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FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

2019-2020
Paperwork Checklist

Items below need to be completed and all forms are available at
http://www.mcgawymca.org/childrens-center/current-parents/
Please return all items by **July 26th, 2019** to keep your child's registration in good standing.

- ❑ Emergency Consent and Release *(Must have at least 2 emergency contacts outside of the home)*
- ❑ Photo Release
- ❑ Developmental History
- ❑ Copy of Birth Certificate
- ❑ Medical Form – must be updated as follows:
  - Every 6 months – 2 years and younger
  - Every year – 2 – 6 years old
  - Every 2 years – 6 years and older

  (This must be submitted on the DHS Certificate of Child Health Examination Form included in your packet)
- ❑ Late Pick-Up Policy
- ❑ Acknowledgement of On-Site Services
- ❑ Childcare Network of Evanston (CNE) LT Program Acknowledgement *(Does not apply for School Age program participants)*
- ❑ Annual CACFP Enrollment Form
- ❑ Household Eligibility Form *(If applying for Scholarship)*
- ❑ Infant Formula/Food Waiver **For children 1 year or younger** *(Does not apply for School Age program participants)*
- ❑ DCFS Summary of Licensing Standards *(Please detach and return only the last page)*
- ❑ Food Allergy Action Plan *(If your child has an allergy that requires medicine)*
- ❑ Food Substitution Form *(For substitutions other than allergies)*
- ❑ Automatic Bank Draft Form *(Fill out only if you want to sign up for a monthly automated draft for tuition)*

Illinois State licensing standards require that each child's file must be complete before the child may attend the Children's Center. Thank you for your cooperation.

We will be offering paperwork check-in nights to ensure this process is an easy one. We'll have all the forms available and the files ready to be re-signed. Just a reminder, all of our paperwork is also available online at the McGaw YMCA Children's Center website.

For your convenience, we are offering the following paperwork check-in times:

Tuesday, July 9th from 4:00 pm – 6:00 pm
Wednesday, July 17th from 4:00 pm – 6:00 pm
Thursday, July 25th from 11:00am – 1:00pm

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McGaw YMCA Children's Center
EMERGENCY CONTACTS, CONSENT AND RELEASE FORM

PERSONAL INFORMATION Child's Classroom_____

Child's Full Name: _____ Birth Date_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # (____) _____

What is the primary language spoken at home? Are there any additional languages spoken?

In an emergency call first: Name: _____ Relationship: _____ Phone: _____

Parent/Guardian #1 (Relationship to Child):	Parent/Guardian #2 (Relationship to Child):
Name:	Name:
Employer:	Employer:
Dept/Position:	Dept/Position:
Work Phone:	Work Phone:
School: Hours:	School: Hours:
Cell Phone:	Cell Phone:
Email:	Email:

Other Family Members:_____

Is there a court order that limits either parent from visiting this child or from removing him/her from the Center? Please Note: The Children's Center cannot limit parent's access to their children without a notarized court order, which must be attached to this form and kept at the Center. ☐ YES ☐ NO

Health care/ Insurance child is under _____

Policy Holder Name _____

Child's Physician: _____ Phone # _____

Child's Dentist _____ Phone # _____

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EMERGENCY CONTACTS, CONSENT & RELEASE

Please list names, addresses, relationship and phone numbers of any persons you would like to have on your permanent list, who have your consent for the Center to release your child from our care into their custody. These people may also be called in emergencies, if the Center is not able to contact the legal guardians or caregivers or adults, residing in the household at the numbers given previously:

Please list the name and relationship of other adults living in your household (grandparent, nanny, etc.):

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

You must completely fill out at least TWO Emergency Contacts and Authorized Pick Ups who do not live in your household. Anyone listed must have complete contact information.

Required Contacts

1. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

2. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

Additional Contacts

3. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

4. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

I authorize the McGaw YMCA Child Care Center to release my child to the person(s) listed above to act on my behalf in an emergency in the event that I cannot be reached. These persons will show staff proper identification with matching addresses before my child will be released. It is my responsibility to keep all information current.

_____ _____

Parent/Legal Guardian Signature Date

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MEDICAL CONSENT

I, the parent/legal guardian of _____ give consent to have my child receive first aid by Center staff. I understand that the center staff receives training in the basics of first aid and CPR. I authorize the McGaw YMCA Child Care Center to secure emergency medical treatment for my child. I give consent for those listed as pick-up and emergency contacts to act on my behalf until I am available. I accept responsibility for any and all expenses incurred in securing emergency medical treatment for my child.

I authorize the McGaw YMCA Child Care Center, and its staff and agents, to administer medication (over the counter and prescribed) to my child as specified in the physician's written instructions or instructions on packaging. The McGaw YMCA Child Care Center has my permission to apply any topical ointment, such as diaper ointment, sunscreen, lip balm, lotion, insect repellent, etc.

Parent/Legal Guardian
Signature _____ Date _____

CONSENT FORMS: Initial & sign in the spaces below to indicate your acknowledgement and acceptance of the outlined terms and conditions.

_____I authorize the McGaw YMCA Children's Center, its staff, and agents, to take my child on walking trips, excursions, and field trips. I also give permission for my child to be transported in a school bus contracted by McGaw YMCA, or as a passenger in any vehicle owned or leased by the McGaw YMCA. I am responsible for communicating with the McGaw YMCA Children's Center before the designated time if my child will not attend that day.

_____I give permission for my child to participate in physical activities such as gym and swimming. I understand that physical activities are a regular part of the program my child attends.

_____I have read the Parent Handbook and agree to abide by the policies and regulations therein including the Guidance and Discipline policies. The Parent Handbook is located online and in your child's classroom.

_____I authorize the McGaw YMCA Children's Center to send electronic information through the email and cell phone provided.

_____I would like to be added to the McGaw YMCA Children's Center school directory. This directory can aid families and our PAG who wish to communicate about events happening within their class or center-wide.

Parent/Legal Guardian
Signature _____ Date _____

Each year your child attends our programs; the information on this form must be reviewed for accuracy.

Signature lines provided below are designated for annual reviews of this form.

I have reviewed the information on this form and verify all information is still accurate:

_____ _____
Parent/Legal Guardian Signature Date (2020/2021)

_____ _____
Parent/Legal Guardian Signature Date (2021/2022)

_____ _____
Parent/Legal Guardian Signature Date (2022/2023)

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PHOTO AND VIDEO/AUDIO RECORDING RELEASE

I am 18 years of age or older and, if not, my Mother/Father/Legal Guardian has also signed below.

For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA) , I hereby give my permission and consent, now and for all time, to YMCA of the USA and collaborating third parties to make, reproduce, edit, broadcast or rebroadcast any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities, for publication, display, sale or exhibition thereof in promotions, advertising, education and legitimate business uses without any compensation to, and/or claim, by me. I may, or may not be, identified in such reproductions; however, I shall not be stated by name to have endorsed any particular commercial products or commercial services.

I further agree to the following:

- Any video film, footage, sound track recordings, and photo reproductions of me and/or my narrative account of my experience during said activities, I authorize, according to this Release, shall belong to YMCA of the USA and collaborating third parties. Therefore, they will have full right of disposition of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities;
- Any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities will not be subject to any obligation of confidentiality and may be shared with and used by YMCA of the USA and collaborating third parties;
- YMCA of the USA and collaborating third parties collaborating shall not be liable for any use or disclosure to a third party of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience; and
- YMCA of the USA and collaborating third parties shall exclusively own all known or later existing rights to worldwide and shall be entitled to the unrestricted use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience for any purpose without compensation to me.

I agree that my consent and this release are irrevocable. I hereby release and discharge YMCA of the USA and collaborating third parties from any and all claims in connection with the uses and reproductions, any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience as described herein.

Signature: _____ Date: _____

Printed Name: _____ Age: _____

Address: _____

_____

I am the Mother/Father/Legal Guardian of (child's name). For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Signature of Mother/Father/Legal Guardian: _____

YMCA OF THE USA
101 N Wacker Drive, Chicago IL 60606
P 800 872 9622 F 312 977 9063 ymca.net

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MCGAW YMCA CHILDREN'S CENTER
Developmental History Form
Preschool

Childs Name: _____

Child's Nickname: _____ **Date of Birth:**_____

FAMILY BACKGROUND

Marital status of parents:

☐ Married ☐ Domestic Partners ☐ Divorced ☐ Separated ☐ Single Parent
☐ Other_____

What home or family factors will might help us to understand your child better? Consider changes such as recent move, births, illnesses, divorce, separation, or any unusual circumstances.

What language(s) do you speak at home?

What language does your family prefer written and verbal communication in?

If you are in need of a translator please inform the McGaw YMCA Children's Center Registration Department. Do you feel that you will need a translator provided for communications?

❑ Yes ❑ No

Are there any ways that you would like to participate in your child's classroom (i.e. sharing a book or story, playing an instrument, volunteering, sharing family traditions)?

CULTURAL DEVELOPMENT

What is your family's ethnicity?

Are there any words that we should use to communicate well with your child?

Are there any child-rearing cultural beliefs that we should try to incorporate into our classrooms?

What does your family celebrate?

Are there any celebrations you would not like your child to participate in?

HOME ROUTINES:
What time does the child wake up and go to sleep?

Does your child nap? If so, for how long and how often throughout the week.

Does your child generally wake up naturally or need to be woken up?

Does your child sleep through the night? ☐ YES ☐ NO
*If not how many times does your child get up during the night and what routines do you use?

How often does your child use a pacifier?
☐ Never ☐ Only at sleep/nap ☐ When fussy ☐ Never without it ☐ No longer uses one

CHILD'S PERSONALITY
Please briefly describe your child's temperament, personality, social relationships, needs, abilities, etc. What are your child's favorite activities?

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Please describe any situations in which your child tends to become tense, angry, scared, etc. How does your child show these emotions?

What is the best way to help calm him/her?

Does your child receive care from other individuals outside of your family? If so, how does your child respond to this care?

Has your child previously been in a group childcare setting? When? Where?

How does your child typically adjust to group situations?

What do you hope your child will gain from his/her experience with us?

☐ Kindergarten Readiness ☐ Enriched experiences ☐ Learn social skill

☐ Increased self-esteem ☐ Learn the core values of the YMCA: Caring, honesty, respect, responsibility ☐ Other: _____

_____ _____

Parent/Legal Guardian Signature 2019-2020

Signature lines provided below are designated for annual reviews of this form.

I have reviewed the information on this form and verify all information is accurate:

_____ _____

Parent/Legal Guardian Signature updated 2020-2021

_____ _____

Parent/Legal Guardian Signature updated 2021-2022

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION (**List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**
Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

Late Pick-up Policy

Parents of participants enrolled in **Children's Center Programs** will be charged **$1.00 per minute / family** based on the **program pick-up times** listed below:

- **Part Day Preschool 12:00pm**
- **Explorers Program 2:00pm**
- **Full Day Programs, School's Out, FRC 6:15 pm**
- **Summer Learning Program's – 4pm**
- **Summer Learning Extended Hours, Summer Day Camp - 6pm**

- If you know you are going to be late please notify the center so we can let your child and the teachers know. **Late fee will still be charged.**

- If a parent or authorized pick-up person does not arrive or call by 5 minutes past the designated pick-up up time, staff will assume an emergency exists and will begin to call emergency contacts for your child.

- If no emergency contact can be reached within 1-hour past designated pick-up time, staff may contact the Evanston Police Department who will pick up the child.

- **Late fees must be paid within 5 business days of the late pick up date.**

- Failure to pay late pick-up fees can be cause for the child's suspension or termination from the program.

- Continued disregard for the pick-up times can result in suspension or termination form the program.

It is very important to have updated contact information in your child's file at all times. Any child who is not picked up will be under the supervision of an assigned teacher/administrator until the parent, emergency contact, or the authorities arrive. All information about the incident will be discussed directly with the parent or guardian and never with the child.

Child(ren)'s Name(s): _____

Parent/Guardian Signature:_____ Date:_____

Update Signature: _____ Date:_____

Update Signature: _____ Date:_____

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Acknowledgement of On-Site Services

I, the undersigned parent of _____ acknowledge that
child's name
the vendors listed below provide food and/or services to the McGaw YMCA Children's Center.

- Quality Catering for Kids –
  provides catered lunches daily
- Fox River Foods –
  provides snack and breakfast items weekly
- Renzo Dairy –
  provides milk bi-weekly
- Anderson Pest Control Solution –
  provides indoor and outdoor preventative pest control services monthly
- ABM –
  provides nightly cleaning services

Signature lines provided below are designated for annual reviews of this form

I have reviewed the information on this form and verify all information is accurate:

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

❑ Children's Center only ❑ Membership and Children's Center

McGaw YMCA Children's Center
Checking Account/Credit Card Draft Agreement

This agreement authorizes the McGaw YMCA to charge your bank account or credit card monthly fees. A voided check or copy of credit card must be attached to this form.

Please note: A monthly child care receipt will be mailed to your address on file.

Child's Name: _____ Child's Class: _____

Program Start Date: _____ Draft Start Date: _____

Parent/Guardian Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

The McGaw YMCA is a 501(c)(3) charitable organization. Please consider a tax-deductible contribution to support child care for families who cannot afford to pay full price and check the appropriate box below. Contributions will be processed each month at the same time as your tuition.

☐ $5/month (supports one class section for a child)
☐ $15/month (supports a youth membership)
☐ $30/month (supports two youth membership
☐ $50/month (supports membership for a single-parent family)
☐ Other monthly amount: _____
☐ One-time donation of: _____

FOR CHECKING ACCOUNT DRAFTS
We cannot accept debit cards for bank drafts. To draft from your checking account, please provide a voided check.

Name on account: _____

Routing Number: _____ Account Number: _____

FOR CREDIT CARD DRAFTS
We accept Mastercard, Visa, and Discover.

Name on card: _____ ☐ Visa ☐ MasterCard ☐ Discover ☐ Am Ex

Card Number: _____ Exp. Date: _____ CVV: _____

I authorize the McGaw YMCA to debit the balance of my childcare account from the above listed account on or around the 1st of the month or 15th of the prior month. I understand that bank holidays may delay the draft.

I understand that it is the responsibility of the drafted party to maintain sufficient funds to cover all drafts as well as to inform the McGaw YMCA of any changes in account information. If drafts are refused for any reason, a $25 fee will be charged and payment by cash or money order must reach the YMCA's registration office with 48 hours of notification. Failure to make this payment will result in a discontinuation of childcare services.

I agree to the terms and conditions of the withdrawal of funds from my checking account or credit card as outlined above. I authorize the McGaw YMCA to draft my checking account or credit card for childcare fees. I understand that this draft will continue until the end of the program or 30 Days after the receipt of my cancellation in writing.

Draftee's Signature: _____ **Date:** _____

For office use only:
Received: Staff: _____ Date: _____ **Input:** Staff: _____ Date: _____ **Updated:** Staff: _____ Date: _____

Food Allergy Action Plan

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

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

Place Student's Picture Here

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

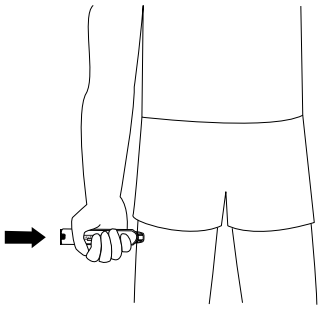
TURN FORM OVER

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

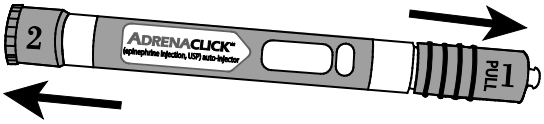
SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_____) Doctor:_____ Phone: (___)_____-_____
Parent/Guardian:_____ Phone: (___)_____-_____

Other Emergency Contacts
Name/Relationship: _____ Phone: (___)_____-_____
Name/Relationship: _____ Phone: (___)_____-_____

Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE
SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)	

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable food accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact McGaw YMCA Children's Center (*Name*) at 847-475-8580 (*Telephone (Include Area Code)*).

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15d that requires food accommodation? *(Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)*
   - ☐ No **If no, go to item 2 below.**
   - ☐ Yes **If yes, provide the following information and complete items 3, 4, and 5 below.**
   - a. What is the disability? _____
   - b. What major life activity is affected? _____
   - c. How does the disability restrict the diet? _____
2. Child has no disability but requires a special diet. Identify medical problem which restricts the child's diet and complete items 3, 4, and 5 below.
3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
5. _____ (*Date*) _____ (*Signature of Physician*)

FOR OFFICE USE ONLY:

- ☐ Form received on _____.
- ☐ Form incomplete. Parent contacted on _____.
- ☐ Form complete. Accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable
- ☐ Form complete. Accommodations will begin on _____.

_____ (*Date*) _____ (*Signature of Food Service Director/Contact*)

Print Reset Form

Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

ILLINOIS STATE BOARD OF EDUCATION
Annual Enrollment Form
Child and Adult Care Food Program

This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.

This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.

Parents/Centers: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. If parent does not complete Section 5, center staff should complete to the best of their ability (by observation) and initial the section. The center will review completed enrollment form.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | **2 DAYS OF WEEK IN ATTENDANCE** | **3 TIMES CHILD NORMALLY ATTENDS DURING WEEK** | **4 MEALS RECEIVED**

First Child

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Second Child

☐ ***Same Days as Above*** ☐ ***Same Times as Child Above*** ☐ ***Same Meals as Above***

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Third Child

☐ ***Same Days as Above*** ☐ ***Same Times as Child Above*** ☐ ***Same Meals as Above***

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Please answer both questions. This information is voluntary.

5 ETHNIC/RACIAL CATEGORIES—

A. Ethnic data of child(ren) — Mark only one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 SIGNATURE

I certify the information above is correct. _____ *Signature of Parent or Guardian* _____ *Date* _____ *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY

Effective Date of this enrollment form: _____

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which this form is received.

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer

Print Reset Form

Dear Parents,

For multiple years, we have partnered with Childcare Network of Evanston's (CNE) Learning Together (LT) program. LT brings experienced mental health consultants (MH), speech/language pathologists (SLP), and occupational therapists (OT) into the classroom to support our teachers and children. Through observation, consultation with center staff and classroom based services, consultants help prepare children for lifelong learning and success.

The LT team will collaborate with the center staff and reach out to parents if needed regarding children's development and progress. Information gathered by the LT consultants from their work in the classrooms and with teachers is shared within the LT team and childcare centers only. The information obtained will be treated as private healthcare information. This information will not be shared with any outside entities without parent/caregivers written consent. No written records will be kept in your child's file beyond this written consent form, without your consent.

The LT program is funded fully by grants. In order to keep the funding for this valuable program, we will be collecting demographic information, such as date of birth, ethnicity, family income, etc. which will be shared with funders for data collection purposes. No identifying names or information will be shared.

I acknowledge the partnership between my child's center and Childcare Network of Evanston's Learning Together program to offer child development support and enhancement services to my child and the center staff.

Childs Name_____ Date of Birth _____

Check one:

☐ Evanston Resident
☐ Non-Evanston Resident

Parents Name_____ Phone Number_____

Parents Email_____

Parents Signature_____

Date (month/day/year) _____

The Learning Together Staff:

Chava Alpert, LCSW is a Licensed Clinical Social Worker specializing in the early childhood years (0-10 years) for the last 20 years. Chava is the LT program manager and has been part of LT for the past 12 years. In addition to LT consultation, Chava also has a private practice here in Evanston providing social skills groups, play therapy, family therapy, parent guidance, and professional development seminars. While at our center she conducts individual and classroom assessments and links the results with hands-on practical structural and interactional recommendations to the center staff, parents and children. At many of her sites Chava has introduced the Sunshine Circles group time program.

Nancy Bruski, LCSW is a Licensed Clinical social worker who has worked with young children and families for over thirty years. She is a frequent presenter of workshops for early childhood educators and for parents locally and nationally, offers counseling for young children and families, and provides mental health consultation to early childhood programs. Her book, The Insightful Teacher: Reflective Strategies to Shape Your Early Childhood Classroom, was published by Gryphon House in 2013 and received a professional development award from Learning Magazine in 2015. Nancy has been a part of the LT team for 12 years. While at her sites she works closely with staff and children developing intervention and support plans.

Lisa Jablon Fowler, LCPC, is a Licensed Clinical Professional Counselor who has worked in the field of Early Childhood Education for thirty years. Lisa been a part of the LT team for eleven years. Lisa also has a private practice in Wilmette and is a Psychotherapist for A Home Within, an organization that provides Psychotherapy free of charge for a for a foster care child for as long as they require. Lisa has been a pre-school teacher, Assistant Director and Director. While at her LT sites Lisa conducts classroom observations linking these with direct recommendations for classroom interventions. Lisa frequently conducts small playgroups at her sites focusing on play and regulation.

Toby Meyer, Ph.D. CCC-SLP is a licensed speech/language pathologist who has been in private practice for over 30 years. She has been part of the LT team for 5 years. Toby has provided speech services in a variety of settings including hospitals, in-home and in-classroom. She has addressed the language and cognitive needs of preschoolers through adults. Her areas of expertise include language/learning disorders, motor speech disorders such as dyspraxia, and pervasive developmental delays in preschoolers. While at our center Toby completes play based speech and language evaluations, develops individualized intervention plans for teacher implementation and will periodically work directly with children on speech and language challenges.

Linnea Vantrease, MS, OTR/L, is a pediatric occupational therapist. She is certified in Early Intervention through the State of Illinois. She has provided occupational therapy services in charter and therapeutic schools. Linnea received specialized training in the DIR Floortime model. She has been consulting with the Learning Together Program, for 4 years while also working with families in the clinic at Beth Osten and Associates, and providing occupational therapy services in homes and preschools through Early Intervention. Through LT Linnea conducts in classroom observations and screenings and develops classroom and individualized plans.

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
CHILD AND ADULT CARE FOOD PROGRAM

1. All Household Members

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	2. FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6	3. SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

4. Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

_____ Signature of Homeless Liason, Migrant Coordinator, or Head Start Director

_____ Date

5. Total Household Gross Income (before deductions) You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "*I do not have a Social Security Number*" box.

X X X - X X - _ _ _ _
Social Security Number

☐ I **do not** have a Social Security Number.

I certify all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date | *Printed Name of Adult Household Member* | *Signature of Adult Household Member*

7. Contact Information (Optional)

Work Telephone Number (Include Area Code) | *Home Telephone Number (Include Area Code)* | *Home Address (Number, Street, City, State, ZIP Code)*

8. Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

9. Optional – Sharing Information With All Kids Insurance Program

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If ***yes***, do not sign below.
☐ No, I do not want my information from this application shared with the *All Kids Insurance Program*.

Date: _____ Sign here: _____

CHILD CARE REPRESENTATIVE USE ONLY

Eligibility Determination - Complete Sections A and B Below

SECTION A **Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12**

Convert income only if different frequencies of pay are reported.

TOTAL INCOME $ _____ **Per:** ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

☐ **Free based on:**
- ☐ foster child
- ☐ SNAP or TANF
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ household's income
- ☐ Head Start

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied — Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

SECTION B **Signature of Determining Official:** _____ **Date:** _____

Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

Print Reset Form

INSTRUCTIONS FOR APPLYING - COMPLETE ONE APPLICATION PER HOUSEHOLD

Follow These Instructions and Return the Completed form to your Center. Once approved for meal benefits, a child's Household Eligibility Application is effective for 12 months.

FOSTER CHILD(REN)

A foster child remains the legal responsibility of the state through a foster care agency or the court. If you submit documentation from the state or local agency that the child is in foster care, that documentation replaces completing a Household Eligibility Application.

1) If all children in your household (who attend this center) are foster children that are the legal responsibility of a foster care agency or court, provide the following:
   - Part 1 — List the name(s) and age(s) of your foster child(ren) attending this center.
   - Part 2 — Check the box(es) indicating a foster child(ren).
   - Part 3 — 5 Skip
   - Part 6 — Provide a signature of an adult household member and date the application.
   - Parts 7-9 — (OPTIONAL)

2) If you have some foster children that are the legal responsibility of a foster care agency or court along with other children attending this center, please provide the following:
   - Part 1 — List ALL household members, including the foster child(ren), and the age(s) of the child(ren) attending the center.
   - Part 2 — Check the box(es) identifying the foster child(ren).
   - Part 3 — Record a valid SNAP/TANF case number if applicable
   - Part 4 — Skip
   - Complete Parts 5 and 6 if applicable. See the instructions for **INCOME–HOUSEHOLDS REPORTING** section.
   - Parts 7-9 — (OPTIONAL)

SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING

If any member (child or adult) of your household receives SNAP or TANF benefits, provide the following:
- Part 1 — List ALL people in your household (including grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the center.
- Part 2 — Skip
- Part 3 — Record a valid SNAP or TANF case number for any member (child or adult) of this household. You will find your SNAP or TANF case number on your letter of eligibility for benefits.
- Part 4 — 5 Skip
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

HOMELESS, MIGRANT, RUNAWAY, OR HEAD START

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant, a runaway, or head start, follow these instructions.
- Part 1 — List ALL household members, and the age(s) of the child(ren) attending the center.
- Part 2 — 3 Skip
- Part 4 — If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your local school.
- Part 5 — Complete only if a child in your household isn't eligible under Part 4. See instructions for **INCOME – HOUSEHOLDS REPORTING** section below and complete Parts 5 and 6.
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

INCOME - HOUSEHOLDS REPORTING

If no one in your household receives SNAP or TANF benefits, please report all household income. The Household Eligibility Application must include the following information:
- Part 1 — List the names of ALL household members and the age(s) of the child(ren) attending the child care center.
- Part 2 — 4 Skip
- Part 5 — List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
  - o For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - o If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
  - o If you have no income, list zero in the earnings from work column.
- Part 6 — Provide a signature of an adult household member and date the application. Also, provide the last four digits of the Social Security Number for the adult signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a Social Security Number, mark the box, I do not have a Social Security Number.
- Parts 7-9 — (OPTIONAL)

PRIVACY AND DISCRIMINATION STATEMENT

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve 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 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 if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. 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.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.