

CHILD NAME: _____

DOB: _____

Start Date: _____

FRONT OF FILE

- Parent Orientation Checklist
- Child Enrollment Form
- Health History Form
- Handbook Sign-off
- Daily Connect
- Financial Agreement/ACH
- Schedule
- School-Age Bussing Agreement
- Court Files
- Pre-enrollment

INSIDE OF FOLDER

- Child Health Report
 - 2,3,4 month
 - 6,9 month
 - 12 month
 - 18 month
 - 2 year
 - 4 year
- Immunization Record

BACK OF FILE

- Expired Authorization to Administer Medication Forms
- Financial Papers
- Expired Sunscreen Forms
- Expired Health History Forms
- Illness forms



Welcome to Sycamore!

New Family Orientation

- Tour of the center
- Enrollment packet received
 - State licensing forms
 - USDA Food Program
 - Financial Policy
- Enrollment packet completed and returned
 - Field Trip Permission Slip Signed (if applicable)
- Meet teachers
- Classroom Welcome Letter
- Classroom tour
 - Parent board, lesson plan, menu, event calendar, administration of medication
- Child cubbies
- Child Needs:
 - All Ages
 - Shoes (age one and up)
 - Extra clothing - 2 sets
 - Seasonal outerwear
 - Family picture
 - Sleeping bag (ages 1-5)
 - Infant/Toddler
 - Bottle - no glass; labeled with first & last name, dated daily. Send enough for each feeding
 - Nuk (if needed)
 - Formula or breast milk - if not using formula provided by center
 - Diapers/wipes, Diaper Cream
- Preschool
 - Tennis shoes for outdoor play
- School Age - Summer
 - Tennis shoes for outdoor play & field trips
- Please feel free to come in and drop off any supplies prior to the first day to make your drop off a little lighter 😊
- Parent Handbook - available in main office and on the website
- Family Resources
- Check out our Facebook page - Sycamore Tree A Christian Child Care Center

The Sycamore Tree offers an open door policy to our enrolled families. We welcome you and your family to visit at any time of the day. You and your child are also welcome to visit their new classroom before the first full day for a comfortable transition.

Parent Signature: _____ Date: _____



2025 Financial Policies & Contract

Tax Statements: Tax Statements are available on MyProcure. If you prefer a printed statement, please email the main office.

Tuition Rates: Tuition rates are continuously evaluated and will change based on the needs of the center.

Payments: Families may pay with credit card (there is a 5% surcharge on each transaction), on their own in MyProcure, or enroll in weekly or bi-weekly ACH withdrawals. Debit card transactions are no longer accepted. For families that pay through MyProcure, an ACH withdrawal account or credit card must be on file and will be used to pull funds if necessary due to non-payment. If families do not make a payment within two weeks' time, they will need to meet with the administrative staff to set up a payment plan. If the plan isn't followed up on the next week, the family will be dismissed. Administration reserves the right to adjust the payment plan as needed.

Family Discounts: A discount is provided to families with multiple full-time children enrolled in our Infant through 4K wrap around program. No School Age discount is available.

NSF: Payments made with non-sufficient funds will be charged a \$50 fee.

Annual Registration: A \$125 annual fee is billed February 1st. Families that are newly enrolled in fall (beginning September 1st or after) will have their annual fee waived.

Holidays: The center will be closed for the following holidays. No credit is given; these are paid holidays for our staff. You may use vouchers if you wish.

Good Friday: April 18, 2025

Memorial Day: May 26, 2025

Independence Day: July 4, 2025

Labor Day: September 1, 2025

Thanksgiving: Nov. 27 & 28, 2025

Christmas: December 24th, 2025 – December 26th, 2025

New Year's: December 31st, 2025 – January 2nd, 2026

Teacher In-service Days: The center will be closed on Presidents Day and Columbus Day. No credit is given; these are paid workdays for our staff.

Monday, February 17, 2025

Monday, October 13, 2025

An annual calendar representing closure dates is included for your reference

Attendance: Guardians are responsible for escorting their child into & out of their classroom. If your child will not be attending, please call or email within 1 hour of typical arrival. We will call you or message you in Daily Connect if we have not heard from you regarding attendance for the day.

Vouchers: Families enrolled in the Infant through 4K program will receive vouchers redeemable for free days of

care. Voucher values are determined by the child's age and elected program. Vouchers are prorated by start date and expire December 31. Current 4K students' vouchers expire August 29. Vouchers may be used for tuition credit for center closings, child's absence, or holidays.

Change of Schedule: Changes to schedules must be made 2 weeks in advance with written notice to the office. Approval of temporary schedule change is subject to staffing and will be communicated within 1 week of submission.

Suspensions: If a child has been suspended from the center, tuition will not be reimbursed for the days the child is out on suspension. If a child has been expelled from the center, no credit will be issued for the remainder of the week. The Sycamore Tree retains the right to suspend or expel any child/ren that is felt may pose a danger to themselves or others at the center, including staff. In addition, The Sycamore Tree retains the right to deny care to any family whom it is felt that a member of the family may pose a danger to others at the center, including staff. This will be at the discretion of the Administrator and/or Director.

Late Pick-ups: The center is licensed from 6am-6pm. Any drop-off before 6:00am or pick up after 6:00pm will result in a \$25 fee per child. At 6:15pm, the Hartford Police will be notified if there has been no contact from the family. \$25 per 30 minutes will be charged after 6:15pm.

Signature

Family Last Name - Printed

Date

PLEASE RETURN TO THE OFFICE

(Please request a copy if desired upon return of this form for your records.)

SYCAMORE TREE CHILD CARE CENTER

310 N. Wilson Ave
Hartford, WI 53027
262 - 673 - 0161

sycamoretreecildcare@gmail.com



2025 REQUIRED PAYMENT & SCHEDULE CONTRACT

Age Group	4 Days	5 Days
Infants	\$340	\$355
One Year Olds	\$320	\$335
2 Year Olds	\$310	\$325
3 Year Olds	\$290	\$305
4 Year Olds until 4k	\$280	\$295
4K	\$265	\$280
Summer School Age (5K & up)	\$230	\$245
School Age Before AND After - Same Day	\$25/day	
School Age Before OR After - 1 session	\$20/session	
School Age - Early Release	\$35/day	
School Age - Full Day - No School	\$50/day	

- 4% surcharge: A 4% convenience fee will be applied to your account for each payment made with a credit card.
- Tuition rates are continuously evaluated and will change based on the needs of the center.
- Sibling Discount is \$20 off tuition for each child after the first, and is applied to the children in the oldest age groups. Sibling discount applies to school agers only during summer months.
- All childcare fees are due in advance. There is a \$50 fee for insufficient funds.
- Your account will be drafted every Monday or Tuesday depending on your bank, or every other Monday or Tuesday.
- Vouchers will be applied to the following withdrawal after the office receives them.
- For families that pay with MyProcure or monthly check, an ACH withdrawal account or credit card must be on file, and used to pull funds if necessary due to non-payment.
- If families do not make a payment within two weeks time, they will need to meet with administrative staff to set up a payment plan. If the plan isn't followed upon the next week, the family will be dismissed. Administration reserves the right to update the payment plan as needed.

PLEASE SELECT PAYMENT OPTION:

Weekly ACH withdraw

BiWeekly ACH withdraw

Weekly Credit Card Charge

BiWeekly Credit Card Charge

Weekly MyProcare*

BiWeekly MyProcare*

Advance Monthly Check

*If you enroll in MyProcure, you are responsible for going online to pay- it is not an automatic withdrawal.

(over)

Please approximate your child(ren)'s daily schedule and give times in/out, and day off if applicable.

	Monday	Tuesday	Wednesday	Thursday	Friday
Time In:					
Time Out:					

EXAMPLE	Monday	Tuesday	Wednesday	Thursday	Friday
Time In:	7:00am	7:00am	7:00am	7:00am	OFF
Time Out:	5:00pm	5:00pm	5:00pm	5:00pm	OFF

*Changes to schedules must be made two weeks in advance with written notice to the office. Approval of temporary schedule changes are subject to staffing and will be communicated within one week of submission.

Family Name: _____ Date: _____

Parent Signature: _____

(Please request a copy if desired upon return of this form for your records.)

2025 SYCAMORE TREE CALENDAR

JAN

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEB

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

MAR

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

APR

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

JUN

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

JUL

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AUG

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SEP

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

OCT

S	M	T	W	T	F	S
		1	2	3	4	
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOV

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DEC

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].
 Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Address - Home (Street, City)	Telephone Number	Birthdate (mm/dd/yyyy)	First Day of Attendance
------------------------	-------------------------------	------------------	------------------------	-------------------------

PARENT OR GUARDIAN - All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any.

Relationship to Child	Name	Address - Home (Street, City)	Home / Cell Telephone No.	Name and Address - Place of Employment OR Where Reachable While Child is in Care	Telephone No.
Mother					
Father					
Guardian					
Guardian					

AUTHORIZED PERSONS - Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

Relationship to Child	Name	Address - Home (Street, City)	Home / Cell Telephone No.	Name and Address - Place of Employment OR Where Reachable While Child is in Care	Telephone No.

EMERGENCY CONTACT - The person to be notified in an emergency when parents / guardians cannot be reached. Yes No This person is authorized to pick up the child.

Relationship to Child	Name	Address - Home (Street, City)	Home / Cell Telephone No.	Name and Address - Place of Employment OR Where Reachable While Child is in Care	Telephone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number
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AUTHORIZATION

- Yes No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- Yes No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
- Yes No I give permission for my child to participate in field trips and other activities during operating hours. Transported Walking
- Yes No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE - Parent or Guardian

Date Signed

Health History and Emergency Care Plan

Use of form: This form is voluntary and meets the requirements in DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian may complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)
------------------------	------------------------	--------------------------------------

Home Address (Street, City, State, Zip Code)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address
Physician Name	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
 - No specific medical condition
 - Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
 - Asthma
 - Cerebral palsy / motor disorder
 - Diabetes
 - Epilepsy / seizure disorder
 - Gastrointestinal or feeding concerns, including special diet and supplements

Other condition(s) requiring special care – Specify.

Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

Food allergies – Specify food(s).

Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

a.

b.

c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____

PARENTS

1. A copy of the State Licensing Regulations, Sycamore Tree Policies, and the Parent Handbook are available for you to review at any time.

2. The designated Emergency medical facility is:

Aurora Medical Center

1032 E. Sumner Street (Hwy 60)

Hartford, WI 53027

(262) 673-2300

3. The medical log book and your child's records are available for you to view at any time.

PARENT HANDBOOK

Parent Acknowledgment Form

The parent handbook describes important information about Sycamore Tree. I understand that I should consult the Director or Program Coordinator with any questions that are not answered in the handbook.

I understand and acknowledge that there may be changes to the information and policies in the handbook. I understand that Sycamore Tree may add new policies to the handbook as well as replace, change, or cancel existing policies.

I understand and acknowledge that this handbook is not a contract or a legal document. I understand that the handbook is available for my viewing at www.sycamoretreechildcare.org or by request in the office at any time. I understand that it is my responsibility to read and follow the policies contained in this handbook and any changes made to it.

PARENT'S NAME (printed): _____

PARENT'S SIGNATURE: _____

DATE: _____



Daily Connect

Daily Parent Communication App

Daily Connect is our way of daily parent communication and is set up through your email. You will receive an email on your child's first day, or sooner. Please click the link to register to buy the app when you receive the email from Daily Connect. If you need assistance, we would be more than happy to help you! We will not be doing the billing section of the app.

You will only be able to view your child's information; no one else can see your child's information, except the teacher's in your child's classroom. The information is secure and 24/7 monitored and protected. It's super simple to create a log in and view your child's information for the day.

How it works: When you click on your child's name, you will see an ongoing newsfeed of your child's day. Diapering, meals, activities, mood, accidents/incidents, medicine administration, and pictures of your child can all be included in this daily newsfeed for your child. You can message your child's teacher and they can message you back, when time allows. The teachers will have to catch up on logging diapers and meals at naptime of classrooms with larger/older groups of children. **Please do not be discouraged if something isn't updated right away.** We do not want this app to be a distraction to the teachers, but to make it helpful and easy for parents and teachers to communicate. For example- is all of the class wakes up at the same time and bathrooms have to be done right away, they may go back in and change their nap to the correct time they woke up after they catch up.

You can log on to view your child's day or set up notifications on your phone.

Download app to see what and when your child ate, how they slept, activities they've done, their mood and behaviors, pictures of your child, and important messages and reminders for your child's teacher!

One Time \$4.99



Can't download the app? You can log onto www.dailyconnect.com for free! You will also get an email about your child's day, when your child gets picked up at the end of the day. However, we encourage you to purchase the app to see all of the features it has to offer.

-----Cut here and return email address(es) you'd like added to your child's Daily Connect account-----

Child's Name: _____

Parent/Guardian Name: _____ email: _____





Automated Payment Processing
Safe - Convenient - Easy

We are excited to offer the safety, convenience and ease of Tuition Express—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Form fields for Section A: Cardholder Name, Phone #, Cardholder Address, City, State, Zip, Account Number, Expiration Date, Cardholder Signature, Date.

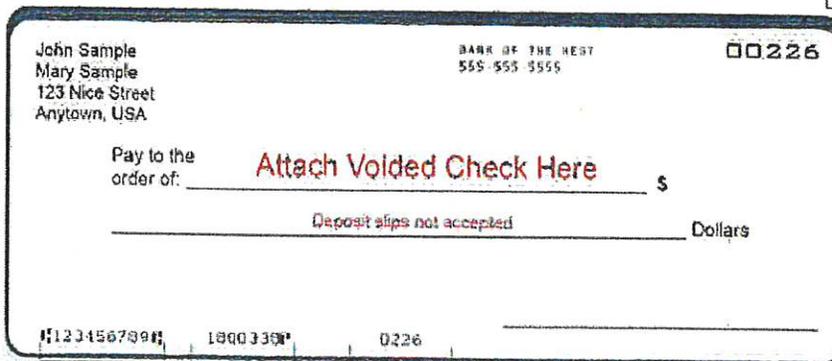
SECTION B (Bank Account)

Form fields for Section B: Your Name, Phone #, Address, City, State, Zip, Bank or Credit Union Name, Bank or Credit Union Address, City, State, Zip, Routing Transit Number, Account Number, Checking, Savings.

Authorized Signature and Date fields.

For Official Use Only

Date Received and Employee Signature fields.



Weekly Schedule

Child name(s): _____

Please put and **X** through any regular OFF days and write **approximate** drop off and pick up times:

	Monday	Tuesday	Wednesday	Thursday	Friday
Drop off Time:					
Pick up Time:					

Schedule changes are due two weeks in advance to the main office. (if # of days is changing permanently)

Switching which days are off/drastric time changes for pick up or drop off, can be told to the child's classroom teacher.

If your child will be arriving 1 hour or more after their normal drop off time, please email, call, or message your child's teacher via Daily Connect.

Weekly Schedule

Child name(s): _____

Please put and **X** through any regular OFF days and write **approximate** drop off and pick up times:

	Monday	Tuesday	Wednesday	Thursday	Friday
Drop off Time:					
Pick up Time:					

Schedule changes are due two weeks in advance to the main office. (if # of days is changing permanently)

Switching which days are off/drastric time changes for pick up or drop off, can be told to the child's classroom teacher.

If your child will be arriving 1 hour or more after their normal drop off time, please email, call, or message your child's teacher via Daily Connect.



HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household. Refer to the accompanying Household Letter for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren): Center

PART 1: BENEFITS

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPiR? If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

FoodShare Wisconsin (10-digit case number): DO NOT list a 16-digit Quest Card number or number that starts with 5077. Wisconsin Works Programs (10-digit case number): DO NOT provide a WI Childcare Subsidy number. This is NOT a WI Works Program and does not qualify a child as free in CACFP. FDPiR (9-digit case number):

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete a, b, and c below; then go to PART 3.

a) Household Members Information: List full names of all members in first column, including yourself and all children. b) List all income on the same line as the person who receives it. Record each income source only once. Check the box for how often each income source is received.

Table with columns: Household Member Names, Age, Check if Foster Child, Check if No Income, Gross wages, Net income, Retirement, Social Security, VA benefits, Child Support, Alimony, Private pensions, Trusts, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income. Includes frequency options: Weekly, Every 2 Weeks, Twice per Month, Monthly, Annually.

c) Record total # of household members: _____

PART 3: SIGNATURE

An adult household member must sign and date this form

If PART 2 is completed, the adult signing the form must list the last four digits of their SS# OR check "None" if they do not have a SS#.

ETHNICITY AND RACE DATA COLLECTION - Completion is optional This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. Please answer both questions.

IS YOUR CHILD(REN) HISPANIC OR LATINO? Yes, Hispanic or Latino No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN): American Indian or Alaska Native Black or African American White Asian Native Hawaiian or Other Pacific Islander

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member Signature Date Mo./Day/Yr. Last 4 digits of SS# (or check "None" if you do not have a SS#)

FOR CENTER USE ONLY - Complete all 3 sections

Section 1: Basis of Determining Eligibility (A or B) Section 2: Eligibility Determination Section 3: Determining Official's Initials/Approval Date Effective Month of Determination

*Convert to yearly income only when multiple pay frequencies are reported, using only these multipliers: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12 **This form expires one year from the Effective Month of Determination.

Dear Parent or Guardian:

The Sycamore Tree Christian Child Care Center is enrolled in the CACFP, a USDA program which
 (Name of Agency)

provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year. Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files. Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher ("Free" or "Reduced-price") meal reimbursement rates for your enrolled children, for 12 months from the Effective Month of Determination regardless of any change in your household size and/or income or termination from Benefits Programs.

- You are not required to complete this HSIS if no one in your household receives benefits from FoodShare WI (the Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), Wisconsin Works Programs and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

Determining Eligibility based on Participation in Benefits Programs → Complete Part 1 and Part 3 of HSIS form

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDPIR, or WI Works Programs. Wisconsin Works Programs is Wisconsin's Temporary Assistance for Needy Families (TANF) program. It provides temporary cash assistance through work placement and training programs and IS NOT the WI Child Care Subsidy Program. WI Works Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), Case Management, W-2 Transitions (W-2T), Custodial Parent of an Infant (CMC), Minor Parents Services, Noncustodial Parents, Pregnant Women, Learnfare and Emergency Payments.

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDPIR, WI Works Programs:

- (a) The names of your enrolled children;
 - DO NOT list case numbers for:
- (b) Checked box for the benefit your household receives and its case number; &
 - Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- (c) The signature of an adult member in the household & signature date
 - DO NOT list 16-digit Quest Card number (starts with 5077) for FoodShare WI

Determining Eligibility by Household Size and Income → Complete Part 2 and Part 3 of HSIS form

Household-Size Income Scale (Effective July 1, 2024 to June 30, 2025)

Household Size	Annual Income Level (at or below)
1	\$ 27,861
2	\$ 37,814
3	\$ 47,767
4	\$ 57,720
5	\$ 67,673
6	\$ 77,626
7	\$ 87,579
8	\$ 97,532
For each additional Household Member, add:	+\$ 9,953

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates ("Free" or "Reduced-price" meal rate) for your children. For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):

- (a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
- (b) Income received by each household member identified by source of income and its pay frequency;
- (c) Total number of household members;
- (d) The signature of an adult member of the household and signature date; and
- (e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.

- Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children

enrolled in Head Start: Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below. The respective documentation is required for these

children to be eligible for Free Meals: These children's eligibility for Free meals does not extend to other children in your household.

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, WI Works Cash Programs, or FDPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

Sharing Eligibility Information: Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, unless you tell us not to. This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Filling out this HSIS does not automatically enroll your children in these programs. If you do not want your information to be shared with these programs, notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement. Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

Refer to the [USDA Non-Discrimination Statement and Complaint Filing Procedure \(https://dpi.wi.gov/nutrition#discrimination\)](https://dpi.wi.gov/nutrition#discrimination). This institution is an equal opportunity provider.


 Signature of Agency Representative



Wisconsin WIC Program Information & Income Eligibility Guidelines

Purpose:

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a nutrition program for pregnant women, infants, women who are breastfeeding, postpartum women, and children younger than 5. WIC provides nutrition education, breastfeeding education and support, supplemental nutritious foods, and connections to other community services.

Wisconsin families want to raise strong and healthy kids, and WIC is here to help. Health benefits of WIC have reduced premature births, low birthweight, and long-term medical expenses.

Who is Eligible for WIC?

To qualify for WIC benefits in Wisconsin, a person must:

- Live in Wisconsin
- Meet the income guidelines (*listed on the next page*)
- Have a health or nutrition need. A nutrition assessment will be completed at the WIC clinic.
- Be pregnant; be breastfeeding a baby under 1 year of age; had a baby in the past six months; be a baby under age 1; or be a child younger than 5 years of age
- A person may qualify if someone in their family is receiving WI FoodShare, Medicaid, BadgerCare Plus, Wisconsin Works Program (W2), Temporary Assistance to Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)
- Foster children, Kinship Care recipients under age 5, and pregnant foster teens are eligible for WIC

Benefits Received by WIC Participants

All participants receive:

- Screening for nutrition and health needs
- Information on how to use WIC foods to improve health
- Benefits to buy foods that help keep you and your children healthy and strong
- Referrals to doctors; dentists; programs like FoodShare, Medicaid, BadgerCare Plus, W-2, Head Start

Women receive:

- [WIC foods](https://www.dhs.wisconsin.gov/wic/approved-foods.htm) (<https://www.dhs.wisconsin.gov/wic/approved-foods.htm>)
- Information on healthy eating during pregnancy and breastfeeding
- Help with starting or continuing breastfeeding

Infants receive:

- Help with starting or continuing breastfeeding
- Infant formula, if needed
- Immunization referrals

Parents/caretakers receive information on taking care of babies

Children receive:

- [WIC foods](https://www.dhs.wisconsin.gov/wic/approved-foods.htm) (<https://www.dhs.wisconsin.gov/wic/approved-foods.htm>)
- Immunization referrals

Parents/caregivers receive information on food shopping, recipes, and feeding your child

Go to [DHS Wisconsin](https://www.dhs.wisconsin.gov/wic/local-projects.htm) (<https://www.dhs.wisconsin.gov/wic/local-projects.htm>) to locate your local WIC office to apply:

For other health information and referral services contact *Well Badger Resource Center*: Call 800-642-7837, email help@wellbadger.org or go to [Well Badger Resource Center](https://wellbadger.org/) (<https://wellbadger.org/>)

Wisconsin WIC Program - Income Eligibility Table

The income levels are based on 185% of the US Dept. of Health and Human Services Nonfarm Income Poverty Guidelines for Gross Income (*before deductions*). Applicants exceeding 185% are not eligible.

July 1, 2023 – June 30, 2024

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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- | | | |
|--|---|---|
| <p>1. mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or</p> | <p>2. fax:
(833) 256-1665 or (202) 690-7442; or</p> | <p>3. email:
program.intake@usda.gov</p> |
|--|---|---|

This institution is an equal opportunity provider.

Tuition Rates 2025

Age Group	4 Days	5 Days
Infants	\$340	\$355
One Year Olds	\$320	\$335
2 Year Olds	\$310	\$325
3 Year Olds	\$290	\$305
4 Years Old until 4K	\$280	\$295
4K	\$265	\$280
Summer School Age (5K & up)	\$230	\$245
School Age Before AND After - Same Day	\$25/day	
School Age Before OR After - 1 session	\$20/session	
School Age - Early Release	\$35/day	
School Age - Full Day - No School	\$50/day	

5% surcharge: A 5% convenience fee will be applied to your account for each payment made with a credit card or debit card.

Sibling Discount: Sibling discount is given as \$20 off weekly tuition. The sibling discount applies to school-age children only during summer months.

Board Discount: Board members are given 10% off weekly tuition for each child.

Vouchers: All families with children enrolled in the Infant through the 4K program will receive vouchers. New children that enroll during the year will receive a prorated number of vouchers determined by their start date.

- Vouchers may be submitted for days your child(ren) are **absent** (sick days, holidays, days we are closed). Please write the date on the voucher that it should be used for and submit it to the main office.
- ACH is submitted on Mondays for the current week. If you turn in vouchers after that day has passed or after ACH was already submitted, your account will not reflect the vouchers until the following week.
- **Each voucher is worth 1 day of your child's tuition.**
- Families will receive one set of vouchers per child, per year. Please hold on to them!
- **Any family that receives a sibling or board discount will forfeit the week's discount when using a voucher.**
- Vouchers cannot be used as a payment method. They may only be redeemed for accounts that are current and up to date.
- Vouchers expire on December 31st. Current 4K families- vouchers expire August 31st (because Kindergarten starts).





Sunscreen Application Permisson Form

THIS FORM IS INTENDED TO FULFILL THE REQUIREMENTS OF HFS 46.07(6)(F) AND ANY APPLICABLE CODES.

INSTRUCTIONS:

This form is to be completed by a parent prior to a child's use of sunscreen.

This notice is required to be updated every 6 months in accordance with code.

HFS 46.07(6)(F) "2. Sunscreen and insect repellent may only be applied upon the written authorization of the parent. The authorization shall include the brand and ingredient strength of the sunscreen or repellent. Authorizations shall be reviewed every 6 months and updated as necessary. The recording of the application of sunscreen or insect repellent is not required."

I give Sycamore Tree personnel permission to apply sunscreen to my child,

_____ (child's first and last name)

_____ I allow the center to use the center provided sunscreen, equate brand 50+ SPF
sunscreen on my child.

_____ I allow the center to use sunscreen that I provide on my child: (please specify below)

Brand: _____ SPF: _____

Parent/Guardian: _____ (Signature)

Date: _____

Has your child ever been stung by a bee? (please circle one) YES / NO



Media Release for Sycamore Tree

The following form is required and must be completed and submitted to Sycamore Tree. Should you have any questions, please do not hesitate to contact us at (262) 673-0161.

- Yes, I give permission for my child, _____ to be photographed and/or videotaped during Sycamore Tree activities for the following purposes (please circle all that you give permission for):
 - Pictures posted in the hallway and classroom
 - Pictures sent via Daily Connect
 - Sycamore Tree's Facebook Page
 - Sycamore Tree's Website (www.sycamoretreechildcare.org)

- No, I do not give permission for my child, _____ to be photographed and/or videotaped during Sycamore Tree activities for any of the above purposes.

Parent/Guardian: _____ (Signature)

Parent/Guardian: _____ (Printed Name)

Date: _____

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.04(6)(a)4, and DCF 251.04(6)(a)8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other HealthCheck provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)

Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

Yes No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

Yes No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: _____ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other HealthCheck Provider (type or print)

Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other HealthCheck Provider

Date of Examination

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within 30 school days (6 calendar weeks) of admission to the day care center. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

Yes year _____ (Vaccine is not required)

No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child WITHIN ONE YEAR and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

Physician's Signature Required

For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

For personal conviction reasons this child should not be immunized (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian

Date Signed

Parent Questionnaire

CHILD

Full Name: _____

Home Address Street _____

City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____

Who is completing this parent questionnaire?

_____ Mother _____ Father _____ Other Relative

_____ Guardian _____ Caregiver _____ Other

FAMILY

Mother Name _____

Home Address Street _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Place of Employment _____

Description of Occupation _____

Father Name _____

Home Address Street _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Place of Employment _____

Description of Occupation _____

Other Family Information

With whom has the child lived for most of the past year?

_____ Mother _____ Father _____ Both _____ Guardian _____ Other

Other children in the family-How many older? _____ How many younger? _____

Please list with ages _____

Other people living in the household _____

What language(s) are spoken at home? _____ English _____ Other

If other please list. _____

Any special custom/ celebration or practices we should be aware of:

Have there been any recent changes in routine/ family structure that may impact your child's behavior: _____

Other Family Information Continued

Do you have any pets? Please list. _____

Parent involvement:

Please indicate if you are interested in volunteer opportunities at the center.

____brat fry ____chaperone field trips ____coordinator for fundraisers
____other

CHILD CARE HISTORY

Has your child attended preschool/ child care before? Yes No

If yes, for how long? ____ 6 months ____ 1 year
 ____ 2 years ____ more than 2 years

MEDICAL HISTORY

Child's Health

Has your child ever had any major injuries or hospitalizations?

Since Birth

If yes, please explain _____

Does your child have any allergies? ____ Yes ____ No

If yes please list. _____

If yes, please explain and provide a physicians' note _____

Is your child currently taking any medications?

If yes, please explain _____

Has your child ever had trouble walking, climbing, reaching, holding on to things? ____ Yes ____ No

Does your child get frequent ear infections? ____ Yes ____ No

Has you child ever had trouble hearing? ____ Yes ____ No

Has your child ever had trouble seeing? ____ Yes ____ No

Have you ever suspected that your child have any vision problems?

____ Yes ____ No

CHILD'S DEVELOPMENT

Is your child potty trained? ____ Day ____ Night

Does your child require help? ____ Yes ____ No

Need to be reminded? ____ Yes ____ No

Other comments _____

How does your child react to new foods? _____

Is your child willing to try new foods? _____

Do you have any concerns about sleeping habits? ____ Yes ____ No

CHILD'S DEVELOPMENT CON'T

Can your child:

- Feed him or herself using utensils? _____ Yes _____ No
- Wash and dry their own hands? _____ Yes _____ No
- Dress with little or no assistance? _____ Yes _____ No
- Speak so that they can be understood? _____ Yes _____ No
- Express their thoughts and needs easily? _____ Yes _____ No

Is your child:

- Affectionate _____ Yes _____ No
- Shy/ Quiet _____ Yes _____ No
- Talkative _____ Yes _____ No
- Emotional _____ Yes _____ No
- Stubborn _____ Yes _____ No
- Highly Active _____ Yes _____ No

Does your child:

- make friends easily? _____ Yes _____ No
- have tantrums? _____ Yes _____ No
- use crayons/ markers to scribble or draw? _____ Yes _____ No
- listen to stories being read? _____ Yes _____ No
- turn pages of a book and look at pictures? _____ Yes _____ No
- recall stories or events? _____ Yes _____ No
- enjoy playing alone or with imaginary friends? _____ Yes _____ No
- talk with friends? _____ Yes _____ No
- follow age appropriate directions? _____ Yes _____ No
- have fears of:
- strangers _____ Yes _____ No
 - storms _____ Yes _____ No
 - dark _____ Yes _____ No
 - animal _____ Yes _____ No
 - other _____

How do you handle the fears? _____

What are your child's favorite activities? _____

Does your child have opportunities to play with other children? _____

Who are your child's playmates? _____

Are there other things you would like to share about your child? _____

REFERRAL INFORMATION

If you would like referral information for community resources for your family, please indicate below.

Social Services _____ Food Pantry _____ Head Start _____

Birth To Three _____ Health Department _____ Counseling Services _____

Is your child currently enrolled in:

_____ Head Start _____ Speech _____ Other Please specify _____

Does your child have an IEP from a referral agency? _____ yes _____ no

If yes please indicate which agency and or district _____

