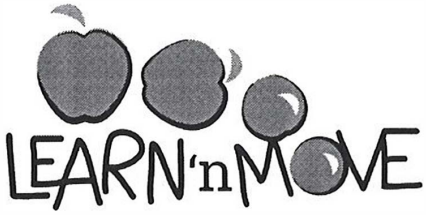

CHILDCARE CENTER

Welcome to Learn 'n Move Childcare Center! We are excited to welcome you and thrilled to have this opportunity to provide your child with the highest quality education where your child will learn the importance of physical activity and a healthy lifestyle through best practices in child development and learning. As a part of the enrollment process, Learn 'n Move is required to obtain additional information about your family.

Our Center Director, Stephanie Collins, will be happy to answer any questions you may have as well as provide you with any additional forms that may be needed.

Our Required Enrollment Forms:

☐ Child Enrollment Form Packet

☐ All About Me Form

☐ Birth Certificate

☐ Childcare Assistance Form (If Applicable)
http://www.nd.gov/dhs/services/financialhelp/childcare.html

☐ ChildCare Aware Care Plan

☐ Parent Statement of Health

☐ Up to date Immunization Record

☐ USDA Food Program Form (Step 1 & Step 4 REQIRED!)

☐ TNT Registration Form

☐ Signed Parent Handbook (last page - both parents must sign!)

Please mail, email, or drop off these completed forms and the enrollment fee **($50 per child)** to ensure your spot at Learn 'n Move is held for you! Please speak with Stephanie, our center director regarding opening dates and availability.

Thank you for choosing Learn 'n Move Childcare Center! We look forward to working with you and your family!

LEARN'nMOVE
CHILDCARE CENTER

LEARN `n MOVE ENROLLMENT FORM

CHILD'S INFORMATION

Child's Name: _____ Date of Birth: _____

Place of Birth: _____ Primary Language: _____

Family Customs or Traditions to Share with childcare staff: _____

_____

Parent/Guardian Information

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

E-Mail Address: _____ E-Mail Address: _____

Cell Phone: _____ Cell Phone: _____

Parent/Guardian Work Information

Company Name: _____ Company Name: _____

Address: _____ Address: _____

Business Phone: _____ Business Phone: _____

E-mail Address: _____ E-mail Address: _____

Medical Information

Eye Color: _____ Hair Color: _____ Sex: _____

Height: _____ Weight: _____ Race: _____

Identifying Marks:

_____

Identified Allergies:

_____

Special Needs or Program Adaptations:

_____

Health Insurance Provider:

_____

Physician Information

Name of Physician/Clinic: _____ Phone: _____

Learn 'n Move Enrollment

I grant my informed consent for my child: _____ (child's name) to participate in the child care program operated by Learn 'n Move Childcare Center. By signing these forms, I acknowledge and accept the following program conditions:

Access

I have full access to the center without notification whenever my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

Child Release

For children's safety Learn 'n Move will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below by the parent/guardian.
Learn 'n Move will not release my child to any other person unless I notify the center, following the guidelines listed below:

- If the person (spouse, relative, friend) picking up my child is listed on this form but does not regularly pick up my child or has never before picked up my child, I will notify the center verbally, in advance.
- If the person picking up my child is NOT listed on this form, I must notify the center in writing, in advance.
- Photo identification will be required of any person picking up my child.

NAME_____ADDRESS_____

CITY/TOWN_____ ZIP_____ RELATIONSHIP TO CHILD_____

DAY PHONE _____ EVENING PHONE_____ E-MAIL_____

NAME_____ADDRESS_____

CITY/TOWN_____ ZIP_____ RELATIONSHIP TO CHILD_____

DAY PHONE _____ EVENING PHONE_____ E-MAIL_____

NAME_____ADDRESS_____

CITY/TOWN_____ ZIP_____ RELATIONSHIP TO CHILD_____

DAY PHONE _____ EVENING PHONE_____ E-MAIL_____

LEARN'n MOVE
CHILDCARE CENTER

"ALL ABOUT ME" FORM

Child's Name: _____ Date of Birth: _____

What would you like us to call your child? _____

DEVELOPMENTAL HISTORY:

Age child began sitting: _____ crawling _____ walking _____ talking _____

Any speech difficulties?

_____

Best time of day? _____

FAMILY INFORMATION

With whom does the child reside?

_____

Who else lives in the home (siblings, extended family members, pets)?

_____

_____

What does child call family members?

_____

Language spoken at home: _____

Are books read in languages other than English? Yes/No

If yes, what language(s)? _____

Are there words in your home language that we should know?

_____

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful:

_____

_____

HEALTH/DEVELOPMENT

Serious illnesses or hospitalizations? Describe:

History of colic?

Any physical/chronic conditions, disabilities, including allergies? Describe:

Regular medications: (please fill out Medication Authorization) _____

Is your child presently or ever been diagnosed with a special need? Yes/No

If so, is he/she receiving any special services? Yes/No Explain if Yes:

EATING HABITS

Any food allergies?

Special diet: _____

Special characteristics or difficulties?

_____

Favorite foods: _____

Foods refused: _____

Child eats with:

spoon, fork, hands, other:_____

TOILETING HABITS

How does child indicate bathroom needs (include special words)?

_____

Is child reluctant to use the bathroom? Yes/No If yes, how do you handle?

_____

Does your child need any help while in bathroom (wiping, hand washing, flushing) Yes/No Explain:

_____

Is your child toilet trained? Yes/No

Bowel Movements : Regular How often:

Does child have accidents? YES/NO If yes, how often and when? _____

SLEEPING HABITS

Does child become tired or nap during the day (include when and how long)?

Describe nap routine?

What time does child go to bed at night: _____ awake in morning: _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking):

Are there any sleep/wake time routines

SOCIAL RELATIONSHIPS

How would you describe your child in social situations?

Describe any previous experience with children:

Has there been any previous child care experience? Yes/No If so, did it meet your needs and expectations? YES/NO Please explain Reaction to strangers:

Prefers to play alone or in groups?

Favorite toys and activities

How do you comfort your child?

How do you discipline your child?

DAILY SCHEDULE

Describe your child's schedule on a typical day:

Wake up

Morning

Lunch

Afternoon

Evening

Bedtime

What would you like your child to gain from the child care experience?

Anything else you would like us to know about your child?

How did you hear about us?

Signatures:

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Parent/Guardian Signature) (Date)

FOR CENTER USE

Classroom: _____ Date of Admission: _____

Age of Admission: _____

Date Registration Fee Received: _____ Birth Certificate Viewed: Y N

Walk/Local Parks Permission

As part of the program, children will go on walks in the surrounding area and outdoor playground supervised by the teachers weather permitting. Young toddlers will go in a buggy or stroller.

A separate Field Trip Permission Slip describing the field trip will be posted if your child will be leaving the center for an extended period of time.

Child Illness

In case of illness, I will be called and possibly required to pick up my child(ren) as soon as possible. We ask that for your child's comfort and to reduce the risk of contagion, children be picked up within 1 hour of notification. Until then, your child will be kept comfortable and will continue to be observed for symptoms. Children need to remain home for 24 hours without symptoms and without the use of fever reducing medications before returning to the program. This means that the child needs to remain out of the center for the remainder of the day he/she is sent home and the following day (if a child is sent home on Friday, he/she may return on Monday), unless the center receives a note from the child's medical provider stating that the child is not contagious and may return to the center. In the case of a (suspected) contagious disease, rash, or continuing symptoms, a note from the child's medical provider may be required before returning.

Children's Injuries

If my child sustains a minor injury (e.g., scraped knee) during care, I understand that I will receive an Incident Report outlining the incident and course of action taken by the staff member when I arrive to pick up. I will be contacted immediately if the injury produces any type of swelling, is on the face or head, or needs medical attention.

Emergency Medical Care

Every effort will be made to contact me in the event of an emergency requiring medical attention for my child, _____(Child's full name). If I cannot be reached, the emergency contacts listed above will be called. I authorize Learn 'n Move to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. Staff is trained in the basics of first aid and CPR and I authorize them to give my child first aid. In a center, any member of the staff responsible for the care and education of my child may view my child's health information, as well as state licensors and health care consultants for compliance purposes.

Child's Health Insurance Provider _____

Name of insured _____

Policy number _____

SUNSCREEN AND INSECT REPELLANT PERMISSION

- All sunscreen or sun block will have a UVB and UVA protection of at least 15 or higher.
- All sunscreen/sun block and insect repellant must be provided in the original container
- All products require a valid expiration date, where applicable.
- Containers must be labeled clearly with the child's full name.

Note: When recommended by public health authorities or requested by a parent/guardian, the use of insect repellants containing DEET should be used. Repellants containing DEET are to be applied only to children over the age of 2 months and no more than once a day.

All sunscreen/sun blocks and insect repellants will be applied according to the directions on the label. Insect repellants will be washed off when the child has returned indoors. Combined sunscreen/sun block and insect repellants should be avoided due to the variation in application times.

I give Learn 'n Move staff permission to apply the following to my child (IF YOU ARE OKAY WITH USING WHAT LEARN 'N MOVE PROVIDES, PLEASE PUT "ANY":

_____, _____, _____

(name of sunscreen) (name of insect repellant) (other)

Special instructions _____

_____

Parent Signatures:

_____

(Parent/Guardian/s Signature (Date)

_____

(Parent/Guardian/s Signature (Date)

ChildCare Aware® OF NORTH DAKOTA

Care Plan: _____

(Child' First and Last Name)

Child's Birth Date		Child's Height		Child's Weight	

Parent's (Guardian) Name		**Cell Phone Number**	
		Work/Home Number	
Emergency Contact Person (Name/Relationship)		**Phone Number**	
Primary Health Care Provider		**Phone Number**	
Specialty Provider		**Phone Number**	

Child Health Information: *(Please attach additional information/documentation as needed)*

My child has a special health care need or diagnosis: ○Yes ○No	If yes, please specify	
Allergies: ○Yes ○No	If yes, please specify	
Medication Needs: ○Yes ○No	If yes, please specify	
Diet/Feeding Needs: ○Yes ○No	If yes, please specify	
Sleeping Needs: ○Yes ○No	If yes, please specify	
Toileting Needs: ○Yes ○No	If yes, please specify	
Equipment/Medical Supply Needs: ○Yes ○No	If yes, please specify	
Other Needs: ○Yes ○No	If yes, please specify	

Child Developmental Information: *(Please attach additional information/documentation as needed)*

My child has special developmental needs: ○Yes ○No	If yes, please specify	
Developmental Accommodations Needed: ○Yes ○No	If yes, please specify	
Additional Developmental Information		

Child Behavioral Information: ***(Please attach additional information/documentation as needed)***

My child has special behavioral needs: ◯Yes ◯No	If yes, please specify	
Possible Causes/Purposes for Behavior:	☐NA ☐Tension Release ☐Frustration ☐Attention Getting ☐Access to Restricted Items	☐Escape ☐Poor Self Regulation Skills ☐Developmental Disorder ☐Neurological ☐Other:_____
Behavioral Accommodations Needed: ◯Yes ◯No	If yes, please specify	
Specific Equipment Needs Related to Behavior: ◯Yes ◯No	If yes, please specify	
Additional Information regarding behavioral needs:		

Other important Information about child:_____
_____
_____

Child receives additional services related to medical, developmental, or behavioral needs. (Early Intervention, Outpatient Therapy, Psychological Services, Regular Medical Follow up, School Special Education Services, etc). ◯Yes ◯No
If yes, please list: _____
_____

Staff need the following training, related to medical, developmental, or behavioral needs, to care for child: _____
_____
_____

Consent for health care or other provider to communicate with my child's child care provider to discuss information relating child's medical or behavioral needs. ◯Yes ◯No ◯NA

Date Plan Written:_____ Date to Review Plan:_____
Health Care (or other provider) Signature_____ Date:_____
Parent/Guardian Signature_____ Date:_____
Child Care Provider Signature_____ Date:_____

PARENT'S STATEMENT ON HEALTH OF CHILD

ND DEPARTMENT OF HUMAN SERVICES/CFS

SFN 847 (Rev. 11-2008)

INSTRUCTIONS: This form must be completed annually for any child enrolled in a licensed early childhood facility. This form is completed by a parent or guardian of the child.

Full Legal Name of Child:	Birth Date:	Enrollment Date:	Please check one: ☐ FT ☐ PT ☐ Dropin ☐ B/A School
Full Legal Name(s) of Parent or Guardian:			Relationship:
Address:	City:	State:	ZIP Code:
Home Telephone Number:	Work Telephone Number:	Family Dentist:	
Family Physician:	Clinic:	Telephone Number:	
Hospital:			Telephone Number:
Last Visit to Doctor:	Child's Height:	Child's Weight:	

Does The Child Have Any food, medication or environmental allergies: ☐ Yes ☐ No

If Yes, List Allergies:	Describe Allergy Reaction:	Usual Treatment:

Please Check If Any Of The Following Conditions Exist:

☐ Asthma ☐ Heart Condition ☐ Hearing Impairment ☐ Behavioral Issues

☐ Diabetes ☐ Seizure Disorder ☐ Frequent Earaches ☐ Other Conditions (please specify): _____

☐ Vision Impairment

Please Explain All Checked Items:

Is The Child Under Current Medical Treatment? ☐ Yes ☐ No If yes, please list:

Are There Any Medications That The Child Takes Daily? ☐ Yes ☐ No If yes, please list:

Describe Any Limitation Your Child May Have For Participation In An Early Childhood Program:

Is there a health care plan for your child? ☐ Yes ☐ No If yes, please attach

INSURANCE:

Liability insurance is not a requirement for a license to provide family or group child care. Please review with your child care provider the liability coverage that is presently in place.

CERTIFICATION:

I certify that the above information is true to the best of my knowledge.

Parent or Guardian's Signature:	Date

PHOTO RELEASE FORM

(Please Circle Yes or No)

Yes/No - I authorize Learn `n Move Childcare Center to include my child's photo in promotional displays, printed promotional materials and brochures for this program. I understand that the photographs of my child may be used to accompany written training materials or promotion of the program.

I understand that my child's name will NOT be used in any printed materials. However for displays/bulletin boards, my child's first name may be included.

Yes/No - I give permission for my child's photos to be placed on the Learn `n Move Facebook page and the Learn `n Move website.

Yes/No - I agree that I am to receive no compensation for my child's appearance or participation in any of the above listed materials.

Child's Name _____

Parent or Guardian _____

Date_____

LEARN'nMOVE

CHILDCARE CENTER

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 was 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 2020-2021

Household Size	1	2	3	4	5	6	7	8	Each Additional Person:
Yearly	$23,606	$31,894	$40,182	$48,470	$56,758	$65,758	$73,334	$81,622	$8,288
Monthly	$1,968	$2,658	$3,349	$4,040	$4,730	$5,421	$6,112	$6,802	$691
Weekly	$454	$614	$773	$933	$1,092	$1,251	$1,411	$1,570	$160

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, 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.

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION

CACFP Enrollment Form / Free and Reduced-Price Income Application (Child Care)

Complete one application per household. Please use a pen (not a pencil).

Center Name

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						Check all that apply		
		Arrival Time	Leave Time	M	T	W	T	F	S	S	B	AM	L	PM	D	EV	Foster Child	Migrant	Head Start

PARENTS OF INFANTS

My Choice of CACFP Infant Participation is:

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.

- ☐ 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 ☐ FDPIR?

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? Weekly ○ Bi-Weekly ○ Monthly ○ 2xMonth ○	Welfare/Child Support/Alimony	How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2xMonth ○	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2xMonth ○
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	
	$		$		$	

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member: X X X | X X | ☐ (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	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• 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	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• 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**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• 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

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.

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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

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? Weekly ○ | Bi-Weekly ○ | Monthly ○ | 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ | Reduced ○ | Denied ○

Determining Official's Signature | Date | Confirming Official's Signature | Date | Follow-up Official's Signature | Date

Registration Form
TNT Kid's Fitness & Gymnastics

2800 Main Ave Fargo, ND 58103
www.tntkidsfitness.org
Phone: 701-365-8868 Fax: 701-365-8870
Email: kidscomefirst@tntkidsfitness.org

Parent / Guardian Information

Parent / Guardian Name: _____ _____
(First) (Last)

Phone Number: _____ Email Address: _____

Parent / Guardian Name: _____ _____
(First) (Last)

Phone Number: _____ Email Address: _____

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

How did you hear about us? _____

Child 1

Child Name: _____ _____ Birth Date: _____ Gender: _____
(First) (Last)

Class Choice: _____ Day: _____ Time: _____

Child 2

Child Name: _____ _____ Birth Date: _____ Gender: _____
(First) (Last)

Class Choice: _____ Day: _____ Time: _____

Child 3

Child Name: _____ _____ Birth Date: _____ Gender: _____
(First) (Last)

Class Choice: _____ Day: _____ Time: _____

ASSUMPTION OF RISK, WAIVER OF LIABILITY, & MEDICAL AUTHORIZATION

In consideration for allowing my child(ren)to use these facilities, I, on my behalf of my child(ren) and as legal parent/guardian, I recognize what potentially severe injuries, including permanent paralysis or death can occur in sports or activities involving height or motion, including but not limited to gymnastics, tumbling & trampoline, birthday parties, special events & activities including inflatables, camps, parent participant activities and any and all other programs offered at TNT Kid's Fitness. I further recognize that participation in these activities could result in my child(ren)'s exposure to illness and communicable diseases including but not limited to MRSA, influenza, and COVID-19. Preventative measures and personal discipline may reduce the risks of exposure, however, I understand the risk of serious illness including death does exist. Being fully aware of these dangers, I voluntarily consent to the aforementioned person(s) participating in any and all TNT Kid's Fitness programs and activities and I ACCEPT ALL RISKS associated with that participation. By your attendance in class or events at TNT, you are granting your permission for you and your child(ren) to be filmed, videotaped, audio taped, or photographed by a means and are granting full use of your likeness, voice, and words without compensation. In the event that transportation is provided to an activity at TNT Kid's Fitness, I hereby give permission for my child(ren) to travel to and from those activities in the vehicle provided and agree not to hold TNT Kid's Fitness, its directors, officers, agents, or employees liable for any accident or injury suffered or contracted in connection with such travel. In the event of an emergency I would like my below mentioned child(ren)/ward to be taken to a hospital for medical treatment and I hold TNT Kid's Fitness and its representatives harmless in their execution of this action. Additionally, I hereby agree to individually provide for all possible future medical expenses which may be incurred by my child ward as a result of any injury sustained while participating at or for TNT Kid's Fitness.

I have read and understood this ASSUMPTION OF RISK, WAIVER OF LIABILITY, & MEDICAL AUTHORIZATION.

Parent/ Guardian Signature: _____ Date: _____