



**Nehemiah**  
C E N T E R

# Application Check List

Kindergarten – High School		Pre-Kindergarten	
1.	<input type="checkbox"/> Please attach a copy of your STAAR	1.	<input type="checkbox"/> Completed Meal Application Form
2.	<input type="checkbox"/> Last Report Card (Most Recent Copy)	2.	<input type="checkbox"/> Copy of Immunization Records
3.	<input type="checkbox"/> Stanford Scores	3.	<input type="checkbox"/> Complete Medical Form
4.	<input type="checkbox"/> Completed Meal Application Form	4.	<input type="checkbox"/> Residential Verification (Utility Bill w/current address)
5.	<input type="checkbox"/> Copy of Immunization Record	5.	<input type="checkbox"/> 1040 Income Verification or letter from employer
		6.	<input type="checkbox"/> Birth Certificate

Last Name (child) \_\_\_\_\_

First Name (Child) \_\_\_\_\_

School \_\_\_\_\_

Grade Level \_\_\_\_\_

Please return all completed admission forms to Dr. Okere or Ms. Jazmin

Please make sure that everything on the form is filled out and signed. Forms with missing information will be rejected

(Do not write below this line)

## OFFICE USE ONLY

\_\_\_\_\_ Application Date

\_\_\_\_\_ Application Approval Date (all items are present)

\_\_\_\_\_ Enrollment Date

\_\_\_\_\_ Start Date (Billing Begins)



### Admission Information

Use this form to collect all required information about a child enrolling in day care.

**Directions:** The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

#### General Information

Operation's Name: <b>Nehemiah Center</b>		Director's Name: <b>Tonia Labbe</b>	
Child's Full Name:		Child's Date of Birth:	Child Lives With? <input type="radio"/> Both parents <input type="radio"/> Mom <input type="radio"/> Dad <input type="radio"/> Guardian
Child's Home Address:		Date of Admission: <b>8/12/2024</b>	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian (if different from the child's):	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? <input type="radio"/> Yes <input type="radio"/> No
<b>In case of an emergency, call:</b>			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation to <b>release</b> my child to leave the child care operation <b>ONLY</b> with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	
Name:		Area Code and Phone No.:	

#### Consent Information

<b>1. Transportation:</b>
I give consent for my child to be transported and supervised by the operation's employees (Check all that apply). <input type="checkbox"/> for emergency care <input type="checkbox"/> on field trips <input type="checkbox"/> to and from home <input type="checkbox"/> to and from school
<b>2. Field Trips:</b>
<input type="radio"/> I give consent for my child to participate in field trips. <input type="radio"/> I do not give consent for my child to participate in field trips.
Comments: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

**3. Water Activities:**

I give consent for my child to participate in the following water activities (Check all that apply).

water table play    sprinkler play    splashing or wading pools    swimming pools    aquatic playgrounds

<p>Is your child able to swim without assistance?</p> <p><input type="radio"/> Yes   <input type="radio"/> No</p>	<p>Does your child have any physical, health, behavioral or other condition that would put them at risk while swimming?</p> <p><input type="radio"/> Yes   <input type="radio"/> No</p>
<p>Do you want your child to wear a life jacket while in or near a swimming pool?</p> <p><input type="radio"/> Yes   <input type="radio"/> No</p>	

**4. Receipt of Written Operational Policies:**

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

<input type="checkbox"/> Discipline and guidance	<input type="checkbox"/> Procedures for release of children
<input type="checkbox"/> Suspension and expulsion	<input type="checkbox"/> Illness and exclusion criteria
<input type="checkbox"/> Emergency plans	<input type="checkbox"/> Procedures for dispensing medications
<input type="checkbox"/> Procedures for conducting health checks	<input type="checkbox"/> Immunization requirements for children
<input type="checkbox"/> Safe sleep	<input type="checkbox"/> Meals and food service practices
<input type="checkbox"/> Procedures for parents to discuss concerns with the director	<input type="checkbox"/> Procedures to visit the center without securing prior approval
<input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions	<input type="checkbox"/> Procedures for supporting inclusive services
<input type="checkbox"/> Procedures for parents to participate in operation activities	<input type="checkbox"/> Procedures for parents to contact Child Care Regulation (CCR), DFPS, Child Abuse Hotline, and CCR website

**5. Meals:**

I understand that the following meals will be served to my child while in care (Check all that apply):

None    Breakfast    Morning snack    Lunch    Afternoon snack    Supper    Evening snack

**6. Days and Times in Care:**

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

**7. Receipt of Parent's Rights:**

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

\_\_\_\_\_  
Signature — Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

**8. Child's Special Care Needs (check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Environmental allergies                                 | <input type="checkbox"/> Limitations or restrictions on child's activities        |
| <input type="checkbox"/> Food intolerances                                       | <input type="checkbox"/> Reasonable accommodations or modifications               |
| <input type="checkbox"/> Existing illness  | <input type="checkbox"/> Adaptive equipment ( <i>include instructions below</i> ) |
| <input type="checkbox"/> Previous serious illness                                | <input type="checkbox"/> Symptoms or indications of complications                 |
| <input type="checkbox"/> Injuries and hospitalizations ( <i>past 12 months</i> ) | <input type="checkbox"/> Medications prescribed for continuous long-term use      |
| <input type="checkbox"/> Other: _____  |   |

Explain any needs selected above:

Does your child have diagnosed food allergies?  Yes  No Food Allergy Emergency Plan Submitted Date: \_\_\_\_\_

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit <https://www.ada.gov/resources/child-care-centers/>. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_

**9. School Age Children**

My child attends the following school:	School Area Code and Phone No.:
--	---------------------------------

My child has permission to (*check all that apply*):

walk to or from school or home  ride a bus  be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

**Authorization For Emergency Medical Attention**

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_



### Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

**Varicella (Chickenpox)**

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about            [date] and does not need varicella vaccine.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date Signed**

**Additional Information Regarding Immunizations**

For additional information regarding immunizations, visit the Texas Department of State Health Services website at [www.dshs.state.tx.us/immunize/public.shtm](http://www.dshs.state.tx.us/immunize/public.shtm).

**TB Test (If required)**

Positive    Negative   Date: \_\_\_\_\_

**Gang Free Zone**

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

**Privacy Statement**

HHSC values your privacy. For more information, read our privacy policy online at: <https://hhs.texas.gov/policies-practices-privacy#security>

**Signatures**

\_\_\_\_\_  
**Child's Parent or Legal Guardian**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Center Designee**

\_\_\_\_\_  
**Date Signed**

**Physician or Public Health Personnel Verification**

Signature or stamp of a physician or public health personnel verifying immunization information above:

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date Signed**



### CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Part 6. Participant's ethnic and racial identities (optional)	
Mark one ethnic identity:	Mark one or more racial identities:
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> Black or African American
<b>Don't fill out this part. This is for official use only.</b>	
Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12	
Total Income: \$ _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year Household size: _____	
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Tier I ___ Tier II ___	
Reason: _____	
Temporary: Free ___ Reduced ___ Time Period: _____ (expires after ___ days)	
Determining Official's Signature: _____ Date: _____	
Confirming Official's Signature: _____ Date: _____	
Follow-up Official's Signature: _____ Date: _____	

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

Household size	Yearly
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person:	

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 the participant 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 for the participant or other (FDPIR) identifier 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired 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."





# CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

## Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**Part 2. Benefits:** If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**  
 NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

**Part 3.** 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 at Phone #] Homeless  Migrant  Runaway

## Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List <b>only</b> household members with income)	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
<i>(Example)</i> Jane Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$ / Select One
	\$ / Select One	\$ / Select One	\$ / Select One	\$ / Select One
	\$ / Select One	\$ / Select One	\$ / Select One	\$ / Select One
	\$ / Select One	\$ / Select One	\$ / Select One	\$ / Select One
	\$ / Select One	\$ / Select One	\$ / Select One	\$ / Select One
	\$ / Select One	\$ / Select One	\$ / Select One	\$ / Select One

**Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**  
 An adult household member must sign this form. **If Part 3 is completed, 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.** (See Statement on the back of this page.)

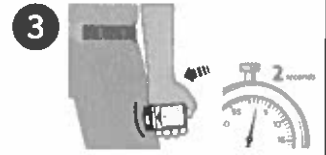
*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Last four digits of Social Security Number: \* \* \* - \* \* \* - \_\_\_\_\_  I do not have a Social Security Number



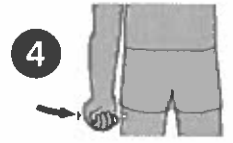
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



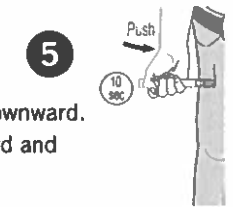
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE SYMJEPi™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPi by finger grips only and slowly insert the needle into the thigh. SYMJEPi can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

## OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_



**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

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

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

**THEREFORE:**

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

## FOR ANY OF THE FOLLOWING: **SEVERE SYMPTOMS**



### **LUNG**

Shortness of breath, wheezing, repetitive cough



### **HEART**

Pale or bluish skin, faintness, weak pulse, dizziness



### **THROAT**

Tight or hoarse throat, trouble breathing or swallowing



### **MOUTH**

Significant swelling of the tongue or lips



### **SKIN**

Many hives over body, widespread redness



### **GUT**

Repetitive vomiting, severe diarrhea



### **OTHER**

Feeling something bad is about to happen, anxiety, confusion

**OR A  
COMBINATION**  
of symptoms  
from different  
body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## **MILD SYMPTOMS**



### **NOSE**

Itchy or runny nose, sneezing



### **MOUTH**

Itchy mouth



### **SKIN**

A few hives, mild itch



### **GUT**

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## **MEDICATIONS/DOSES**

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_



# Parent/Guardian Acknowledgement Form

Please acknowledge receipt of the  
**“Parent’s Guide to Child Care”** by  
Signing below.

Local Child-Care Licensing Office  
PO Box 16014  
Houston, Texas 77222-6017

Parent/Guardian Name \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_  
Names of Child(ren) \_\_\_\_\_  
Date \_\_\_\_\_



# Parent/Guardian Acknowledgement Form

***Please write and sign your name at the bottom of the page to certify that you agree with the following statements regarding policies and/or expectations of the Nehemiah Center. RETURN SIGNED COPY TO STAFF.***

## A

I have read and understood the policies and expectations set forth in the Nehemiah Center, Inc. Parent Handbook. I agree to abide by the policies and will work towards remaining in good standing with the Center to ensure my child's enrollment privileges in the Center's programs.

## B

I agree that the Nehemiah Center, Inc. shall not be responsible for any personal injuries or losses sustained by my child(ren) while on the Center's premises or in vehicles as a result of any Nehemiah sponsored activities. I further agree to indemnify and hold harmless the Nehemiah Center from any claims or demands arising out of any such injuries or losses.

## C

I give authorization for my child to be photographed, videotaped, and or digitally recorded for all purposes toward the Center's daily operations. This includes but is not limited to: **Annual Newsletters; Thank You Letters; Photo Albums; Off-Campus Activities; Family Services; Volunteer Program; College Prep Program; Fundraising & Development; Marketing & Advertising.**

## D

I acknowledge that report cards and other standardized test scoring are to be received by the Director of Education from myself or my child **upon the day of the release of academic information** that is set by Houston Independent School District (HISD). I Understand that photocopies of academic grades and/or test scores will be kept in my child's individual academic file. In the event that academic reporting is not received within one week of release from the school, the Director of Education reserves the right to contact the school about my child's grades and overall conduct.

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Names of Child(ren) \_\_\_\_\_

Date \_\_\_\_\_



**Nehemiah**  
CENTER

# Parent Data

Today's Date \_\_\_\_\_

Mother's Name \_\_\_\_\_ # of years at Nehemiah \_\_\_\_\_ Check if New

Marital Status  Single  Married  Separated  Divorced

Mother's Occupation \_\_\_\_\_ Name of Employer \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Home Address \_\_\_\_\_

Education: Highest level of education completed?

High School or Less  Some College  Associates Degree  College Degree  Post-Graduate

Annual Household Income \_\_\_\_\_

Father's Name \_\_\_\_\_ # of years at Nehemiah \_\_\_\_\_ Check if New

Marital Status  Single  Married  Separated  Divorced

Father's Occupation \_\_\_\_\_ Name of Employer \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Home Address (if different from mother's) \_\_\_\_\_

Education: Highest level of education completed?

High School or Less  Some College  Associates Degree  College Degree  Post-Graduate

## LIST EVERYONE IN YOUR HOUSEHOLD:

	Last Name	First Name	Age	Grade
1				
2				
3				
4				
5				
6				
7				
8				

Dear Parent/Guardian:

Children need healthy meals to learn. Your child's school offers healthy meals every school day. Your children may qualify for free meals or for reduced price meals.

1. **DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD?** No. You can use *one Free and Reduced Price School Meals Application for all students in your household*. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to one of your children's school.
2. **WHO CAN GET FREE MEALS?** All children in households receiving benefits from the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations or, in some States Temporary Assistance for Needy Families (TANF), can get free meals regardless of your income. Also, your children can get free meals if your household's gross income is within the free limits on the Federal Income Eligibility Guidelines.
3. **CAN FOSTER CHILDREN GET FREE MEALS?** Yes, foster children that are under the legal responsibility of a foster care agency or court, are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income.
4. **CAN HOMELESS, RUNAWAY, AND MIGRANT CHILDREN GET FREE MEALS?** Yes, children who meet the definition of homeless, runaway, or migrant qualify for free meals. If you haven't been told your children will get free meals, please call or e-mail your child's school to see if they qualify.
5. **WHO CAN GET REDUCED PRICE MEALS?** Your children can get low cost meals if your household income is within the reduced price limits on the Federal Eligibility Income Chart, shown on this application.
6. **SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE APPROVED FOR FREE MEALS?** Please carefully read the letter you got and follow the instructions. Call your child's school if you have questions.
7. **MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE?** Yes. Your child's application is only good for that school year and for the first few days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.
8. **I GET WIC, CAN MY CHILD(REN) GET FREE MEALS?** Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out an application.
9. **WILL THE INFORMATION I GIVE BE CHECKED?** Yes and we may also ask you to send written proof.
10. **IF I DON'T QUALIFY NOW, MAY I APPLY LATER?** Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free or reduced price meals if the household income drops below the income limit.

11. **WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION?** You should talk to school officials. You also may ask for a hearing to have the decision reviewed.
12. **MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN?** Yes. You or your child(ren) do not have to be U.S. citizens to qualify for free or reduced price meals.
13. **WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD?** You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.
14. **WHAT IF MY INCOME IS NOT ALWAYS THE SAME?** List the amount that you normally receive. For example, if you normally make \$1000 each month, but you missed some work last month and only made \$900, put down that you make \$1000 per month. If you normally get overtime pay, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.
15. **WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME?** If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.
16. **MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HER COMBAT PAY COUNTED AS INCOME?** No, if the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your child's school for more information.
17. **MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR?** To find out how to apply for other assistance benefits, contact your local assistance office.



**Income Eligibility Guidelines  
for Determining Free or Reduced-Price Benefits  
July 1, 2024 – June 30, 2025**

Children from households whose incomes are at or below the levels shown below, or who receive Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits, are eligible for free or reduced-price meals.

Adult Day Care participants whose household incomes are at or below the levels shown below, or who receive Medicaid, Supplemental Security Income (SSI), or SNAP benefits, are eligible for free or reduced-price meals.

**Ingresos máximos para determinar la elegibilidad  
para beneficios gratuitos o a precio reducido  
1 de julio de 2024 - 30 de junio de 2025**

Los niños de hogares con ingresos iguales o menores a los niveles que se muestran a continuación, o que reciben Asistencia Temporal para Familias Necesitadas (TANF), ayuda del Programa Suplementario de Asistencia Nutricional (SNAP), o del Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) califican para recibir comidas gratuitas o a precio reducido.

Las personas que participan en programas de Cuidado Diario para Adultos cuyos ingresos familiares son iguales o por debajo de los niveles que se muestran a continuación, o que reciben Medicaid, Seguridad de Ingreso Suplementario (SSI), TANF, o beneficios de SNAP o FDPIR califican para recibir comidas gratuitas o a precio reducido.

FAMILY SIZE	ANNUAL	MONTHLY	TWICE MONTHLY	BI-WEEKLY	WEEKLY
1	\$27,861	\$2,322	\$1,161	\$1,072	\$536
2	\$37,814	\$3,152	\$1,576	\$1,455	\$728
3	\$47,767	\$3,981	\$1,991	\$1,838	\$919
4	\$57,720	\$4,810	\$2,405	\$2,220	\$1,110
5	\$67,673	\$5,640	\$2,820	\$2,603	\$1,302
6	\$77,626	\$6,469	\$3,235	\$2,986	\$1,493
7	\$87,579	\$7,299	\$3,650	\$3,369	\$1,685
8	\$97,532	\$8,128	\$4,064	\$3,752	\$1,876
For each additional family member add:	\$9,953	+\$830	+\$415	+\$383	+\$192



# Building for the Future

This child care receives Federal cash assistance to serve healthy meals to your children.  
Good nutrition today means a stronger tomorrow!

Meals served here must meet nutrition requirements established by USDA's  
Child and Adult Care Food Program.

## Questions? Concerns?

Call USDA at  
1-866-873-2263

Food and Nutrition Division at  
1-800-TELL-TDA  
(835-5832)

OR

Your child care at <Insert Entity Name Here>

Contact Information:

Address:

Phone Number:

Email Address:

Other Necessary Information:



Food and Nutrition Division  
Child and Adult Care Food Program

TEXAS DEPARTMENT OF AGRICULTURE  
**COMMISSIONER SID MILLER**

Fraud Hotline: 1-866-5-FRAUD-4 or 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711  
Toll Free: (877) TEX-MEAL | For the hearing impaired: (800) 735-2989 (TTY)

This product was funded by USDA.  
This institution is an equal opportunity provider.



Updated 8/1/2024  
www.SquareMeals.org





# Construyendo Para El Futuro

Este cuidado infantil recibe asistencia federal en efectivo para server comidas saludables a sus hijos. Una Buena nutricion hoy en dia significa una manana mas fuerte.

Las comidas servidas aqui cumplen con los requisitos de nutricion establecidos por el Programa de Alimentos para el Cuidado de Ninos y Adultos (Child and Adult Care Food Program) de USDA.

## ¿Preguntas? ¿Preocupaciones?

Llame gratuitamente a USDA al  
1-866-873-2263

OR

División de Alimentos y Nutrición al  
1-800-TELL-TDA  
(835-5832)

Centro de cuidado de niños de su hijo al <Inserte el nombre de la entidad aquí>

Contact Information:

Address:

Phone Number:

Email Address:

Other Necessary Information:



DEPARTAMENTO DE AGRICULTURA DE TEXAS  
**COMISIONADO SID MILLER**

Línea directa de fraude: 1-866-5-FRAUD-4 o 1-866-537-2834 | P.O. Box 12847 | Austin, TX 78711  
Llamada gratuita: (877) TEX-MEAL | Para personas con problemas de audición: (800) 735-2989 (TTY)

Food and Nutrition Division  
Nutrition Assistance Programs

Este producto fue financiado por el USDA.  
Esta institución proporciona igualdad de oportunidades.



Updated 8/1/2024  
www.SquareMeals.org

**Good nutrition today means a stronger tomorrow!**

# Building for the Future

## with CACFP

This day care  
receives support  
from the Child and  
Adult Care Food  
Program to serve  
healthy meals to your children.



**Meals served here must meet USDA's  
nutrition standards.**

### **Questions? Concerns?**

*[Here is space for the State agency and sponsoring organization to add  
contact information]*

Learn more about CACFP at USDA's website:

<https://www.fns.usda.gov/>

USDA is an equal opportunity provider, employer and lender.

United States Department of Agriculture  
Food and Nutrition Service FNS-317  
November 2019

¡Buena nutrición hoy significa un mañana más saludable!

# Construyendo para el Futuro

## con CACFP

Esta guardería infantil recibe ayuda del Child and Adult Care Food Program para servir comidas nutritivas a sus niños.



**Comidas servidas aquí deben de seguir los requisitos nutricionales establecidos por USDA.**

## ¿Preguntas? ¿Inquietudes?

*[Here is space for the State agency and sponsoring organization to add contact information]*

Aprenda más información sobre CACFP en el sitio web del USDA: <https://www.fns.usda.gov/>

USDA es un proveedor, empleador y prestamista que ofrece igualdad de oportunidades.

United States Department of Agriculture  
Food and Nutrition Service FNS-317  
Noviembre 2019



# Join Texas WIC

## We're here for you

“Thanks to WIC,  
I now have the tools  
I need to make  
sure my family  
stays on the path to  
a healthy lifestyle.”

—Roxie, WIC Client



### As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

### Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

### Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	\$ 3,041	\$ 36,482
3	\$ 3,833	\$ 45,991
4	\$ 4,625	\$ 55,500
5	\$ 5,418	\$ 65,009
6	\$ 6,210	\$ 74,518

Effective April 1, 2023

\* A pregnant woman's household is increased by the number of infants she is expecting. If you have any income questions, call 1-800-942-3678.

**Start now. Call 1-800-942-3678 or visit [TexasWIC.org](https://TexasWIC.org)**



This institution is an equal opportunity provider.

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# Ven a WIC de Texas

## Estamos aquí para servirte

“Gracias a WIC, ahora tengo las herramientas que necesito para asegurar que mi familia siga el camino hacia un estilo de vida saludable.”

—Roxie, cliente de WIC



### Como cliente de WIC, recibirás:

- Alimentos deliciosos
- Asesoramiento individualizado con nutricionistas
- Recetas sencillas de preparar
- Clases sobre nutrición
- Apoyo para la lactancia
- Evaluaciones médicas y sobre las vacunas
- Demostraciones de cocina
- Apoyo personalizado
- Actividades para niños

### ¿Calificas?

Ocho millones de mujeres, bebés y niños reciben beneficios de WIC. El Programa WIC va dirigido a mujeres embarazadas, nuevos padres, bebés y niños menores de cinco años. Si ya recibes Medicaid, TANF o SNAP, es posible que califiques.

### Requisitos de ingresos de WIC de Texas

Número de personas en el hogar*	Ingresos mensuales	Ingresos anuales
2	\$ 3,041	\$ 36,482
3	\$ 3,833	\$ 45,991
4	\$ 4,625	\$ 55,500
5	\$ 5,418	\$ 65,009
6	\$ 6,210	\$ 74,518

Vigente a partir del 1 de abril de 2023

\* El número de personas en el hogar de una mujer embarazada aumenta de acuerdo con el número de bebés que espera. Si tienes alguna pregunta relacionada con los ingresos, llama al 1-800-942-3678.

**Empieza hoy mismo. Llama al 1-800-942-3678 o visita [TexasWIC.org](https://www.texaswic.org)**



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