

CHILD INFORMATION		Enrollment Date:	
Child's Name:		Gender:	Date of Birth:
Ethnicity: ___ Non-Hispanic ___ Hispanic Race: ___ White ___ Black/African American ___ Asian ___ American Indian/Alaskan Native ___ Pacific Islander			
Child's Name:		Gender:	Date of Birth:
Ethnicity: ___ Non-Hispanic ___ Hispanic Race: ___ White ___ Black/African American ___ Asian ___ American Indian/Alaskan Native ___ Pacific Islander			
Child's Name:		Gender:	Date of Birth:
Ethnicity: ___ Non-Hispanic ___ Hispanic Race: ___ White ___ Black/African American ___ Asian ___ American Indian/Alaskan Native ___ Pacific Islander			
Child's Home Address:			
Typical Days & Hours of Attendance:			
Language(s) Spoken in the Home:			
School Child will attend other than Neighborhood House (if any)			
PARENT / GUARDIAN INFORMATION		U.S./Naturalized Citizen Yes No	Authorized to Pick Up Yes No
Name:		Home Phone:	
Relationship to Child:		Cell Phone:	
Address:			
Employer:		Work Phone:	
Email address:		Would you like to receive notifications through: Email Text message	
PARENT / GUARDIAN INFORMATION		U.S./Naturalized Citizen Yes No	Authorized to Pick Up Yes No
Name:		Home Phone:	
Relationship to Child:		Cell Phone:	
Address:			
Employer:		Work Phone:	
Email address:		Would you like to receive notifications through: Email Text message	
EMERGENCY CONTACTS & PERSONS AUTHORIZED TO PICK UP CHILD (other than Parent/Guardian)			
Name:	Relationship to Child	Cell Phone: Work Phone:	
Name:	Relationship to Child	Cell Phone: Work Phone:	
Name:	Relationship to Child	Cell Phone: Work Phone:	
OUT OF STATE CONTACT FOR EMERGENCIES			
Name:	Relationship to Child	Phone:	

HOUSEHOLD / FINANCIAL INFORMATION		
Parent / Guardian Responsible for Payment to Neighborhood House	Social Security #	
Marital Status: Married Single		
Please list all sources of Gross Monthly Income for the Household: (income before taxes and deductions)		
Earned Income from employment for Head of Household		\$ _____
Earned Income from employment for all other household members		\$ _____
Monthly Income from child support or alimony		\$ _____
All other Income (social security, rehab, DFS, retirement, pensions, etc)		\$ _____
TOTAL MONTHLY INCOME:		\$ _____
YOU WILL BE REQUIRED TO SUBMIT PROOF OF ALL INCOME (Please provide your most recent tax return statement for income verification. If this is unavailable, please speak with administration for possible alternative options. Provide statement for all other sources of income.)		
Do you qualify for childcare assistance, such as through DWS, NACCRRRA, or your employer? Yes No		
Are you receiving any of the following state assistance: Food stamps Housing Medical Financial		
For statistical purposes, please circle one of the following regarding your housing: Rent Own Temporary		
Total Number of Household Members	Total Children	Total Adults
Please list other dependents living in the home who will NOT be entering Neighborhood House		
Name	Date of Birth	Relationship to Child
Have you ever had children attend Neighborhood House in the past?		
If yes, name of child	Year(s) of Attendance	
Do you have an outstanding balance owed to Neighborhood House? Yes No Unsure		

This form will need to be reviewed with updated information provided annually.

Parent/Guardian Signature _____

Date _____

Child Health & Nutrition Information (Please complete one for each child)	
Child's Name:	Date of Birth:
Does your child have any known allergies or sensitivities to food, medications, or other? Yes No If yes, please explain:	
Does your child have any special dietary needs that are based on cultural, religious, ethical, medical needs, or personal preference?	
Has your child been diagnosed with any of the following: Please check any that apply <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Heart Problems <input type="checkbox"/> Hearing Impairment/Chronic Earaches/Tubes <input type="checkbox"/> Visual Impairments/Glasses <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Physical Impairment <input type="checkbox"/> Behavioral or Emotional Problems <input type="checkbox"/> Other 	Do you have any concerns about your child: Please check any that apply <ul style="list-style-type: none"> <input type="checkbox"/> Speech and Language <input type="checkbox"/> Emotional or Behavioral <input type="checkbox"/> Ability to Learn <input type="checkbox"/> Physical Impairment <input type="checkbox"/> Eating Difficulties <input type="checkbox"/> Other: Please explain
List any additional health information, special instructions, or requested accommodations we should be aware of:	
Does your child take any medications regularly? Does this medication need to be administered during hours your child will be in our care?	
Is your child completely toilet trained?	
Is your child currently receiving any special education services, early intervention or on an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)? If yes, where?	
Child's primary doctor or health clinic: Phone Number: _____ Date of last physical: _____ Preferred Hospital or Emergency Care location: _____	
Child's dentist or dental clinic: Phone Number: _____ Date of last visit: _____	
Medical/Dental Insurance Provider <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Private with whom? Medical Insurance ID# _____ Dental Health ID# _____	

Please provide copies of medical instructions from your doctor for any special dietary or medical accommodations.

Parent/Guardian Signature _____ Date _____

Please review this form annually and note any changes, then sign below

Parent/Guardian Signature _____ Date _____

Consent Form		
Child Name: _____		
I authorize Neighborhood House staff to administer First Aid/CPR to my child as needed and to obtain and provide emergency medical care and transportation should it become necessary. I understand that I or my insurance, if applicable, will be billed for such emergency medical treatment.	Yes	No
I give permission for Neighborhood House staff to administer medication to my child. I understand I need to complete a medication release form for all medications.	Yes	No
I give permission for Neighborhood House staff to assist as needed in applying lotions, sunscreen, insect repellent, diaper cream, lip balm, toothpaste, or other preventatives.	Yes	No
I give permission for my child to be transported by Neighborhood House.	Yes	No
I give permission for my child's photos/video to be used for publicity purposes.	Yes	No
I understand that Neighborhood House may utilize the assistance of consultants, evaluators, and/or early childhood experts to observe in our classrooms and help to support better classroom practices and development of children. I also understand that Neighborhood House serves as a learning site for college students entering the field of early childhood education and that college students may be observing or assisting in the classroom. I give permission for my child to be present during these observations and for the observer to discuss their observations with Neighborhood House staff.	Yes	No
I understand Neighborhood House staff will conduct regular developmental and learning assessments regarding my child to help guide classroom curriculum and teaching strategies.	Yes	No
I give permission for Neighborhood House to discuss information regarding my child and share my child's educational records as needed with the following school _____, and/or with the following relevant provider, agency, counseling service, or other service of my choice:	Yes	No
I have read and understand the Neighborhood House Parent Handbook	Yes	No

I have answered the questions on this application truthfully. I understand that it is my responsibility to notify the administrator or administrative assistant of Neighborhood House of any updates in the information I have provided on this application.

Parent/Guardian Signature _____

Date _____

Food Allergies/Intolerances:

For milk allergies, medical documentation describing the dietary restrictions due to the food allergy and/or intolerance is needed from the participant's physician. There are other restrictions that may also require documentation from a doctor—you will be notified if this is necessary.

CHECK ALL THAT APPLY:

Does your child have any known allergies or sensitivities to food? Yes No

Is your child a vegetarian? Yes No

Food Allergy(s): Dairy Soy Eggs Wheat

Peanuts Pork Beef Fish/Shellfish

Other, please list: _____

Food intolerance: Gluten (Celiac disease or non-celiac gluten sensitivity, includes wheat, barley, oats, rye)

Lactose Other, please specify _____

Types of contact that will cause a reaction: Airborne Trace-cross-contact

Actual ingestion of food Other

Please explain reaction: _____

Other special dietary needs or restrictions (ex. Diabetes, IBS, religious beliefs, etc.) please explain:

Please provide either parent phone number or email, whichever is the best way to contact you

Phone number: _____

Email address: _____



State of Utah
Department of Workforce Services
Office of Childcare
ELIGIBILITY FORM

Child Name: _____
Date of Birth: _____
Parent(s) Name: _____
Address: _____

Phone Numbers: _____
Neighborhood School: _____

For Office Use Only	
Is child eligible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If child is eligible, under which criteria:	<input type="checkbox"/> Economically disadvantaged + risk factor
	<input type="checkbox"/> English Learner
	<input type="checkbox"/> Both

1. Is your child eligible for Kindergarten (5 years-old on or before September 1st, 2020)?

Yes No

If you selected no, please continue to complete the form

2. Is your child eligible for free or reduced priced lunch?

Yes No I don't know

3. Is your child an English Learner (learning English as a second language)?

Yes No I don't know

RISK FACTOR ASSESSMENT

Review the list below. How many of these circumstances apply to your child? (Do not mark which of these apply to your child. We only want to know how many apply).

- Child born to a mother who was 18 years old or younger
- A member of child's household is incarcerated
- Child lives in a neighborhood with high violence/crime
- One or both parents has a low reading ability
- Family has moved at least once in the last year
- Child has ever been in foster care
- Lives in a household with multiple families
- Child exposed to physical abuse or domestic violence in the home
- Child exposed to substance abuse (drugs or alcohol) in the home
- Child exposed to stressful life events (death, chronic illness or mental health issues of a parent or sibling)
- Language spoken in the home most often is NOT English
- A parent of the child did not graduate from high school

Select the number range of Risk Factors that apply to your child:

0 1-2 3-5 6-8 9-10 11-12

Affirmation: I certify that the above information is true and accurate to the best of my knowledge.

Parent Signature: _____ Date: _____

Equal Opportunity Employer/Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals who are deaf, hard of hearing, or have speech impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.



State of Utah
Department of Workforce Services
Office of Child Care

SCHOOL READINESS ELIGIBILITY RESOURCE DOCUMENT
School Year 2020-2021

Economically Disadvantaged

Locate your household size in the chart below, move across the row and find the amount your income (before deductions) is equal to or less than.

If your income is **over** the amounts listed below, your child is not eligible for free or reduced priced lunch.

Household Size	185% Federal Poverty				
	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	613
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,111	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
For each additional family member, add:	8,288	691	346	319	160

(Modified from "Children Nutrition Programs: Income Eligibility Guidelines," Federal Register Notice Vol. 85, No. 55, Friday, March 20, 2020).

English Learner Definition

According to ESSA, an EL is an individual who

- 1) is aged 3 through 21;
- 2) is enrolled or preparing to enroll in an elementary school or secondary school;
- 3) meets one of the following criteria—
 - a) was not born in the United States, or whose native language is a language other than English;
 - b) is a Native American or Alaska Native, or a native resident of the outlying areas; and comes from an environment where a language other than English has had a significant impact on the individual's level of English language proficiency (ELP); or
 - c) is migratory, whose native language is a language other than English, and who comes from an environment where a language other than English is dominant—and
- 4) has difficulties in speaking, reading, writing, or understanding the English language, that may be sufficient to deny the individual
 - a) the ability to meet the challenging state academic standards;
 - b) the ability to successfully achieve in classrooms where the language of instruction is English; or
 - c) the opportunity to participate fully in society.

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