



Jasmin Child Care and Preschool

WELCOME| SOO DHAWOO| KARIBU| أهلا

Welcome to Jasmin! Whether you are a new or returning family, we are excited to welcome you and take this opportunity to provide your child with the highest quality care. As part of the enrollment process, Jasmin is required to obtain additional information about your child and family. Our center director or program supervisor can answer any questions you may have and provide any additional forms that may need to be completed.

COMPLETED APPLICATION AND ALL REQUIRED DOCUMENTATION MUST BE RECEIVED BEFORE STARTING

REQUIRED ENROLLMENT FORMS:

- Release of Information Authorization for Families Receiving Child Care Assistance
- Family Survey (information will not be shared with any agency and is for internal use)
- CACFP Program Income Eligibility Form
- Child Information Form
- Parent Statement of Health (completed annually)
- Privacy Policy
- Emergency Transportation Permission Agreement
- Infant Sleep Permission Form completed for children under two years.
- Signed Copy of Parent Handbook on Center Policy and Procedures
- Signed Care Agreement
- PRESENT IDENTIFYING DOCUMENT OF CHILD** (Birth Certificate/Passport/SSN etc.)
- CHILD IMMUNIZATION RECORDS**
- Care Plan (children with medical conditions)



New Family Survey

Name: _____

Date: _____

1. **Ethnicity:** Are you Hispanic? Yes No

2. **Race**

Black/African American White Asian/Asian Pacific Islander

Indigenous American

3. **Immigration Status?**

Resettled – how many years? _____ Green card Holder Citizen

4. **Household size** (number of people in your family including you) _____

5. **Single-parent household?** Yes No

6. **Child Care Assistance Program Participant?** Yes No

7. **English Proficiency?** Good Limited

8. **Employment Status** Full-time (40+ hours) Part-time (less than 40 hours)

9. **Hourly Wage** \$15 and above under \$15

10. **Schedule** 1st shift (7am-5pm) 2nd shift (4pm-1am) 3 shift (11pm-7am)

Dear Family:

Our center has been approved for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses the center for the partial cost of meals. Participation in the CACFP enables us to keep our fees lower as well as serve nutritious meals to children in our program.

The parent/guardian must complete Parts 1 and 4 Part 2 and Part 3 are optional however, if you feel you qualify for either free or reduced-priced meals, those parts are used to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our files and treated as confidential information. **Note: no white out or erasure should be used. If there is an error cross through, correct, and initial.**

Part 1 FOR CHILD ENROLLMENT:

- **CHILD'S NAME:** List the first and last name of all children enrolled at this center.
- **DATE OF BIRTH:** List each child's date of birth.
- **TIMES OF CARE, DAYS OF CARE and MEALS SERVED:** List the regular times of care for each child by listing their arrival time and leave time, check each day the child will be in care and check each meal type received while in care.
- **FOSTER CHILD, MIGRANT OR HEAD START:** If the child is a foster child (the legal responsibility of a foster care agency or the court), Migrant or Head Start check the box.

Part 2 FOR A HOUSEHOLD RECEIVING BENEFITS FROM THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), TEMPORARY ASSISTANCE FOR FAMILIES (TANF), OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR):

- Complete Parts 1, 2 and 4.
- Provide the name and case number for the program from which benefits are received.

Part 3 FOR ALL OTHER HOUSEHOLDS:

- Complete Parts 1, 3 and 4.
- **HOUSEHOLD NAMES:** Write the names of everyone in your household not listed in Part 1. Include yourself and all other children, your spouse, grandparents, other relatives and unrelated people in your household. Use a separate sheet of paper if you do not have enough space.
- **GROSS INCOME BEFORE DEDUCTIONS:** Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see list below). Next to the amount of income write how often the income was received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.
 - OTHER INCOME:** strike benefits, unemployment compensation, worker's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trust/investments, royalties/annuities/rental income, and regular contributions from persons not living in the household.
 - MILITARY HOUSING BENEFITS:** Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
 - MY SPOUSE IS DEPLOYED TO A COMBAT ZONE.** If the combat pay is received in addition to their basic pay because of their deployment and it wasn't received before they were deployed, combat pay is not counted as income. Contact your school for more information
 - SELF-EMPLOYMENT:** Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.
- **SOCIAL SECURITY NUMBER:** Write the last four (4) digits of the social security number of the adult household member who signs the form. If the adult household member does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

For School Year 2023-2024

Household Size	1	2	3	4	5	6	7	8	Each Additional Person:
Yearly	\$26,973	\$36,482	\$45,991	\$55,500	\$65,009	\$74,518	\$84,027	\$93,536	\$9,509
Monthly	\$2,248	\$3,041	\$3,833	\$4,625	\$5,418	\$6,210	\$7,003	\$7,795	\$793
Weekly	\$519	\$702	\$885	\$1,068	\$1,251	\$1,434	\$1,616	\$1,799	\$183

Part 4 SIGNATURE AND CONTACT INFORMATION:

- Sign and date the application. The form must be signed by the parent or guardian.
- Complete the contact information – name, address, telephone number, and employer information.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. fax:
(833) 256-1665 or (202) 690-7442; or
3. email:
program.intake@usda.gov

This institution is an equal opportunity provider.

STEP 1 REQUIRED The parent / guardian must complete Parts 1 and 4. List ALL Children who attend day care

CHILD's	Last Name, First Name	Date of Birth	Time of Care		Regular Days of Care							Meals Served During Care							
			Arrival Time	Leave Time	M	T	W	T	F	S	S	B	AM	L	PM	D	EV		

Check all that apply

Foster Child	Migrant	Head Start

PARENTS OF INFANTS Your child care center must offer at least one brand of formula if your child is on formula. You have the option of declining that brand and supplying your own formula. Children must be served breast milk or iron-fortified infant formula until they are one year of age. All other food items must be provided by your center when age-appropriate, consistent with CACFP guidelines.

My Choice of CACFP Infant Participation is:

I choose to supply expressed breast milk to my child care provider to serve at meal time.

I choose to accept the iron-fortified infant formula (brand: _____) that my child care center has offered.

My child care center has offered the following brand, _____. I have chosen to decline this brand and provide the formula for my infant.

STEP 2 Optional Do any household members (including you) currently participate in one or more of the following assistance programs: **SNAP TANF, or FDIPIR?**

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3) **CASE NUMBER:** _____ Write only one case number in this space.

STEP 3 Optional Parent / guardian should fill out household income to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our confidential files.

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income
 Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income: \$ _____ How often? Weekly Bi-Weekly Monthly Bi-Monthly

B. All Other Household Members (Including yourself)
 List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members not listed in Step 1 (Last Name, First Name)	Earnings from Work	How often?				Welfare/Child Support/Alimony	How often?				Pensions/Retirement/Social Security/SSI/VA Benefits	How often?			
		Weekly	Bi-Weekly	Monthly	2xMonth		Weekly	Bi-Weekly	Monthly	2xMonth		Weekly	Bi-Weekly	Monthly	2xMonth
	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	\$ _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Household Members (Children and Adults) _____ Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member: _____ (Mark if No Social Security Number)

STEP 4 REQUIRED Sign and date the application. The form must be signed by the parent or guardian.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form	Signature of Adult	Today's Date
Address	City	State
	Zip	Phone/Email

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages
Social Security <ul style="list-style-type: none"> - Disability Payments - Survivors Benefits 	<ul style="list-style-type: none"> A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	<ul style="list-style-type: none"> A friend or extended family member regularly gives a child spending money
Income from any other source	<ul style="list-style-type: none"> A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	Public Assistance/Alimony/Child Support	Pensions/Retirement/All other sources of income
<ul style="list-style-type: none"> Salary, wages, cash bonuses Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

<p>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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.</p>	<p>In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.</p> <p>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, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:</p> <p>MAIL*: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410</p> <p>FAX: (833) 256-1665 or (202) 690-7442; or EMAIL: program.intake@usda.gov.</p> <p><i>*Only use this address if you are filing a complaint of discrimination.</i></p> <p><i>This institution is an equal opportunity provider.</i></p>
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DO NOT FILL OUT 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	How often?	Household size	Eligibility															
<input type="text"/>	<table border="1" style="font-size: small;"> <tr> <td>Weekly</td> <td>Bi-Weekly</td> <td>Monthly</td> <td>2xMonth</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	Weekly	Bi-Weekly	Monthly	2xMonth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<table border="1" style="font-size: small;"> <tr> <td>Free</td> <td>Reduced</td> <td>Denied</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	Free	Reduced	Denied	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Categorical Eligibility <input type="checkbox"/>
Weekly	Bi-Weekly	Monthly	2xMonth															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>															
Free	Reduced	Denied																
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>														
Determining Official's Signature	Date	Confirming Official's Signature	Date	Follow-up Official's Signature														
				Date														

**AUTHORIZATION TO DISCLOSE INFORMATION**

ND DEPARTMENT OF HUMAN SERVICES

LEGAL SERVICES

SFN 1059 (Rev. 05-2003)

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

INSTRUCTIONS: Provide information as it existed when the service was provided.

Name of Client: (Last, First, Middle Initial)	Social Security Number:	Date of Birth:	
Street Address:	City:	State:	Zip Code:

CLIENT RELEASE AND SIGNATURE**1. I Hereby Authorize:**

Name of Person/Agency:

Street Address:	City:	State:	Zip Code:
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2. To Release Information To:

Name of Person/Agency to Receive Information:

Street Address:	City:	State:	Zip Code:
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3. The Following Information Is Requested: (Be Specific)

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4. The Information Identified Above Will Be Used For: (List Each Purpose)

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5. This Authorization to Disclose Information Remains in Effect Until: (Date)

OR: (Specific Event Terminating Operation of the Release)

CLIENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Client:	Date:
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Signature of Parent/Guardian or Custodian (if needed and Relationship):	Date:
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Signature of Witness (if needed):	Date:
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CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS
 This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

DISTRIBUTION: To agency/person from whom information is sought Client
 Requesting Agency Other

RAHODA CLM1



Privacy Permission Agreement

Our priority is to protect your child's health and safety. We also wish to protect your family's privacy. We may take photos and videos at our events to showcase children's involvement in activities they have participated in and or completed. We share photos and videos in our magazines, websites, blogs, or social media (like Twitter, Instagram, or Facebook) to promote our center and our mission as a non-profit organization. This includes the following:

- Placing photos of your child around the center.
- Use photos of your child in photo albums for viewing by prospective clients.
- Using photos of your children in our marketing flyers.
- Post your child's artwork and other projects with your child's name around the center.
- Use your child's photo or name in our newsletter, bulletin board, and website.

Parent or legal guardian's signature

Date of signature

Parent or legal guardian's signature

Date of signature

RHODA CLIMA

Director's signature

Date of signature



Jasmin Child Care

Emergency Transportation Permission Agreement

I hereby give permission for ___Jasmin Child Care and Preschool___ child care program to transport my child, _____, to an emergency relocation site for staff, teachers and children when it is unsafe to remain at the child care facility. I understand that normal safety rules will be followed, as much as possible, but that the highest priority is to relocate to a safe location.

This agreement shall remain in effect until _____.
The agreement may be terminated before this by either party but only with written notification.

Parent/Guardian Printed Name

Home Address

Phone

Special considerations for emergency transportation:

Parent or Guardian

Date





Jasmin Child Care and Preschool

Infant Sleep Permission Form

The American Academy of Pediatrics recommends keeping soft objects and loose bedding (including blankets) out of the crib/playpen to reduce the risk of SIDS, suffocation, entrapment, and strangulation for infants under the age of 12 months. The AAP recommends the use of pacifiers for sleep. Studies have reported a protective effect of pacifiers on the incidence of SIDS. The pacifier is not recommended to be attached to the infant's clothing or to a stuffed animal/toy. The pacifier should be checked for tears before each use.

Effective January 1, 2013, ND Child Care Licensing Regulations state:

With written parental permission, the provider may place one individual infant blanket or sleep sack, a pacifier, and a security item that does not pose a risk of suffocation to the infant in the crib or portable crib while the infant is sleeping or preparing to sleep.

Parent/Guardian Authorization

I have read the information on this form and give _____
Print Name or Provider/Program

permission to use the following checked item(s) when my infant _____
is sleeping or preparing to sleep: *Print Infant's Name*

One infant blanket (a thin blanket is recommended)

- If infant is being swaddled, the blanket should not come any higher than to the shoulders of the infant; blanket needs to be loose enough for a hand to fit between the blanket and the infant's chest; blanket should be kept loose around infant's hips.

Pacifier

Security item (specify item) _____

Name of Parent/Guardian (please print) _____

Parent/guardian Signature _____ Date: _____

Sources:

Caring for Our Children National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care, 3rd Edition, 2011

ND Child Care Licensing Regulations

Technical Report -SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment", AAP, Pediatrics 2011

Policy Statement – SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment", AAP, Pediatrics 2011

AAP News

Jasmin Child Care

By signing this contract, parents/guardians and provider agree to abide by the written policies as stated in this handbook.

Director's Name

RHODA ELMAS

Director's Signature

Date_____

Parent's Name

Parent's Signature

Date_____

Parent's Name

Parent's Signature

Date_____



Care Agreement

Child's name:		First	Middle	Last					
Parent or guardian name:		First	Middle	Last					
Parent or guardian name:		First	Middle	Last					
Days and times my child will receive care:									
Check days of care	Sunday	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	Saturday		
Arrival time									
Departure time									
MAX 10 HOURS OF CARE PER CHILD PER DAY - OVERTIME RATE APPLIES									
Tuition Fee Per Week:			Date payment due: FRIDAY AT NOON						
			Source of payment: <input type="checkbox"/> Parent <input type="checkbox"/> Child Care Assistance Program						
Overtime rate: \$8 PER HOUR OVER 10 HOURS OF CARE				Late fee: \$1.00 PER MINUTE AFTER 5:30PM					
Other Fees: \$ 5.00 PER DIAPER / WIPE			Description: - IF DIAPER AND WIPES ARE NOT SUPPLIED AFRER NOTICE						
\$150 Registration & Activities Fee			- YEARLY REGISTRATION AND ACTIVITIES FEE PER CHILD						
<p>I have received, read, understand and agree to comply with the policy and procedures and information given and stated in the Parent Handbook provided to me. I understand that I am fully responsible for the terms of this agreement as stipulated. I acknowledge and understand:</p> <ul style="list-style-type: none"> • I agree to promptly notify the child care provider of any changes of the above information. • I agree to provide a 2 week notice to leave the program. • I am responsible for the remaining balance of tuition that CCAP does not cover as result of, but not limited to, my attendance or changes to my approval status(Full-time/Part-time). • All families participating in CCAP are required to complete and sign the Authorization to Disclose allowing Jasmin Child Care and Preschool to community with ND DHS strictly regarding their CCAP. • I agree to provide my employment schedule prior to starting and when requested. 									
Parent or guardian signature			Date		Parent or guardian signature			Date	
I agree to provide child care services according to the above plan. I agree to promptly notify the parents or guardians of any changes to above information.									
Licensee signature <i>RHODA ELMA</i>							Date		
Street address			City		State		Zip code		
4720 7th Ave South Suite E			Fargo		North Dakota		58103		
Comments									



Child's Name: _____

Date of Birth: _____

I have read, understand, and discussed with my child:

1) My child will travel in a motor vehicle driven by an adult and my child is to wear their safety belt during travel;

(2) My child is expected to listen to supervising staff/driver, respect staff and other children, the vehicles they ride in, and the people they travel with during the trip;

(3) Riding in a motor vehicle may result in personal injuries or death from wrecks, collisions or acts by riders, other drivers, or objects; and,

(4) My child is to remain in their seat and not be disruptive to the driver of the vehicle.

Initial Each Statement

_____ I recognize participation in this activity, as with any activity involving motor vehicle transportation, my child may risk personal injury or permanent loss. I hereby attest and verify I have been advised of the potential risks, and I have full knowledge of the risks involved in this activity, and I assume any expenses incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.

_____ As a condition for the transportation received, I, for myself, my child, my executors and assigns, further agree to release and forever discharge Jasmin Child Care and Preschool, and their agents, officers, employees and volunteers from any claim that I might have myself or that I could bring on my child's behalf with regard to any damages, demands or actions whatsoever, including those based on negligence, in any manner arising out of this transportation.

_____ I have read this entire waiver and authorization form, I fully understand its terms and conditions, and I agree to be legally bound by its terms.

Parent Name: _____

Parent Signature: _____