **Child Development & Developmental Milestones:**
 - Provide insights into child development stages and milestones.
9. ☐ **Encouragement for Information Sharing:**
 - Encourage parents to communicate any specific needs related to CCS enrollment.
10. ☐ **Overview of Family Support Resources:**
 - Information on available community resources and support activities for families.
11. ☐ **Technology Use Policy:**
 - Explain the center's policy on limited technology use to enhance communication.
12. ☐ **Statement on Family Role and Influence:**
 - Emphasize the vital role of families in a child's educational journey.
13. ☐ **Extended Classroom Visit Opportunity:**
 - Offer an extended visit for both parent and child to familiarize themselves with the classroom environment.

Acknowledgment:

I, _____ (Parent Name), have attended the Family Orientation Session at Learning Tree Day School. I confirm that I have received an overview of the program, policies, and resources as outlined in the Family Orientation Checklist above.

Parent Name: _____

Student Name: _____

Date: _____

Administrator Signature: _____

Date: _____

Name: _____ D.O.B.: _____

Allergic to: _____

 Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

 History of anaphylaxis: ☐ **Yes** ☐ **No**

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS


LUNG

Shortness of breath, wheezing, repetitive cough


HEART

Pale or bluish skin, faintness, weak pulse, dizziness


THROAT

Tight or hoarse throat, trouble breathing or swallowing


MOUTH

Significant swelling of the tongue or lips


SKIN

Many hives over body, widespread redness


GUT

Repetitive vomiting, severe diarrhea


OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.



- ADMINISTER EPINEPHRINE IMMEDIATELY.**
- Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve.

ADDITIONAL PHYSICIAN COMMENTS

MILD SYMPTOMS


NOSE

Itchy or runny nose, sneezing


MOUTH

Itchy mouth


SKIN

A few hives, mild itch


GUT

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE
SYSTEM AREA, GIVE EPINEPHRINE AND CALL 911.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine and call 911.

☐ If this box is checked by the child's physician, the child has an extremely severe allergy to _____ and should be given epinephrine at the first sign of any symptoms, even if mild.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

 Epinephrine Dose: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM
☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: _____

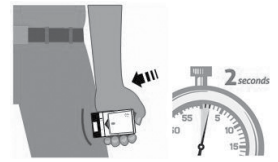
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

☐ Patient may self-carry ☐ Patient may self-administer

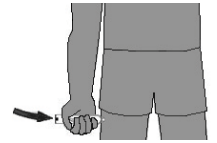
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



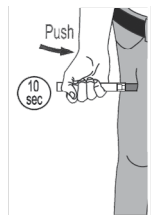
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



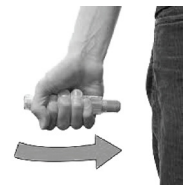
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Medical-Special Dietary Needs Modification Statement

PARENTS: Carefully read and follow the procedures for requesting a special dietary need meal modification.

Incomplete Special Dietary Needs Forms will not be accepted.

When To Use This Form:

- A special dietary need that allows a substitute food component from same food group.....**Complete Parts A, B & C**
(example: child has an intolerance for strawberries and a different fruit can be substituted)
- A medical statement that prohibits the serving of specific food component and lists appropriate substitutions.....**Complete Part D**
(this form can be used in lieu of a Clinic's medical statement as long as a medical authority signs the form)

How To Complete This Form:

Part A - Form must be completed by the Parent/Guardian

Part B - Form must be completed by the Parent/Guardian

Part C - Form must be signed and dated by the Parent/Guardian

Part D - Form must be signed by the licensed Medical Authority

Part A. Student and Parent/Guardian Information – To be completed by a parent/guardian			
Student's Name:	Date of Birth: ____ / ____ / ____		
Parent/Guardian's Name:	Parent/Guardian's Phone: (____) ____ - ____		
Name of Site/Center:	Site/Center Location (city):		
☐ Part B. Special Dietary Need (not requiring a Doctor's Statement)			
List specific food items the child cannot tolerate and parent wishes to substitute with a different item (within same food group):			
☐ Whole Milk: Replaced With _____ Brand Name	Unflavored Lactose Free/Reduced Whole Milk (1 yr olds only)	Center Provided	Parent Provided
☐ Whole Milk: Replaced With _____ Brand Name	Unflavored Soy Milk (1 yr olds only)	☐	☐
=====			
☐ 1% Milk: Replaced With _____ Brand Name	Unflavored Lactose Free/Reduced 1% Milk (2 -5 yr olds only)	☐	☐
☐ 1% Milk: Replaced With _____ Brand Name	Unflavored Soy Milk (2 - 5 yr olds only)	☐	☐
=====			
☐ 1% Milk: Replaced With _____ Brand Name	[] Unflavored [] Flavored Lactose Free/Reduced 1% Milk (6 -18 yr olds only)	☐	☐
☐ 1% Milk: Replaced With _____ Brand Name	[] Unflavored [] Flavored Soy Milk (6 -18 yr olds only)	☐	☐
=====			
☐ _____ Scheduled Component	Replaced With _____ Substituted Component	☐	☐
☐ _____ Scheduled Component	Replaced With _____ Substituted Component	☐	☐
☐ _____ Scheduled Component	Replaced With _____ Substituted Component	☐	☐
☐ _____ Scheduled Component	Replaced With _____ Substituted Component	☐	☐
☐ Part C. Parent/Legal Guardian Permission – To be completed by a parent or legal guardian.			
I certify that all information listed above is true & factual and I give permission for Site/Center personnel responsible for providing my child's diet to discuss my child's special dietary accommodations with the Site/Center's CACFP Sponsor.			
Parent/Legal Guardian's Signature _____ Date of Signature: ____ / ____ / ____			
☐ Part D. Alternate Medical Statement by Medical Authority (This form can be used in lieu of a Clinic's own Medical Statement)			
List specific food items the child cannot tolerate and what food items the child is allowed to have as a replacement.			
Omit The Following Food Components due to a Medical Condition		Substitute Omitted Food Components with these Food Components	
Medical Authority's Signature _____ Date of Signature: ____ / ____ / ____			

CACFP STUDENT ENROLLMENT FORM

CM-1500

Center Name

This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals / snacks for your children. Federal CACFP regulations require all parents/guardians to complete a CACFP Enrollment Form when enrolling their child(ren) and review/update enrollment data annually thereafter.

CHILD INFORMATION

Center Enroll Date / /	Ethnic Identity (Check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /
Child's First Name 	Racial Identity (Check all that apply) ☐ White ☐ Black / African American ☐ Am. Indian / Alaskan Native ☐ Asian ☐ Native Hawaiian / Other Pacific Islander	
Child's Last Name 	Gender ☐ Male ☐ Female	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /
Child's Birth Date / /	Normal Days in Care Center's Days of Operation: ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU	
Normal Hours in Care Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM	Meals/Snacks Child Receives Meals/Snacks Served at Center: ☐ BRK ☐ AMS ☐ LUN ☐ PMS ☐ SUP ☐ EVS	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /
Center Enroll Date / /	Ethnic Identity (Check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Child's First Name 	Racial Identity (Check all that apply) ☐ White ☐ Black / African American ☐ Am. Indian / Alaskan Native ☐ Asian ☐ Native Hawaiian / Other Pacific Islander	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /
Child's Last Name 	Gender ☐ Male ☐ Female	
Child's Birth Date / /	Normal Days in Care Center's Days of Operation: ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /
Normal Hours in Care Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM	Meals/Snacks Child Receives Meals/Snacks Served at Center: ☐ BRK ☐ AMS ☐ LUN ☐ PMS ☐ SUP ☐ EVS	
Center Enroll Date / /	Ethnic Identity (Check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /
Child's First Name 	Racial Identity (Check all that apply) ☐ White ☐ Black / African American ☐ Am. Indian / Alaskan Native ☐ Asian ☐ Native Hawaiian / Other Pacific Islander	
Child's Last Name 	Gender ☐ Male ☐ Female	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /
Child's Birth Date / /	Normal Days in Care Center's Days of Operation: ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU	
Normal Hours in Care Center's Hours of Operation: ☐ AM ☐ PM to ☐ AM ☐ PM	Meals/Snacks Child Receives Meals/Snacks Served at Center: ☐ BRK ☐ AMS ☐ LUN ☐ PMS ☐ SUP ☐ EVS	SITE / SPONSOR USE ONLY Withdrawal Date: / / Re-Enroll Date: / /

PARENT / GUARDIAN INFORMATION

I certify the information on this form is true and correct to the best of my knowledge and that I have received access to WIC and CACFP literature within the last 12 months.

Signature

Date

Parent First Name

Parent Last Name

Cell Phone

SITE / SPONSOR USE ONLY

This institution is an equal opportunity provider.

Infant Declaration Form

Center Name

INSTRUCTIONS TO PARENTS:

Complete **BOTH** sections on this form. Sign and date where indicated. Submit to child care provider.

Section 1

Infant's Name _____ Birth Date: ____ / ____ / ____

Parent's Name _____

My child is allergic to the following foods:

(A Doctor's note is required for any foods that cannot be substituted within the same food group.)

Section 2

Your child care provider offers the following iron-fortified infant formula(s):

Parent Declaration - Select only **ONE** of the following options.

☐ **CENTER** will provide ALL meal components for infant named above.

or

☐ **PARENT** will provide ALL meal components for infant named above.

➔ Iron Fortified Infant Formula / Breast Milk

Infant Formula Brand Name

☐

or

☐ **BOTH PARENT and CENTER** will provide meal components for infant named above, as indicated below.

☐ **Center** or ☐ **Parent** will provide Iron Fortified Infant Formula / Breast Milk



Infant Formula Brand Name

☐

0-5
Months

☐

6-11
Months

☐

☐ **Center** or ☐ **Parent** will provide Iron Fortified Infant Cereal

☐

☐ **Center** or ☐ **Parent** will provide Infant Fruits/Vegetables

☐

☐ **Center** or ☐ **Parent** will provide Infant Meats

☐

☐ **Center** or ☐ **Parent** will provide Crusty Bread/Crackers

☐

*** This form must be updated and submitted any time there is a change in Section 2.

I understand that once my infant child turns 6 months of age, it is my responsibility to notify the child care center director as to any limitations of solid foods that my infant child is not developmentally ready to receive.

Parent Signature

(____)____-____ / ____ / ____
Parent Phone Number

Date

*Please include your phone number so our CACFP Sponsor can contact you if they have any questions.

This institution is an equal opportunity provider.

IDF 4-2026

This letter is intended for the parents or guardians of children enrolled at:

Dear Parent/Guardian:

This center offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP reimburses centers for healthy meals and snacks served to children enrolled in child care based on their eligibility for free or reduced-price meals. Higher reimbursement is received for meals served to enrolled participants who are eligible for free or reduced-price meals, and this reimbursement is then used to purchase healthy food to prepare nutritious meals. Please help us comply with the requirements of the CACFP by completing the attached Meal Benefit Income Eligibility Form so that we can determine your child(ren)'s eligibility for free or reduced-price meals.

1. Am I required to complete a Meal Benefit Income Eligibility Form in order to receive meals? No, but if you choose to do so, this center may receive a higher reimbursement for the meals you receive, which is used to buy nutritious food for meals.

2. Do I need to fill out a Meal Benefit Form for each of my children in day care? If all children enrolled for care at this center live in the same home, you only need to complete and submit one CACFP Meal Benefit Income Eligibility Form for these children. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to the child care center's director.**

3. Who is eligible for free or reduced-price meals? While this center does not charge for meals served, children in households receiving benefits in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR); foster children (reference question #7 for more information on foster children); or children designated as homeless are automatically eligible for free meals, and no additional income information needs to be provided.

Children enrolled in a Head Start Program (HSP), Early Head Start Program (EHSP), or Even Start Program (ESP) (must not have yet entered kindergarten) are also eligible for free meals. Households with children enrolled in an HSP, EHSP, or ESP can provide a certification letter from the program of the child's enrollment and do not need to complete the CACFP Meal Benefit Income Eligibility Form. Note that only the child or children enrolled in these programs will qualify for benefits.

All other children living in households with a combined income that does not exceed the household income thresholds attached to this letter and as documented on the Meal Benefit Income Eligibility Form are eligible for reduced-price meals and may be eligible for free meals based on the determination of this center.

4. Who should I include as members of my household? You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you, including foster children or homeless children who temporarily live with you.

5. How do I report income information and changes in employment status? The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income, providing a current SNAP, TANF, FDPIR case number, or by providing a certification letter establishing participation in an HSP, EHSP, or ESP, your child will remain eligible for those benefits for 12 full months. You should notify us, however, if you or someone in your household becomes unemployed, and the loss of income causes your household income to be within the eligibility standards.

6. What if my income is not always the same? List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you only get it sometimes.

7. What if I have foster children? Foster children who are under the legal responsibility of a foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Households may include foster children on the Meal Benefit Form but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children can provide the Texas Department of Family and Protective Services Form 2085FC, Placement Authorization Foster Care/Residential Care, to their child's caregiver and do not need to complete the CACFP Meal Benefit Income Eligibility Form.

8. We are in the military, do we include our housing and supplemental allowances as income? If 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.

In the operation of child feeding programs, no person will be discriminated against because of race, color, national origin, sex, age or disability.

If you have other questions or need help, call Amy Pringle at (832) 282-1351.

Sincerely,

Texas Department of Agriculture
Form 1625-A
April, 2026

**Income Eligibility Guidelines
for Determining Free or Reduced-Price Benefits
July 1, 2026 - June 30, 2027**

Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.

**Ingresos máximos para determinar la elegibilidad
para beneficios gratuitos o a precio reducido
1 de julio de 2026 - 30 de junio de 2027**

Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	\$29,526	\$2,461	\$1,231	\$1,136	\$568
2	\$40,034	\$3,337	\$1,669	\$1,540	\$770
3	\$50,542	\$4,212	\$2,106	\$1,944	\$972
4	\$61,050	\$5,088	\$2,544	\$2,349	\$1,175
5	\$71,558	\$5,964	\$2,982	\$2,753	\$1,377
6	\$82,066	\$6,839	\$3,420	\$3,157	\$1,579
7	\$92,574	\$7,715	\$3,858	\$3,561	\$1,781
8	\$103,082	\$8,591	\$4,296	\$3,965	\$1,983
For each additional family member add:	\$10,508	+\$876	+\$438	+\$405	+\$203



Name of Child Care Facility

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)**Part 1. All Household Members**

Names of all household members (First, Middle Initial, Last)	CHECK IF ENROLLED CHILD	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) OR A HOMELESS CHILD * IF ALL CHILDREN LISTED BELOW ARE FOSTER OR HOMELESS CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, or FDPIR benefits, provide the name and eligibility number for the person who receives benefits. **If no one receives these benefits, skip to part 4.**

NAME: _____ ELIGIBILITY NUMBER: _____

*SNAP or TANF number must be the 8 or 9 digit **EDG#** assigned by HHSC.**Part 3. (Applies only to parents / guardians with children enrolled in a day care home or day care home provider households)**

If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number:

NAME _____ ELIGIBILITY NUMBER: _____ ☐ Check here if no eligibility number

ADDITIONALLY, PLEASE ATTACH OFFICIAL EVIDENCE OF ENROLLMENT IN THE LISTED PROGRAM. If you are not a day care home provider, do not have a child enrolled at a day care, and/or are not participating in a qualifying program, skip to Part 4.

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	B. Gross income and how often it was received			
	Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	Weekly Every 2 Weeks 2x Month Monthly Annually	Weekly Every 2 Weeks 2x Month Monthly Annually	Weekly Every 2 Weeks 2x Month Monthly Annually	Weekly Every 2 Weeks 2x Month Monthly Annually
Example: Jane Smith	\$ 200 ☒ ☐ ☐ ☐ ☐	\$ 150 ☐ ☐ ☒ ☐ ☐	\$ 100 ☐ ☐ ☐ ☒ ☐	\$ 200 ☐ ☐ ☒ ☐ ☐
	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐
	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐
	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐
	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐	\$ _____ ☐ ☐ ☐ ☐ ☐

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

An adult household member must sign this form. **If Part 4 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 Privacy Act Statement on the next 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: _____

Address: _____

Phone Number: _____

City: _____

State: _____ Zip Code: _____

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



CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ Asian
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- ☐ I do elect to allow my household information to be disclosed.
☐ I do not elect to allow my household information to be disclosed.

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: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility: ____ Date Withdrawn: _____ Eligibility: Free ____ Reduced ____ Denied ____ Tier I ____ Tier II ____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

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 meal benefits. You must include the last four digits of the Social Security Number of the adult household member who signs the application; however, 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), or other qualifying program eligibility 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:

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, 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-05080002-508-11-28-17Fax2Mail.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;
(2) fax: (833) 256-1665 or (202) 690-7442; (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

INSTRUCTIONS FOR CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (CHILD CARE)

Follow these instructions if your household receives SNAP, TANF, or FDPIR benefits:

Part 1: List all enrolled children and household members.

Part 2: List the eligibility number for any household members (including adults) receiving SNAP, TANF, or FDPIR benefits. The SNAP or TANF number must be the 8 or 9-digit EDG# assigned by HHSC.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Sign the form. The last four digits of a Social Security Number are **not** necessary.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Follow these instructions if all children you are applying for are foster or homeless children, or if you are only applying for benefits for the foster or homeless child:

Part 1: List all foster or homeless children. Check the box indicating that the child is a foster or homeless child.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Skip this part.

Part 5: Adult household member must sign the form. The last four digits of the Social Security Number are not required.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

All other households, follow these instructions:

Part 1: List all enrolled children and household members. For any people, including children, with no income, you must check the "No Income Box." Check the box if the child is a foster or homeless child.

Part 2: Skip this part. See instructions above for households participating in SNAP, TANF, or FDPIR.

Part 3: Skip this part.

Part 4: Follow these instructions to report total household income from this month or last month.

Column A – Name: List only the first and last name of each person living in your household who share income and expenses, related or not (such as grandparents, other relatives, or friends who live with you) with income. Include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B – Gross Income and How Often it was Received: For each household member, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month, or monthly.

Box 1: List the gross income, not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub, or your boss can tell you.

Box 2: List the amount each person got from the month from welfare, child support, alimony.

Box 3: List retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits, disability benefits.

Box 4: List ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. For ONLY the self-employed, report income after expenses in Box 1. Box 4 is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.

Part 5: Adult household member must sign the form and list the last four digits of the Social Security Number or mark the box if s/he doesn't have one.

Part 6: Answer this question if you choose.

Part 7: Answer this question if you choose.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.



Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children.
Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by
USDA's Child and Adult Care Food Program.

Questions? Concerns?

Call USDA at
1-866-873-2263

OR

Food and Nutrition Division at
1-800-TELL-TDA
(835-5832)

ADVANCE Child Care, Inc.
(903) 872-5231
cacfpinfo@advcc.org



TEXAS DEPARTMENT OF AGRICULTURE
COMMISSIONER SID MILLER

Fraud Hotline: 1-866-5-FRAUD-4 or 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711
Toll Free: (877) TEX-MEAL | For the hearing impaired: (800) 735-2989 (TTY)



Food and Nutrition Division
Child and Adult Care Food Program

This product was funded by USDA.
This institution is an equal opportunity provider.



Updated 11/17/2021
www.SquareMeals.org

Join Texas WIC

We're here for you

“Thanks to WIC,
I now have the tools
I need to make
sure my family
stays on the path to
a healthy lifestyle.”

—Roxie, WIC Client

As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	\$ 3,337	\$ 40,034
3	\$ 4,212	\$ 50,542
4	\$ 5,088	\$ 61,050
5	\$ 5,964	\$ 71,558
6	\$6,839	\$ 82,066

Effective June 1, 2026

* A pregnant woman's household is increased by the number of infants she is expecting. If you have any income questions, call 1-800-942-3678.

Start now. Call 1-800-942-3678 or visit [TexasWIC.org](https://www.texaswic.org)



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