Please select the center:

- ☐ Webberbrook
- ☐ ClubRowe
- ☐ Oxford Elementary
- ☐ Otisfield
- ☐ Paris Elementary

Intake

Admission Date:_____ Exit Date:_____

Child's Last Name:_____ First Name: _____Child's MI _____

Gender: _____ Date of Birth: _____Phone:_____

Physical Address: _____ Zip Code: _____

Mailing Address: _____ Zip Code: _____

Parent/Guardian information

☐ If there are custody agreements, please check box and provide necessary legal documentation

Parent/Guardian Name: _____ Relationship to Child: _____

Parent/Guardian Physical Address: _____

Parent/Guardian Mailing Address: _____

Parent/Guardian E-mail:_____ Parent/Guardian Home Phone:_____

Parent/Guardian Work phone: _____ Parent/Guardian Cell Phone: _____

Parent/Guardian Employer: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Parent/Guardian Physical Address: _____

Parent/Guardian Mailing Address: _____

Parent/Guardian E-mail:_____ Parent/Guardian Home Phone:_____

Parent/Guardian Work phone: _____ Parent/Guardian Cell Phone: _____

Parent/Guardian Employer: _____

First contact while your child is in care: _____

The facility will immediately notify the child's parent or legal guardian of any illness, serious injury or accident involving your child. An adult designated below by the parent/legal guardian must be provided should the parent be unavailable at the time of emergency.

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact Address: _____

Names of individuals who are to be permitted to remove the child from the child care center.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Immunization Documentation Statement

A current copy of immunizations is required to be on file for your child to attend child care in Maine.

Child Physician: _____ Phone Number _____

Family Dentist: _____ Phone Number _____

Allergies/Medications/Medical Conditions:

_____

AUTHORIZATIONS

Please initial each section, sign the bottom of the form.

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

☐ I have received and read the Oxford SACC Family Handbook.

☐ I authorize the staff of *Oxford SACC* to seek any emergency medical treatment necessary for my child while in their care including but not limited to transporting to the nearest emergency center or summon an ambulance for emergency medical care. If such emergency should arise, I will be notified as soon as possible. I agree that any cost incurred for such services shall be my sole responsibility.

☐ I grant permission for my child to leave *Oxford SACC* premises under the supervision of a staff member for neighborhood walks.

☐ I grant permission for my child to be included in pictures and video taken of program activities for the purposes of developmental documentation or promotional information for any of the *Oxford SACC* programs: **(please check off all that apply)**

☐ **Newspapers** ☐ **Television** ☐ **Facebook page** ☐ **Brochures**

☐ **Newsletters** ☐ **In house postings**

☐ I agree to pay my account in full by **Friday each week unless otherwise approved by senior management**, as stated in my contractual agreement plus any additional charges incurred as a result of late arrival and/or extended hours of childcare as stated in the Family Handbook.

_____ I agree to pay for any unusual damage done to any *Oxford SACC* Property by my child.

Parent/Guardian Printed Name Signature Date

Developmental History and Background

CHILD'S NAME:_____ **DATE OF BIRTH:** _____

DEVELOPMENTAL HISTORY

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

Does your child crawl? _____ Pull to Stand? _____ Walk with support? _____

Approximately how many words does your child say? _____

Any speech concerns?_____

Does your child use pacifier? _____ Suck thumb?_____

Does your child have a fussy time?_____ When? _____

How do you handle this time? _____

HEALTH HISTORY

Any complications at birth? _____

Any serious illnesses and/or hospitalizations? _____

Any physical limitations? _____

MEDICATIONS

List any medications your child takes on a regular basis:

Diagnosis	Medication	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

EATING HABITS

Any feeding difficulties? _____

Favorite foods? _____

Foods refused? _____

Does your child eat at a table? _____ Highchair? _____

Does your child eat with a spoon? _____fork? _____ hands? _____

TOILET HABITS

Are disposable or cloth diapers used? _____

Is there a frequent occurrence of diaper rash? _____

Do you regularly use: diaper cream: _____ powder: _____ lotion: _____other? _____

Are bowel movements regular? _____ How many per day? _____

Any problems with loose stools? _____ Constipation? _____

Has toilet training been attempted? _____

Please describe any particular procedure to be used for your child at the center: _____

_____

What is used at home? Potty-chair _____ Adapted child seat _____ regular toilet seat _____

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

Is your child ever reluctant to use the bathroom? _____

Does your child have regular accidents? _____

SLEEPING HABITS

Does your child sleep in a crib? _____ bed? _____ other: _____

Does your child nap during the day (include when and how long)? _____

_____

When does your child go to bed at night? _____ get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on awakening, etc.): _____

_____

DEVELOPMENTAL CONCERNS

Do you have any concerns about your child's vision? _____

Do you have any concerns about your child's hearing? _____

Do you have any concerns about your child's behavior? _____

Please share any concerns you have about your child's development.

_____

_____

Parent/Guardian Signature: _____ Date: _____

CHILD'S NAME:_____ **DATE OF BIRTH:** _____

General Health _____

Primary language spoken at home: _____

YOUR CHILD AND FAMILY

Please list all household members:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Family Pets and Names:

Favorite indoor toys or activities at home

Favorite outdoor toys or activities at home

What is your child's favorite book? _____

What is your child's favorite character? _____

What is your child's favorite song? _____

What are your child's favorite foods? _____

What foods does your child dislike? _____

What would be a special reward for your child? _____

Previous child care or preschool experiences:

What discipline strategies are used at home?

Please describe your child's schedule on a typical day.

Please share anything else that would help us to make your child's experience more enjoyable:

Sunscreen & Bug Spray Authorization

Name of Child: _____

SUNSCREEN PERMISSION

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission for staff of any **Oxford SACC Programs** to apply a sunscreen product that is broad spectrum with SPF 15 or higher to my child, as specified below, when he/she will be playing outside, especially during the months of March through October and between the daily time of 10 AM and 4 PM.

I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of ears, nose, bare shoulders, arms and legs.

I have *initialed* below **all** applicable information for the use of sunscreen for my child:

_____ I do not know of any allergies my child has to sunscreen.

_____ My child is allergic to some sunscreen and I will provide sunscreen for my child clearly labeled with their name.

_____ For medical or other reasons, please **DO NOT** apply sunscreen to my child.

BUG SPRAY PERMISSION

I give permission for the staff of any **Oxford SACC Programs** to apply a bug spray product to my child, as specified below, when he/she will be playing outside, especially during the months of April through October and between the daily time of 10 AM and 4 PM.

I have *initialed* below **all** applicable information for the use of bug spray for my child:

_____ I do not know of any allergies my child has to bug spray.

_____ My child is allergic to some bug spray. and I will provide bug spray for my child clearly labeled with their name.

_____ For medical or other reasons, please **DO NOT** apply bug spray to my child

Parent/Guardian's Name: _____

Date: _____

Parent/Guardian's Signature: _____

STATE OF MAINE
DEPARTMENT OF EDUCATION
23 STATE HOUSE STATION
AUGUSTA, ME 04333-0023

JANET T. MILLS
GOVERNOR

A. PENDER MAKIN
COMMISSIONER

CHILD CARE CENTERS
July 1, 2023 to June 30, 2024

Dear Parent:

The Child Care Center in which you are enrolling your child participates in the U.S. Department of Agriculture's Child and Adult Care Food Program. This means the Center must serve meals and supplements that meet or exceed the nutritional requirements set forth by the U.S. Government.

In return for serving meals and supplements that meet these requirements, the Center receives payment from the USDA based on the income levels of the families being served. The higher the number of children served by the Center who come from low-income households, the higher is the level of reimbursement received by the Center for the meals and supplements it serves.

In order to determine the level of reimbursement to be received by the Center for meals or supplements served to your child, USDA requests you to complete the attached application and to include all of the following information on the appropriate lines.

1. The name and age of the child for whom you are making application.

2. If the child for whom you are making application, or any other person in your household, is a member of a Supplemental Nutrition Assistance Program (SNAP) Household (formerly known as Food Stamps), Temporary Assistance to Needy Families (TANF) Assistance Unit or a household that receives benefits under the Food Distribution Program on Indian Reservations (FDPIR), you may give their SNAP, TANF or FDPIR case number in PART I and then skip to PART III.

3. IN PART II you must include the name of each person living in the "household". A "household" is any group of persons living together sharing income and living expenses. These persons may or may not all be related to each other.

4. The last four (4) digits of the Social Security number of the household member or guardian who signs the application form.

5. The total income, before deductions, from all sources, for all persons living in the household.

6. The signature, address, and telephone number of the person completing the application form. The date the form was signed must also be included.

A form will not be considered "complete" unless the applicable information listed above is provided. The person who signs the form must understand that if the household income section of the form is left blank, that person is certifying that the household has zero income. The center staff will then consider your child to be in that category of eligibility which qualifies the center to receive the highest level of payment for the meals and supplements your child will receive.

The following chart shows the upper income level for the 'Tier I' category for the period **July 1, 2023 to June 30, 2024**. If the total income for your household size is equal to or less than the amount shown, the center serving your child will be able to receive the Tier I, or highest, level of reimbursement for meals or supplements served to your child.

Eligibility Scale for "Reduced-Price" Meals

Family Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	26,973	2,248	1,124	1,038	519
2	36,482	3,041	1,521	1,404	702
3	45,991	3,833	1,917	1,769	885
4	55,500	4,625	2,313	2,135	1,068
5	65,009	5,418	2,709	2,501	1,251
6	74,518	6,210	3,105	2,867	1,434
7	84,027	7,003	3,502	3,232	1,616
8	93,536	7,795	3,898	3,598	1,799
Each Additional Family Member	9,509	793	397	366	183

If a member of your household becomes unemployed, your child may become eligible for "Free" or "Reduced-Price" meals during the period of unemployment, provided the loss of income causes the household income to fall within the eligibility guidelines for your household size.

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 (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Thank you.

Sincerely,

Child and Adult Care Food Program

APPLICATION FOR "FREE" OR "REDUCED-PRICE" MEALS
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CHILD FOR WHOM APPLICATION IS BEING MADE: Name:_____ Age: _____

Days of the Week in Care	Hours in Care (i.e. 7:30 – 5:00)	Meals Received While in Care*
☐ Monday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Tuesday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Wednesday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Thursday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Friday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Saturday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S
☐ Sunday		☐ Br ☐ AM S ☐ Lu ☐ PM S ☐ Su ☐ E S

* Br = Breakfast AM S = AM Snack Lu = Lunch PM S = PM Snack Su = Supper E S = Evening Snack

NOTE: If you are applying for CACFP benefits on behalf of a Foster Child, please check this box and notify the person to whom you return this form.
☐ Foster Child

PART I: HOUSEHOLDS RECEIVING SNAP, TANF OR FDPIR BENEFITS:

If you, your child, or any other person living in your household, currently receives SNAP, TANF or FDPIR benefits, please provide their SNAP, TANF or FDPIR case number. DO NOT COMPLETE Part II; skip to Part III. Part III must include the **printed name** and **signature of the adult who completes this application.** The **date the application was completed** needs to be included also.

(a) ☐ YES: A member of this household receives SNAP, TANF or FDPIR benefits.

(b) SNAP Case Number: # _ _ _ _ _ _ _ _ _ _ (**not** EBT number)

(c) TANF Case Number: # _ _ _ _ _ _ _ _ _

(d) FDPIR Case Number: # _ _ _ _ _ _ _ _ _ _

If applicable, your child's Free or Reduced-Price meal eligibility information will be disclosed to Medicaid and/or SCHIP unless you elect not to have the information disclosed. The information will be used to identify children eligible for, and to seek to enroll children in, a health insurance program. Your decision on whether to disclose this information will not affect your child's eligibility for Free or Reduced-Price meals.
If you elect not to have this information disclosed to Medicaid and/or SCHIP, please check this box: ☐

NOTE #1:
If no one in your household receives SNAP, TANF or FDPIR benefits, or if you do not provide their case number, you must complete Part II and Part III in order for your child to qualify for either "Free" or "Reduced-Price" meals. **You must also include the last four (4) digits of your Social Security Number on the line next to your signature.**

PART II: ALL OTHER HOUSEHOLDS:

(a) **Household Members:** List the name of every person living in your household. **Be sure to include yourself and the child listed above.**

(b) **Social Security Number**: Section 9 of the National School Lunch Act requires that, unless a SNAP or TANF case number is provided for your child, you must include the last four (4) digits of your Social Security number on the application. This must be the Social Security number of the adult household member signing the application. If the adult household member signing the application does not possess a Social Security number, he/she must indicate so on the application. Provision of a Social Security number is not mandatory, but if the last four (4) digits of the adult household member's Social Security number is not provided or an indication is not made that the adult household member signing the application does not have one, the application cannot be approved. This notice must be brought to the attention of the household member whose Social Security number is disclosed. The Social Security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a SNAP, Indian Tribal Organization or Welfare Office to determine current certification for receipt of SNAP, FDPIR or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

(C) **Income:** List **all** income from **all** sources received last month on the same line as the name of the person who received it. Income must be **gross**, that is, it must be the amount received **before deductions** for taxes, Social Security, dues, insurance, etc. List each amount under the correct column. ***If you are in the Military Privatized Housing Initiative or receive combat pay, please do not include these allowances as income.***

LIST ALL HOUSEHOLD MEMBERS:

Names of Household Members:	Age	Monthly Gross Wages or Net Self-Employment	Monthly TANF, Alimony, Welfare, Child Support	Monthly Pensions, SSI, Social Security, Workers Comp, Unemployment Comp, Insurance & Retirement
1.				
2.				
3.				
4.				
5.				
6.				
(Note: Weekly income x 4.333 weeks; Bi-weekly income x 2.15 weeks) **TOTAL MONTHLY HOUSEHOLD INCOME:**				

PART III:

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 (866) 632-9992 (voice) or (800) 877-8339 (TTY) or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand this information is being given in connection with the receipt of Federal Funds and Program Officials may verify the information on the application and that deliberate misrepresentation of any of the information on this application may subject me to prosecution under applicable State and Federal Criminal Statutes.

PRINT NAME OF ADULT	LAST 4 DIGITS OF SS#	SIGNATURE OF ADULT	DATE

❑ I do not have a social security number

HOUSEHOLD ADDRESS OF ADULT	HOME PHONE	WORK PHONE

ALL HOUSEHOLDS: Racial/Ethnic Identity: *

1. **Ethnicity:**
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino

2. **Race (mark one or more):**
   - ☐ American Indian or Alaskan Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White

*This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws. Your response will not affect consideration of your application.

THIS PORTION MUST BE COMPLETED BY CHILD CARE CENTER PERSONNEL:

Signature: _____ **Date:** _____

Child's Eligibility Category (Circle One): **Free** **Reduced-Price** **Paid**

DEBIT/CREDIT CARD AUTHORIZATION AGREEMENT

Upon processing and approval your designated credit card will automatically be billed each Friday unless otherwised noted on the form for amounts due and a receipt will be emailed.

You may cancel this automatic billing authorization at any time by contacting Oxford SACC's main office in writing or email. Termination of a preauthorized credit card charge does not affect your obligation to make your weekly payment in some other acceptable manner.

To the extent allowable by law, the liability of the Oxford SACC organization in connection with this authorization is limited to the amount of any incorrect charge or withdrawal. Oxford SACC will not be liable for any other damages, whether direct, incidental, special or consequential, whether Oxford SACC had knowledge that such damages might be incurred. Oxford SACC will not be liable for your acts or omissions, including but not limited to improper, unclear or insufficient account or other information, or if you fail to provide current information, should any account or other information change.

DEBIT/CREDIT CARD INFORMATION

Name on Account (Exactly as Printed)						
Address on Account (Address, City, State, Zip):						
Debit/Credit Card Number:						
Expiration Date:						
CSV (3 digits):						
Automatic Withdrawl	Weekly	☐	Biweekly	☐	Specific Day	
Call In Payment Only	☐					
Email Address:						

I authorize Oxford SACC to automatically charge the account designated above each week unless otherwised noted for charges due and payable on my weekly billing cycle.

AUTHORIZATION

Customer Signature _____ Date _____ Customer Name (Please Print) _____

Please return form to Oxford SACC, PO Box 549, Oxford, Maine 04270;
Phone 744-0400 Fax 744-0405; Email info@oxfordsacc.org