

Attach a recent photo of your child

Community Day



School Association

2011-2012 Enrollment Application

Please check one: School-Age Preschool

OFFICE USE:

- Financial Aid
- Parent Handbook received
- Signatures complete
- Form Complete

Date of Admission: _____

BEFORE/AFTER SCHOOL PROGRAM NAME (Use Black or Blue ink to fill out form)		CHILD'S AGE	DATE OF BIRTH	GRADE
CHILD'S NAME	SEX	Ethnicity	HOME PHONE NO.	
CHILD'S ADDRESS		CITY	STATE	ZIP

PARENT/GUARDIAN'S NAME	DATE OF BIRTH	HOME PHONE	CELL PHONE
HOME ADDRESS	CITY	STATE	ZIP
EMAIL ADDRESS	PLACE OF EMPLOYMENT	WORK PHONE NO.	

PARENT/GUARDIAN'S NAME	DATE OF BIRTH	HOME PHONE	CELL PHONE
HOME ADDRESS	CITY	STATE	ZIP
EMAIL ADDRESS	PLACE OF EMPLOYMENT	WORK PHONE NO.	

EMERGENCY CONTACT IF PARENTS CANNOT BE REACHED(Authorized for pick up)	RELATIONSHIP	PHONE NO.
EMERGENCY CONTACT IF PARENT CANNOT BE REACHED(Authorized for pick-up)	RELATIONSHIP	PHONE NO.
OUT OF AREA CONTACT	RELATIONSHIP	PHONE NO.

I AUTHORIZE CDSA TO RELEASE MY CHILD TO THE ADDITIONAL FOLLOWING PEOPLE:

NAME	RELATIONSHIP	PHONE NO.

Parent's Acknowledgements: This is to acknowledge that the CDSA has provided me with my own CDSA Family Information Guide. I agree to read and adhere to the information included.

Child's Description

Hair Color: _____ Eye Color: _____ Height: _____
 Weight: _____
 Distinct Features (scars, birthmarks, etc): _____

Parent Signature: _____ Date: _____

CUSTODY/ COURT ORDERS

Are there any court orders affecting custody of this child? Yes No (If yes you MUST provide the CDSA with a copy of these orders)
 Are there any restraining orders? Yes No Who has Primary custody of this child? _____
 Child may be released to: () FATHER () MOTHER () OTHER/NOTES: _____

Parent's Consent

TRANSPORTATION: (required for participation) I hereby give consent for my child to be transported by public transportation and supervised by the CDSA staff and volunteers to and from field trips.

WATER ACTIVITIES: (required for participation) I hereby give my consent for my child to participate in water activities that might be offered by the CDSA. I hereby give the CDSA staff permission to assist my child in the application of sunscreen.

Parent Signature: _____ Date: _____

Health HistoryPlease list any **DIETARY** or **PHYSICAL** restrictions:Please list any known **ALLERGIES**:Treatment to be given when in contact with stated **ALLERGIES**:Please **CHECK** all the following that apply to your child's **HEALTH HISTORY**:

ADD **ADHD** **EXISTING ILLNESS**
 DIABETES **TAKES DAILY MEDICATION**
 ASTHMA **OTHER: Please explain:** _____

Healthy Learning Environment:**To ensure your child has the best tailored academic support needed, please answer the following:**Has your child ever been suspended from school? No Yes
Date: _____ If yes, please explain _____Is, or has your child ever been on an Individual Education Plan? (IEP)
 No Yes If yes, please explain (include specific dates of initial IEP/
and or reviews _____

CDSA generally have staffing ratios in school-age of 1:10 and 1:8 in pre-school. Do you feel this will be adequate for your child's needs?

Yes No If No please explain _____

Parent's Signature: _____ Date: _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the CDSA Director or person in charge to take my child to:

NAME OF LICENSED PHYSICIAN: _____**ADDRESS:** _____**PHONE NUMBER:** _____**NAME OF HOSPITAL OR CLINIC:** _____**ADDRESS:** _____**PHONE NUMBER:** _____

I hereby give permission for my child to be given emergency treatment by a qualified staff member at Community Day School Association, to be transported by ambulance or aid car to an emergency center, and/or to receive whatever medical, surgical, and hospital care, treatment, and procedures are deemed immediately necessary by the attending physician to safeguard my child's health.

Parent Signature: _____ Date: _____

Date of last Health Exam: _____

Date of last Dental Exam: _____

Date of last Tetanus shot: _____

Name of Insurance _____ Policy # _____

Family Biographical Information

We at CDSA strive to insure that your child's needs are served to the capacity of our abilities. We feel in order to achieve that goal, we ask for as much information about your child as possible to enable our staff to serve all aspects of your child's needs.

- Does your child have a nickname that they prefer?
- Please describe some of the activities that your child prefers and some that they dislike.
- What are some of your child's favorite foods, and some of their least favorite?
- When your child is upset, what kind of behaviors are they likely to exhibit?
- At CDSA we are pleased to celebrate family diversity represented in our program population.
Please describe your family to us. (Special family traditions, siblings, relatives in household, etc.)
- Has there been any recent family changes
- What types of activities would you like to see your child participating in at CDSA?
- What expectations do have for the CDSA program

I have read and completed this document to the best of my knowledge and agree that the information provided is true and accurate.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Date: _____

CDSA Mission: CDSA is dedicated to providing affordable quality childcare in safe and caring surroundings. Our goal is to promote each child's intellectual, physical and social development within a diverse community with emphasis on respect for self, others and the environment.



**Community Day School Association
2011-2012 School Age Parent Agreement**

Parent's Name _____

Child's Name _____ Center _____

Please initial each agreement and sign at the bottom.

Initial

_____ 1. I grant permission for CDSA to provide care to my child including use of play equipment and supplies, involvement in all activities and participation in fieldtrips.

_____ 2. I have provided CDSA with the following information on the emergency form:

- _____ **Parent/Guardian name, address, home, cell and work phone numbers**
- _____ **Emergency contacts**
- _____ **Physician name and phone number**
- _____ **Food or drug allergies, asthma, disabilities, any chronic medical need, etc.**
- _____ **Persons authorized to pick up your child from CDSA plus phone numbers**
- _____ **Any additional relevant information**

_____ 3. I understand that CDSA is not responsible for personal items brought from home that may be lost.

_____ 4. I give permission for my child to be included in photographs taken at CDSA. I understand that photographs of my child may be used in our publications, including our website and marketing materials. I am able to withdraw my permission at any time for my child's photograph to be used in CDSA publications and will notify my Center Director in writing.

_____ 5. I have read and understand the Family Information Guide and am aware that CDSA reserves the right to decline enrollment for any of the following reasons:

- a. CDSA Conflict-Resolution Policy
- b. Non-payment of tuition/co-payment by due date
- c. Non-payment of tuition because subsidy has been denied or expired
- d. Physical or emotional problems that are beyond reasonable accommodations
- e. Parent/Guardian failure to comply with CDSA's policies and procedures

_____ 6. I have included on the emergency form all information that could significantly affect my child's ability to work with staff & other children. I will notify CDSA of any address & phone number changes.

_____ 7. CDSA is not responsible for anything that may happen as a result of incomplete information given by a parent/guardian on the emergency form or other documentation at the time of enrollment.

_____ 8. Children with the mental & physical capacity to apply sun screen will self apply under the supervision of CDSA staff. If the child is unable to do so, a CDSA staff member will apply as needed.

_____ 9. I agree to send a nutritionally balanced lunch with my child (ren) daily during full days and breaks. *CDSA is required by law to monitor the nutritional content of food that is consumed during meals and snacks while in our care.*

_____ 10. I understand that I have access to view the center's Disaster Plan, Pesticide and Health Care Policy.

_____ 11. I give permission for my child to participate in walking field trips in the neighborhood. I understand that this will occur without written permission.

_____ 12. I have reviewed the summary of the Disaster Plan in the Family Information Guide and know where a full copy of the plan is located.

Signature: _____ Date: _____



**Community Day School Association
2011 - 2012 School Age Tuition Agreement**

Parent's Name _____

Child's Name _____ Center _____

Please initial each agreement and sign at the bottom.

Initial

_____ 1. An annual registration fee of \$50 per child is payable at the time of registration and is non-refundable.

_____ Paid _____ Included

_____ 2. My base tuition is \$_____ per month, **payable IN ADVANCE**. **School-age tuition** is based on a 12 month school year including summer camp and **100% tuition will be charged September through June**. Winter Break, Mid-Winter Break and Spring Break months are **NOT** discounted. June may or may not be discounted depending on when the school year ends. 10% sibling discount applies to base tuition only.

_____ 3. *(For subsidized families)* My copayment amount is determined by the organization and is subject to change. I understand that I am responsible for payment of care not covered by the funding source and my copayment for care is payable in advance. My funding organization is (circle one) DSHS _____ City of Seattle

_____ 4. *(For subsidized families)* **Written proof of coverage is required before care can begin. If proof cannot be obtained prior to enrollment, you must pay in advance for your child's care.** You must be allocated full-time hours from your subsidy organization to get full time care during school breaks, in-service days, other school closures and summer camp. If you are only allocated half-time care your child may only attend for half a day. **For city subsidy families**, additional fees will be charged for full day care during school breaks, and may be charged for in-service days, and other school closures.

_____ 5. *(For subsidized families)* **DSHS** - Absences may not exceed five (5) per month.
City - Absences may not exceed ten (10) per month. Children with excessive absences will be asked to leave the program.

_____ 6. My child will attend CDSA (*circle days of the week*): 5 days or 3 days ONLY

Before School Only	MON	TUE	WED	THU	FRI
After School Only	MON	TUE	WED	THU	FRI
Before and After	MON	TUE	WED	THU	FRI

_____ 7. CDSA provides optional care on in-service days, early dismissal, and other school closure days. Optional care may not part of your regular tuition and is provided at an additional fee to be paid in advance of the care. Drop in care is also available at an additional fee.

_____ 8. Refunds are not given for sick days, snow days, natural disasters or other unscheduled absences.

_____ 9. I agree that should I need to make a schedule change or cancel childcare needs that I submit a **Schedule Change Form no later than the 20th of the month preceding the change** and I agree that tuition will not be refunded within the month following the date notification of a change was made.

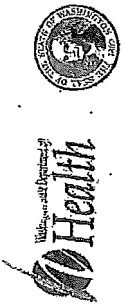
_____ 10. Child(ren) must be picked up by 6 p.m. Beginning at 6:01 p.m., a \$5.00 late charge will be assessed for the first five minutes and then a \$1.00 for every minute thereafter payable to CDSA the same day.

_____ 11. (Optional) I agree to receive my monthly tuition invoice via email

Signature _____ Date _____

How did you hear about CDSA?

- Flier mailed to my home
- Flier came home with my child, from Seattle Public Schools
- Roadside Banner or Lawn Sign
- Internet/Web Site
- CDSA Employee _____
- CDSA Parent _____
- Other _____



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: _____ **First Name:** _____ **Middle Initial:** _____ **Birthdate (mm/dd/yyyy):** _____ **Sex:** _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature Required _____ **Date** _____

Office/Use Only: _____ **Date:** _____

Signed/Certified/Exemption on file? Yes No

I certify that the information provided on this form is correct and verifiable.

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. Mark option 1, 2, 3, OR 4 below - see, back #5.

- 1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry. Must be marked by printout (not by hand) to be valid.
- 2) Chickenpox disease verified by Health Care Provider (HCP). If you choose this box, mark 2A OR 2B below.
- 2A) Signed note from HCP attached OR 2B) HCP signed here and print name below:

Licensed health care provider (HCP) Signature _____ Date _____ (MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

- 3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry. If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

- 4) Chickenpox disease verified by parent*. If you choose this box, fill in the date or child's age when he or she had the disease: _____ Age/Date of disease: _____
- *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box: _____
Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. Signed lab report(s) MUST also be attached.

- Diphtheria Mumps Other: _____
 Hepatitis A Polio
 Hepatitis B Rubella
 Hib Tetanus
 Measles Varicella

Licensed health care provider (HCP) Signature _____ Date _____ (MD, DO, ND, PA, ARNP)
HCP Printed Name: _____

Vaccine	Dose	Month	Day	Year
◆ Polio (IPV, OPV)	1			
	2			
	3			
	4			
◆ Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)	1			
	2			
◆ Varicella (chickenpox), or verify disease 1-4	1			
	2			
◆ Hepatitis A (Hep A)	1			
	2			
◆ Meningococcal (MCV, MPSV)	1			
◆ Human Papillomavirus (HPV)	1			
	2			
	3			

Vaccine	Dose	Month	Day	Year
◆ Hepatitis B (Hep B)	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens	1			
	2			
◆ Rotavirus (RV1, RV5)	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)	1			
	2			
◆ Haemophilus influenzae type b (Hib)	1			
	2			
	3			
	4			
◆ Pneumococcal (PCV, PPSV)	1			
	2			
	3			
	4			

Office/Use Only: Immunization information updated and verified with parent/guardian permission.

Printed Staff Name _____ Date _____
 Printed Staff Name _____ Date _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. Be sure to review all the information, sign and date the CIS in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record; so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

Vaccine	Dose	Month	Day	Year
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as DTaP, Hepatitis B as Hep B, and Polio as IPV.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, use only one of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you CANNOT use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and attach signed lab reports.

#7 Be sure to sign and date the CIS in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine-Trade Names in alphabetical order: (<http://www.cdc.gov/vaccines/pubs/printbook/downloads/appendices/B/us-vaccines-508.pdf>)

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
Acell-HB	Hep B	Epil	IPV	Pentavalent	DTaP + Hep B + Hib	InfHib	DTaP + Hib
Adacel	Tdap	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Triptedia	DTaP
Afluria	Flu (TIV)	Kinaxx (Kinig)	DTaP + IPV	ProQuad (PROB)	PCV or PCV7 or PCV13	Twinnix (Twinn)	Hep A + Hep B
Boostrix	Flu (LAIV)	Menactra	MCV or MCV4	Quadriacel (Quad)	MMR + Varicella	Vaqta	Hep A
Cervarix	HPV2	Menomune	MPSV or MPSV4	Recombivax HB	DTaP + IPV	Varivax	Varicella
Cornvax (Cmva)	Hep B + Hib	Pediarix (Pedr)	DTaP + Hep B + IPV	Rotarix	Hep B		
Daptacel	DTaP	Pentacel (Pent)	Hib	Rotavirus (RV1)			
Decavac	Td		DTaP + Hib + IPV	Rotavirus (RV5)			

Vaccine-Abbreviations in alphabetical order: (<http://www.cdc.gov/vaccines/pubs/printbook/downloads/appendices/B/us-vaccines-508.pdf>)

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus, acellular Pertussis	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	MMR / MMRN	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	OPV	Oral Poliovirus Vaccine	Polio	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	IG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

Reference Guide

Community Day School Association

Celebrating Quality Childcare Since 1977



Community Day School Association (CDSA)
5333 15th Ave S, Suite 1L
Seattle, WA 98108
206-726-7972
communitydayschool.org

"Discovering and Cultivating the Best in Each Child"

Dear CDSA Family,

As a part of the **Child and Adult Care Food Program (CACFP)**, CDSA is able to be reimbursed for a portion of the meal costs for all children in our programs. **This program allows us to provide quality snacks for your children while at the same time helping us to be able to keep other things like tuition costs low for our families.** Please help to continue participating in this program by completing the attached Enrollment/Income Eligibility Application (E/IEA), regardless of income, when you enroll your child. If you have any questions about the application, please speak directly with your Center Director, call the administration office or refer to pages 12 &13 in the Family Information Guide.

Sincerely,



Brianna Jackson

Director of Operations
Community Day School Association

Child and Adult Care Food Program ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 - CHILDREN'S INFORMATION—Required for all children in care												
Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care				Circle Meals and Snacks Normally Received					
			Sun	Mon	Tu	Wed	Th	Fri	Sat	Breakfast	A.M. Snack	Lunch
			Normal Hours _____ to _____				P.M. Snack	Supper	Eve. Snack			
			Normal Hours _____ to _____				Breakfast	A.M. Snack	Lunch			
			Normal Hours _____ to _____				P.M. Snack	Supper	Eve. Snack			
			Normal Hours _____ to _____				Breakfast	A.M. Snack	Lunch			
			Normal Hours _____ to _____				P.M. Snack	Supper	Eve. Snack			

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)
- One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.		
Name	Circle One	Case Number or Identification Number
	Basic Food TANF FDPIR	

PART 3 - FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children	

PART 4 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2				
List Names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month (if None, Write "0") (or net income if self-employed)			
	Earnings from Work Before Deductions	Alimony, Child Support, Welfare	Retirement, Pensions, Social Security	Job Two or Any Other Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PART 5 - SIGNATURE AND CERTIFICATION - REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.

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

Signature of Adult	Date	Print Name of Adult Signing	<input type="checkbox"/> I do not have a Social Security Number
		Social Security Number (last four digits) XXX-XX-	
Address		City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, gender, age, or disability.

Race:

- White
- Black or African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Pacific Islander
- Multi-Racial

If you feel you have been discriminated against, you should write USDA, Director of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410.

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires that, unless a household member's Basic Food, TANF, or FDPIR case number is provided or you are applying on behalf of a foster child, you must include the last four digits of the Social Security Number of the adult household member signing the application, or indicate that the household member does not have a Social Security Number. Provision of the last four digits of the Social Security Number is not mandatory, but if the last four digits of the Social Security Number is not provided or an indication is not made that the signer does not have a Social Security Number, the application cannot be approved in the free or reduced-price category. This notice must be brought to the attention of the household member whose last four digits of the Social Security Number is disclosed. The last four digits of the Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Basic Food or welfare office to determine current certification for receipt of Basic Food or TANF benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY

- Check one: Free Category
 Reduced-Price Category
 Above-Scale Category

Total Monthly Income \$ _____

This form must be signed and dated by the institution's representative.

Signature of Institution's Representative _____

Date _____

Standardized Client Demographic Data Collection Form

For use in School Year 2011-2012

Agency

Community Day School Association (CDSA)

0000012243

Client Instructions: Please neatly enter numbers or make an **X** in the appropriate boxes to answer the questions. Please note your name is not a part of this survey so that your identity is totally confidential.

I. Geographic Region:

1. What is the Zip Code where you live:

Homeless – formerly from ZIP and/or City

2. City Name _____
(if not in a city, write in "Unincorporated")

Unknown

II. Household Composition

1. Number of people living in your household
(including yourself)

Unknown

2. Number of children under 18

Unknown

3. If you are in a single parent household, is the head of the household male or female?

- Male (1)
- Female (2)
- Unknown (9)

III. Household Income Level

1. What is the total gross yearly income for your household, based on King County HUD guidelines? (See Attachment)

- Under 30% of Median Income (1)
- Under 50% of Median Income (2)
- Under 80% of Median Income (3)
- Equal or Above 80% of Median Income (4)
- Unknown (9)

IV. Living Situation

1. Are you Homeless?

- Yes (1)
- No (0)
- Unknown (9)

If homeless "Yes",

2. How many times have you been homeless in the past three years?

Number of times Unknown

3. How long have you been homeless this last time?

Number of months Unknown

V. Age Group

1. What is your child's age at intake?

Number of Years

Age Unknown

VI. Gender

1. Please check one of the following

- Female (1)
- Male (2)
- Transgendered (3)
- Other (4)
- Unknown (9)

VII. Persons with Disabilities

1. Do you consider yourself to be a person with a disability?

- Yes (1)
- No (0)
- Unknown (9)

VIII. Hispanic/Spanish/Latino

1. Are you Spanish/Hispanic/Latino?

- Yes (1)
- No (0)
- Unknown (9)

(Continued on Page 2)

IX. Race

1. What is your race? (Check all that apply)

- a.
 - American Indian (U.S. Tribe)
 - Alaska Native, Aleut, Eskimo
 - Indigenous to Americas (Other than U.S.)
- b.
 - Asian Indian
 - Cambodian
 - Chinese, Except Taiwanese
 - Filipino
 - Japanese
 - Korean
 - Vietnamese
 - Other Asian
- c.
 - Indigenous African/Black
 - African American/Black
 - Other Black
- d.
 - Hawaiian Native
 - Polynesian (Samoan, Tongan, Other)
 - Micronesian (Guamanian/Chamorro, Other)
 - Other Pacific Islander
- e.
 - Arab/Iranian or Middle Eastern
 - Other White/Caucasian
- f.
 - Other
- g.
 - Unknown

X. Refugee/Immigrant

1. Are you an immigrant or refugee or new arrival to this country?

- Yes (1)
- No (0)
- Unknown (9)

XI. Limited English Proficiency

1. Are you limited in your ability to communicate in English?

- Yes (1)
- No (0)
- Unknown (9)

XII. Employment Status at Intake

1. Are you currently employed?

- Yes (1)
- No (0)
- Unknown (9)

XIII. Educational Level Adults (for adults only)

1. What is the highest grade or degree that you have achieved?

- Less than High School graduate (1)
- High School diploma or GED (2)
- Some college—no degree or certificate (3)
- Certificate from business school or other professional program (4)
- Associates Degree (5)
- Bachelors Degree or above (6)
- Child under 18 (7)
- Unknown (9)

XIV. Veterans/Military Status

1. Have you ever served on active duty in the U.S. military (including National Guard or Reserves)

- Yes (1)
- No (0)
- Unknown (9)

XV. Program

1. In what program is your child enrolled?

- Pre-K (1)
- School Age (2)
- Unknown (9)

XVI. Language

1. Other than English, please list other languages spoken in your home.

Thank you for your cooperation. Individual responses will be kept completely confidential at all times



United Way of King County

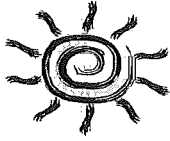
2010 - 2011 HUD Income Categories

Instructions: Find the column for the number of people in your household. Go down that column until you find the income range for your annual gross income last year. Look to the left to see what that row is labeled. That is your income category.

Household → ↓ Category	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
<u>Category A.</u> Very Low. 30% HUD PMSA	Up to \$18,250	Up to \$20,850	Up to \$23,450	Up to \$26,050	Up to \$28,150	Up to \$30,250	Up to \$32,350	Up to \$34,400
<u>Category B.</u> Low. 50% HUD PMSA	\$18,251 to \$30,400	\$20,851 to \$34,750	\$23,451 to \$39,100	\$26,051 to \$43,400	\$28,151 to \$46,900	\$30,251 to \$50,350	\$32,351 to \$53,850	\$34,401 to \$57,300
<u>Category C.</u> Moderate. 80% HUD PMSA	\$30,401 to \$44,950	\$34,751 to \$51,400	\$39,101 to \$57,800	\$43,401 to \$64,200	\$46,901 to \$69,350	\$50,351 to \$74,500	\$53,851 to \$79,650	\$57,301 to \$84,750
<u>Category D.</u> Above Moderate. Above 80% HUD PMSA	\$44,951 or More	\$51,401 or More	\$57,801 or More	\$64,201 or More	\$69,351 or More	\$74,501 or More	\$79,651 or More	\$84,751 or More

Note:

- FY 2011, Washington State Median 4-Person Family Income = \$81,684
- HUD (U.S. Department of Housing & Urban Development)
- PMSA (Primary Metropolitan Statistical Areas)



Sunscreen Authorization Form (Program-Provided/Bulk Sunscreen)

Child's Name:	Date of Birth & Age: (Do not apply on infants 6 months & younger without written permission from health care provider)
Start Date:	Stop Date: (up to 6 months after 'start date')
Times to be Applied:	Special Instructions:

I authorize the use of the following "program-provided" sunscreen on my child.

Parent/Guardian Signature

Date

Daytime Phone Number

Program-Provided Sunscreen *(to be completed by child care provider)*

Name of Sunscreen & SPF:	Active Ingredients:
Possible Side Effects:	Other Label Information:

Reason for medication: Protection from sun
Amount to be given: Cover exposed areas of skin
Route: Topical
Storage: Room temperature

