SAM'S KID SAFARI LEARNING ACADEMY

2761 Rodeo Rd. Abbeville, La 70510 337-422-5227 Lic#60007 Provider# 030000005

Enrollment Application

Child's Full Name:____

Birthdate:__________

Address______________________________ Home Phone/Cell:____________

City:____________________State:________Zip Code:________

Mother's Full Name:____

Phone/Cell:_______________ Email:_________________________________

Address:__________________________City:_________________State:_______Zipcode:_______

(only fill address if different from child----you can put SAME if it's the same)

Occupation:______________________________________Work Phone:__________________

Name of Employer:____

Business Address:______________________________________City:______________________

Work Hours:__________________________________

Father's Full Name:____

Phone/Cell:_____________________ Email:______________________________

Address:____________________________City:______________State:_______Zipcode:_______

(Only fill address if different from child's---you can put SAME if it's the same)

Occupation:____________________________________Work Phone:________________________

Name of Employer:____

Business Address:_____________________________________City:___________________

Work Hours:__________________________

"Instilling Excellence, One Adventure At A Time!!"

Enrollment Application

Parent/Guardian with legal custody:____

Other Household Members:

Name(s) ______________________________ **Age** ___________________________ **Relationship**

Emergency Contacts

Primary Emergency Contact Other Than Parents/Guardians

Name:________________________________Home #:___________________Cell#:___________

Relationship To Child:_______________________

Address:____

Secondary Emergency Contact Other Than Parents/Guardians

Name:_________________________________Home@:__________________Cell#:___________

Relationship To Child:_________________________

Address:____

Person's Authorized to Pick up My Child(Other Than Parents/Guardian)

Name ____ **Relationship To Child**

____

____

____

"Instilling Excellence, One Adventure At A Time!!"

Emergency Release:

Consent to Emergency First Aid & Transportation:

I hereby give permission to the staff at Sam's Kid Safari LLC to give emergency treatment to my child ____________________________________. I also give permission for my child to be transported by car or ambulance to an emergency center for treatment.

Consent to Medical Care and Treatment:

In the event that I cannot be contacted immediately, medical or surgical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician.

Parent's Signature:_________________________

Date:______________

Emergency Information:

1. Child's Physician:_____________________________________
2. Preferred Hospital:____________________________________
3. Regular Medicines:____________________________________
4. Blood Type:____
5. Any & All Allergies(food, meds, etc.)
   ____
6. Any special health conditions(seizures, migraines, ADD, ADHD, etc.):____

Sam's Kid Safari Learning Academy Child Mastercard

Child's Name:____Sex:_____ Birthdate:_________

	Mother	**Father**
Name		
Address		
Employer		
Home Phone#		
Work Phone#		
Cell Phone#		
Email Address		

Person with whom the child lives:____

Child's Doctor:____________________________Doctor's Phone#___________________________

Child's Dentist:____________________________Dentist's Phone#__________________________

Individuals to contact in case of an emergency other than parents:

____Phone #________________________

____Phone #________________________

Does your child have any food allergies? Yes No

Does your child have any other allergies? Yes No

Does your child have any dietary restrictions? Yes No

Please explain any "yes" answer
here:____

My child has permission to be released to the following individuals, childcare facilities, or transportation services in addition to emergency contact persons listed above. (Please notify these individuals that they may be asked to show proof of identity)

Name	**Relationship**

I authorize the facility to secure emergency medical treatment for my child.

Parent's Signature:____Date:____________________

*Date of Admission:*______________*Staff Initials*________

Parental Awareness of Recordings

I am aware that *Sam's Kid Safari Learning Academy* utilizes recordings and/or taping of my child such as digital recordings, videotaping, audio recordings, web cam while in the center for observation/security purposes.

______________________________ __________

Parent's Signature Date

Water Activities Permission Form

My child______________________________has permission to participate in the following types of water activities:

Sand & Water Table, Squirt Toys, & Sprinklers

Location of activity: On school campus

Parent's Signature ***Date***

______________________ __________

5321.B
5321.C
5321.G

As Needed Medication Authorization Form

Medicine Must Be In Its Original Container

Child's Name: ______________________________

Medication Name: ___________________________

Dosage Amount: _____________________

Side Effects/Anticipated Reactions: ___________________

____

Special Instructions/Circumstances for Administering "as needed" medication: _____________________________

____

____

_______________________ ___________________

Parent's Signature **Date**

____

Administration Documentation

Phone Contact Time & Date	**Date Given**	**Time Given**	**Dosage Given**	**Staff Signature**

*shall be updated by parent as changes occur or at least every three months

§1917.H,K

Emergency Medication Authorization Form

Medicine Must Be In Its Original Container

Child's Name: ____

Medication Name: ____

Dosage Amount: ____

How to Be Given: Oral Topical Other: ___________

Symptoms Indicating Need for Administration: ______________________

____

Actions to Take Once Symptoms Occur: ___________________________

____

Side Effects/ Anticipated Reactions: ____________________________

____

______________________________ ______________

Parent's Signature Date

***If all information is not filled in completely, medication will not be given..**

Administration Documentation

Date Given	Time Given	Dosage Given	Symptoms Observed	Actions Taken	Staff Signature	Phone Contact w/whom Time & Date

shall be updated by parent as changes occur or at least every six months

______________________________ ______________

Signature of Staff Completing Form Date

Non-Vehicular Excursion Authorization

My child ___________________________has permission to participate in the following off-site activities when the children are walking or riding in strollers or bye-X cbye buggies and accompanied by staff of the center:

Type of Activity	Location of Activity
Nature Walks/Ride	On back street within ½ mile of center

This validation is valid for 1 year only.

_______________________________ ___________

Parent's Signature Date

Authorization for the Application of Topical Products

Child's Name:______________________________

I give permission for center staff to apply the following topical products to my child whether provided by the center or the parent:

(Circle Yes or Not for each.)

Yes No Sunscreen

Yes No Mosquito Spray

Yes No Diaper Rash Cream

Yes No Lotion

Yes No Other______________________

This one time authorization will remain in effect until a new authorization is signed.

_________________________________ _____________

Parent's Signature Date

Permission to Release Photograph/Video

I give permission for Sam's Kid Safari Learning Academy to release a photograph &/or video of my child,____________________ engaging in school activities, field trips, & programs on/to:

(Check all that apply)

____All Sam's Kid Safari Learning Academy Social Media Pages

____Television & Newspaper Outlets

____Mrs. Sam's FACEBOOK page

__________________________   __________

Parent's Signature   Date

Dropped Date: ___________ Re-Entered Date: ___________ Transferred Date:_____________

CACFP 106 (Rev. 06-22)
FY 2023 FRPM Application

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

MEAL BENEFIT INCOME ELIGIBILITY FORM

FREE AND REDUCED PRICE MEAL (FRPM) APPLICATION FORM (October 1, 2022 – September 30, 2023)

INSTITUTION NAME: ____ **FACILITY NAME:** ______________________

PART1. CHILD OR ADULT ENROLLED TO RECEIVE DAY CARE (USE A SEPARATE APPLICATION FOR EACH PARTICIPANT)

Print Name of Participant:	(First, Middle Initial, Last)		Age	DOB (mm/dd/yy)
Foster Child?	Yes ______	No: ______	If participant is in Foster Care, Eligibility is **FREE**. Enter Foster Child's **Personal Income Earned** in Part 2, Section 4 **(If applicable)**	
Enter CID # for Child or Adult Care, if applicable :				
Enter FITAP or FDPIR # for Child or Adult Care, if applicable:				
Enter SSI/Medicaid # for Adult Day Care Only				

PART 2. Total Household Gross Income

If you listed a CID/FITAP/FDPIR/SSI/Medicaid case # above, Eligibility is FREE (Skip PART 2.)

A. Name (List **everyone** in household, including child listed above)	**B. Gross income and how often it was received** Examples: $100 / monthly $100 / twice a month $100 / every two weeks $100 / weekly				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All Other Income	
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑
	$ /	$ /	$ /	$ /	❑

PART 3: USDA Supplemental Annual Enrollment Information: (This section must be completed annually by an adult household member for all children enrolled at Child Care Centers participating in the USDA Child and Adult Care Food Program.)

Expected Days of participation: _____ **Monday** _____ **Tuesday** _____ **Wednesday** _____ **Thursday** _____ **Friday**

Expected Hours of participation: From____ To ____ or Before School: From _____To_____ Afterschool: From _____To_____

Expected Meal participation: ______ **Breakfast** _______ **Lunch** ______ **Snack**

PART 4. Adult Signature, Social Security Number, and Contact Information

An adult household member must sign this form. If **Part 3** is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on page 2.)

I certify that all information on this form is true and that all income is reported. I understand that the center 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:____________________

Social Security Number: XXX -XX - __ __ __ __ ❑ I do not have a Social Security Number

Part 5. 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 Alaskan Native ❑ Native Hawaiian or Other Pacific Islander

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: ❑ Month, ❑ Twice a month, ❑ Every two weeks, ❑ Week, ❑ Year Household size: ______________

Eligibility Determination: _______Free ❑ CID(Food Stamp)/FITAP/FDPIR/SSI/Medicaid Eligible ______Reduced _______Above/ Paid

Extended Categorical Eligibility Validation Attached ____YES ____NO

Determining Official's Signature: ____ Date: ______________________

The Sponsor/Institution Determining Official will utilize this CACFP 108 (Standards of Eligibility) to confirm participant's eligibility status as Free, Reduced, or Above.

Effective July 1, 2022 to June 30, 2023

Free Price Meal Eligibility:						
Households with incomes **less than or equal to** these levels are eligible for **free** price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	$17,667	$1,473	$737	$680	$340
	2	$23,803	$1,984	$992	$916	$458
	3	$29,939	$2,495	$1,248	$1,152	$576
	4	$36,075	$3,007	$1,504	$1,388	$694
	5	$42,211	$3,518	$1,759	$1,624	$812
	6	$48,347	$4,029	$2,015	$1,860	$930
	7	$54,483	$4,541	$2,271	$2,096	$1,048
	8	$60,619	$5,052	$2,526	$2,332	$1,166
	Each additional family member add	+ $6,136	+ $512	+ $256	+ $236	+ $118

Reduced Price Meal Eligibility:						
Households with incomes **less than or equal to** these levels are eligible for **reduced** price meals.	Household Size	Yearly	Monthly	Twice Per Month	Every Two Weeks	Weekly
	1	$25,142	$2,096	$1,048	$967	$484
	2	$33,874	$2,823	$1,412	$1,303	$652
	3	$42,606	$3,551	$1,776	$1,639	$820
	4	$51,338	$4,279	$2,140	$1,975	$988
	5	$60,070	$5,006	$2,503	$2,311	$1,156
	6	$68,802	$5,734	$2,867	$2,647	$1,324
	7	$77,534	$6,462	$3,231	$2,983	$1,492
	8	$86,266	$7,189	$3,595	$3,318	$1,659
	Each additional family member add	+ $8,732	+ $728	+ $364	+ $336	+ $168

Privacy Act Statement: This explains how we will use the information you give us.
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 your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The 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 (CID), 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 if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. 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.

Nondiscrimination Statement: This explains what to do if you believe you have been treated unfairly. 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, 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 Compliant Form which can be obtained online at: USDA Program Nondiscrimination Complaint Form, 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.

INSTRUCTIONS FOR THE FREE/REDUCED PRICE MEAL (FRPM) APPLICATION FORM

If your household receives SNAP, FITAP, FDPIR, or SSI/Medicaid, follow these instructions:

Part 1: **Child Care Center:** List participant's complete legal name, age and date of birth (DOB). Indicate CID, FITAP or FDPIR case number, if applicable.

Adult Day Care (ADC): List participant's complete name and DOB. Indicate a CID, FITAP, FDPIR, or SSI/Medicaid case number, if applicable.

Part 2: Skip this part.

Part 3: An adult household member must indicate normal days/hours of care and meal types for the enrolled child.

Part 4: An Adult must Sign, enter the last 4 digits of their Social Security Number or mark the box if there is no SSN, date, and complete the contact information.

Part 5: Answering this question is optional.

If you are applying on behalf of a FOSTER CHILD, follow these instructions:

Part 1: Enter the child's name, age, and DOB.
Check "Yes"

Part 2: **NOTE:** A Foster Child is the legal responsibility of a welfare agency or court. Eligibility is categorically Free.
If the Foster Child receives "**personal earned income"** enter that amount in Part 2, section 4.
Income received by the placing agency should not be included as income.

Part 3: An adult household member must indicate normal days/hours of care and meal types for the enrolled child.
(Days, hours, and meal types may vary based on actual participation)

Part 4: Sign the form. A Social Security Number is **not** necessary.

Part 5: Answering this question is optional.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: **Child Care Center:** List participant's complete legal name, age, and DOB. Indicate CID, FITAP or FDPIR case number, if applicable.

Adult Day Care (ADC): List participant's complete name, age, and DOB. Indicate a CID, FITAP, FDPIR, or SSI/Medicaid case number, if applicable.

Part 2: Follow these instructions to report total household income from last month.

Column A–Name: List first and last name of **each** person living in the household, related or not, such as, grandparents, other relatives, or friends, including yourself, the applicant and all other children.

Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** Next to the amount each person received, write how often; for example: weekly, every other week, twice a month, or monthly.

In box 2, list amount each person received last month from welfare, child support, or alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list **ALL OTHER INCOME SOURCES:** Personal earned income by a Foster Child, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people not in your household. Report net income of self-owned business, farm, or rental income. Next to the amount each person received, write how often. Participants of the Military Housing Privatization Initiative should not include housing allowance.

Column C–Check if no income: If the person does not have any income, check the box.

Part 3: An adult household member must indicate normal days/hours of care and meal types for the enrolled child. **ADC:** SSI/Medicaid recipients skip this part.

Part 4: An Adult household member must sign, enter the last 4 digits of their Social Security Number, date, and complete the contact information or mark the box if there is no SSN. Adult Day Care participants, who are unable to sign, may indicate their **"MARK"** as signature with a witness.

Part 5: Answer this question if you choose to.