the sprout school

Dear Parent or Guardian,

Thank you for your interest in the Sprout School. We provide care for children from 2 ½ years to 12 years old. We are dedicated to providing an environment that encourages the social, emotional, physical and intellectual growth and development of children. We understand that childhood is a special time and are 100% committed to providing an environment that will assist your child in being ready for kindergarten and/or being successful in elementary school.

The Sprout School is licensed by the Commonwealth of Virginia. The preschool program is one of only 15 metro-area preschools that are accredited by the National Association for the Education of Young Children (NAEYC). NAEYC accredited programs represent the highest caliber of early childhood education programs and can take years of work to achieve. Our center is also STAR rated by the Virginia Quality Initiative System.

Our Preschool uses an approach which is innovative and inspiring. It values the child as *strong, capable* and *resilient.* Their wonder and desire are nurtured. Each child brings with them deep curiosity and potential that is enhanced through the classroom environment, learning materials and teacher-child interactions.

The Sprout School welcomes the opportunity to serve your family and your child.

Sincerely,

Kathleen Eastman

Kathleen Eastman
Director of Child and Family Development

the sprout school

Child Registration Process

___ Child Registration Form (2 pages)

___ Parental Agreement Form

___ Parent Permissions Form

___ Provide School Entrance Health Form (4 pages) – Immunizations and Physical (completed by physician)

___ Provide Copy of Birth Certificate

___ Fee Agreement Form

___ CACFP Form (does not affect tuition rate)

___ FAST Application for Financial Aid (online - if requesting aid)

___ $45 Registration Fee

___ First Week Tuition

the sprout school

The Sprout School Application

Parent or Guardian Name: _____

Address: _____

_____

Email Address: _____

Phone Contact #: _____

Name of Child: _____

Birthdate: _____

Desired Start Date: _____

Desired Location: _____

_____ _____

Signature of Parent/Guardian Date

The Sprout School - Child Registration Form

Date of Enrollment _____
Date of Withdrawal _____

Child Information

First Name: _____ M.I. _____ Last Name: _____
Name child prefers to be called: _____
Child's Address: _____
Gender: _____ Race (optional): _____ Date of Birth: _____
Please list any allergies or medical conditions requiring special care:

_____
Physician's Name: _____ Phone: _____
Physician's Address: _____
Health Insurance Company: _____ Policy #:_____
Has your child attended child care or school previously? ____ yes ____no
If so, where_____
Is your child currently attending another child care of school? ___ yes ___no
If so, where_____

Parent/Guardian 1 Information

Relationship to child: _____ Lives with child? _____
First Name: _____ Last Name: _____
Address: _____
Is this parent employed? ___ yes ____ no
If yes, name and address of employer
Name:_____ Address:_____
Home Phone Number _____
Work Phone Number _____
Cell Phone Number _____
Email (if available) _____

Parent/Guardian 2 Information

Relationship to child: _____ Lives with child? _____
First Name: _____ Last Name: _____
Address:_____

_____
Is this parent employed? ___ yes ____ no
If yes, name and address of employer
Name:_____ Address:_____
Home Phone Number _____
Work Phone Number _____
Cell Phone Number _____
Email (if available) _____

(see back)

Emergency Contacts/Authorized Persons for Release (MUST LIST AT LEAST 2)

Contact 1
Name: _____
Address: _____
Phone: _____
Relationship to child: _____
_____ **contact in case of emergency** _____**can pick up child**

Contact 2
Name: _____
Address: _____
Phone: _____
Relationship to child: _____
_____ **contact in case of emergency** _____**can pick up child**

Contact 3
Name: _____
Address: _____
Phone: _____
Relationship to child: _____
_____ **contact in case of emergency** _____**can pick up child**

Contact 4
Name: _____
Address: _____
Phone: _____
Relationship to child: _____
_____ **contact in case of emergency** _____**can pick up child**

No child will be released to any person not authorized by the parent/guardian.
Are there any persons legally prohibited from picking up the child?
If so, list name and address and provide legal documents (custody, restraining order)

_____
_____

Additional Information:

_____
_____
_____
_____

_____ _____
Signature of Parent/Guardian **Date**

The Sprout School
Parental Agreement Form

Please initial each agreement:

_____ The parent/guardian must provide the child's immunization record and birth certificate prior to the child being enrolled.

_____ The parent/guardian must provide a current physical form completed by the child's physician within 1 month of enrollment, and requested to remain up-to-date.

_____ The parent/guardian authorizes The Sprout School to obtain immediate medical care if an emergency occurs and the parent/guardian can not be located immediately.

_____ The parent/guardian agrees to notify The Sprout School immediately of any changes in contact information including home address, phone numbers, and changes to emergency contacts' information.

_____ In the event that The Sprout School contacts that parent/guardian because their child is ill (as defined in the parent handbook), the parent/guardian agrees to arrange to have the child picked up as soon as possible (within 1 hour).

_____ The parent/guardian agrees to inform The Sprout School within 24 hours (or the next business day) if the child or any member of the household has developed a reportable communicable disease, as defined by the State Board of Health. Life threatening diseases must be reported immediately.

_____ The parent agrees to inform The Sprout School if their child will not be attending for the day by calling the center by 9:00 am.

_____ The parent/guardian agrees to provide at least 1 set of labeled clothing to be kept at The Sprout School at all times during the child's enrollment and to replace it as needed.

_____ The parent/guardian agrees to pay tuition by Friday for the upcoming week, unless other arrangements are made. If tuition payments are not made in a timely manner, enrollment will be terminated.

_____ If the child uses The Sprout School transportation, the parent/guardian (or a documented release person) agrees to accompany the child to the van at pick-up and be waiting to remove the child from the van at drop-off.

_____ I have received a copy of The Sprout School Parent Handbook and agree to follow the policies, procedures and expectations described in the handbook. I understand that I am responsible to the appropriate behavior of any one acting on my behalf, i.e.: picking up my child.

_____ I understand that failure to comply with the above agreements or the policies, procedures and expectations described in the parent handbook could affect the continued enrollment of my child.

_____ _____

Signature of Parent/Guardian Date

The Sprout School
Parent Permissions Form

Name of child: _____

I give permission for The Sprout School to obtain medical care for my child if an emergency occurs and I can not be reached.
_____ yes ____ no

I give permission for my child to participate in the following screenings: development, vision, hearing, behavioral, dental and physical. I will be informed of the date and time of the screening and may attend any that I would like to attend.
_____ yes _____no

I give permission for my child to go on field trips (including walks in the neighborhood) and to be transported for events away from The Sprout School. I will be notified of any field trip requiring transportation ahead of time including the date, destination, departure time and return time. I understand the teacher and volunteers will chaperone my child and that I may choose to attend as a chaperone.
_____ yes _____ no

I give permission to The Sprout School to offer additional services to my child/family including but not limited to, case management/counseling, resource referral for food, clothing or services, or donated items at no charge to me.
_____ yes _____ no

I give permission for my child to be filmed/photographed to support the work of the YWCA of Richmond. I understand that the services of The Sprout School are only possible because of public awareness and special funding and that this funding sometimes requires photographic evidence of the work we do with children. These films/photographs are used on social media, newsletters, annual reports, etc. and are generally used to let the public know how their support benefits the community.
_____ yes _____ no _____ yes, if I know the purpose and time of the photography

_____ _____
Signature of Parent/Guardian **Date**

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Name of Parent or Legal Guardian 2: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Emergency Contact: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school.*** *When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____ Date: _____/_____/_____

Signature of person completing this form: _____ Date: _____/_____/_____

Signature of Interpreter: _____ Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |___|___|___|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**___/___/____

Student's Name:_____ Date of Birth: |___|_ __|___ _|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

TB Screening: ☐ **No risk for TB infection identified** ☐ **No symptoms compatible with active TB disease**
☐ **Risk for TB infection or symptoms identified**
Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result: ☐ **Positive** ☐ **Negative**
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ ☐ **Normal** ☐ **Abnormal**

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead: _____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

Stereopsis	☐ Pass	☐ Fail		☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test – needs rescreen**

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):
☐ **Well child; no conditions identified of concern to school program activities**
☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epinephrine auto-injector ☐ other: _____

___ **Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ Date: ____/____/_____

Practice/Clinic Name: _____ **Address:** _____

Phone: _____-_____-_____ **Fax:** _____-_____-_____ **Email:** _____

The Sprout School Fee Agreement

Child's Name _____

Service Provided _____

Cost of Service _____

Start Date _____

End Date _____

Signature of Parent/Guardian _____

Date _____

For Office Use Only:
___ New
___ Change
___Termination

Annual Enrollment Form

Virginia Child and Adult Care Food Program

ONE FORM PER ENROLLED CHILD, NEW FORM MUST BE COMPLETED EVERY 12 MONTHS

This form is required for:	This form is NOT required for:
Child Care Centers, Head Start, Even Start, and Licensed Outside School Hours Programs	At-Risk After-School, or Emergency Shelters

Center Information – *Sponsoring Institutions should pre-fill this section*

_____ *Cer*

_____ *Center Address*

The Sprout School
6 N. 5th Street
Richmond, VA 23219

_____ *CACFP Sponsor Number*

_____ *State* _____ *Zip Code*

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 12 months thereafter. This information will help ensure all children receive appropriate meals during their care. **The parent or guardian must complete Sections 1 through 6. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6.**

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
		TIME IN (check AM/PM and record time)			TIME OUT (check AM/PM and record time)			TIME CHILD ATTENDS SCHOOL (record in/out times)	
		AM	PM	Time	AM	PM	Time	Leaves Center	Returns To Center	
_____ *Child's First Name*	☐ Monday									☐ Breakfast
_____ *Child's Last Name*	☐ Tuesday									☐ Lunch
	☐ Wednesday									☐ PM Snack
	☐ Thursday									
	☐ Friday									
_____ *Date of Birth* _____ *Age*	☐ Saturday									
	☐ Sunday	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours.								

5 Ethnic/Racial Categories

Please answer both questions. This information is voluntary.

A. Ethnic data of child(ren): **Mark one only**	☐ Hispanic or Latino	☐ Not Hispanic or Latino			
B. Racial data of child(ren): **Mark one or more that apply**	☐ Asian	☐ White	☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander	☐ American Indian or Alaska Native

6 Signature and Date (parent or guardian must complete this section)

I certify the information above is correct.

_____ *Signature of Parent or Guardian* _____ *Date* _____ *Parent's Telephone Number (optional)*

NON-DISCRIMINATION STATEMENT: 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 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 and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

Child Care Representative Use Only

Effective Date of This Enrollment Form: _____

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

This form is effective for 12 months from the date of parent signature.

_____ *Signature of Center Representative* _____ *Date*

VIRGINIA CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

1 All Household Members | 2 | 3

NAMES OF ALL HOUSEHOLD MEMBERS [Adults and Children] First, Middle Initial, Last		Check if NO income	Ages of children at center	2 FOSTER CHILD Skip to Part 6 if all are foster children.	3 SNAP, TANF or FDPIR CASE # Skip to Part 6 if you list a SNAP, TANF or FDPIR case number. MUST BE SEVEN (7) DIGITS
1.		☐		☐	
2.		☐		☐	
3.		☐		☐	
4.		☐		☐	
5.		☐		☐	
6.		☐		☐	

4 Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your School Homeless Liaison, Migrant Coordinator.

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 IS RECEIVED (Example: $100/month, $100/twice a month, $100/every other week, $100/week)							
	Earnings From Work		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 Part 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 that all information on this form is true and that all income is reported. I understand that the center or day care home 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.

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 Optional - Sharing Information with Virginia's Health Insurance Program for Children (FAMIS)

May we share your information on this application with the *FAMIS*, the complete health insurance program for every child in Virginia? If **yes**, do not sign below.

☐ No, I do not want my information from this application shared with the FAMIS. Date: _____ Sign here: _____

PRIVACY ACT 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 your 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.

NON-DISCRIMINATION STATEMENT: 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 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 and wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish). USDA is an equal opportunity provider and employer.

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:	☐ **REDUCED** based on:	☐ **DENIED** reason:
☐ foster child ☐ migrant ☐ SNAP or TANF ☐ homeless ☐ runaway ☐ household income	☐ household income	☐ income too high ☐ incomplete application ☐ non-qualifying SNAP/TANF

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

The Sprout School uses the online service of ism's Financial Aid for School Tuition (FAST) to process applications. FAST will be the standard submission format for all applications.

FAST does not decide whether financial assistance will be given or how much to give; rather FAST provides a need-based financial aid analysis service which includes a recommendation of what a family should reasonably contribute toward tuition. All information from FAST is kept confidential. Results are reviewed by the Sprout School. Upon approval, scholarship amounts are then sent to families.

As a reminder, you must reapply each year. To start the process, please do the following:

- Log onto the School's website at www.sproutschoolrva.org.
- Click into Enrollment.
- Click on the "FAST" logo/link.
- Click 'Start Application' to begin.
- The application process is self-guided. You may navigate in and out of the program allowing you to partially complete an application and go back to it at another time. FAST has a 24/7/365 helpline available to you should you have any questions, which can be reached by calling 1-877-326-FAST (2378). Please do not call the school with questions.
- The charge for the application is $41.00 and to be paid by credit card (Visa, MasterCard or American Express) after all sections have been completed. If you do not have a credit card, please call the Sprout School for assistance.
- After completing the online application, you will be required to scan or mail your 2015 tax documents (Federal taxes including all schedules and W-2's to FAST for verification purposes:

  Independent School Management
  Attn: FAST Processing Center
  1316 N. Union Street
  Wilmington, DE 19806

Your tax return must follow the submission of the online application and be submitted to FAST.