



Bienvenidos a Mi Familia!

We are thrilled to have your family join the Mi Familia family.

Enclosed is our contract and enrollment forms that are required before the first day of care. Please fill them out in detail, returning with the registration fee for the first week of tuition.

Please call or email me with any further questions.

Thank You,

A handwritten signature in black ink that reads 'Sandra Perez'.

Sandra Perez
Director/Owner

(651) 270-7037

mifamiliacare@gmail.com



Enrollment Forms

Child's Full Name: _____

Date of Birth: _____

Home Address: _____

Parent / Guardian Information

Parent/Guardian #1 Name: _____

Address: _____

Cell Phone: _____

Work Phone: _____

Occupation & Place of Work: _____

Email: _____

Parent/Guardian #2 Name: _____

Address: _____

Cell Phone: _____

Work Phone: _____

Occupation & Place of Work: _____

Email: _____

Child lives with: Mother ____ Father ____ Both ____ Other (Please Specify) _____

Both parents/guardians are assumed as authorized to pick up the child and to be contacted by the program as needed and unless we have a court order on file specifying otherwise.

Emergency Contacts & Authorized Pick-Up

It is a state requirement that there be a minimum of two emergency contacts, other than the parents or guardians, who are authorized to pick up your child (no maximum).
Emergency contacts must include their legal name, full address, relationship to the child and at least one phone number.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Medical & Insurance Information

Doctor's Name: _____ Phone: _____

Address: _____

Dentist's Name: _____ Phone: _____

Address: _____

Hospital Name: _____ Phone: _____

Address: _____

Optional:

Health Insurance Provider: _____

Policy and Group Number: _____

Medical Conditions

Please describe any dietary and/or medical needs or specifications. (ex. special conditions, disabilities, allergies, etc.) *additional paperwork will be required

If applicable, please provide documentation of any individual child care program (ICCP) needs.

We must receive a completed Health Care Summary and Immunization Record signed by your child's health care provider prior to admission to our program. You are required to submit additional medical information at least annually and/or whenever your child advances into an older age category.

As a parent/legal guardian, I give consent to **Mi Familia** to administer to my child emergency first aid by the program staff. I understand that, if necessary, 911 will be called and my child may be transported to receive emergency care. I understand that I will be responsible for all emergency transportation and any charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to update this information whenever a change occurs.

Parent/Guardian #1 Signature: _____ Date: _____

Parent/Guardian #2 Signature: _____ Date: _____

Schedule

What days will your child attend?	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F
What times will your child attend?	Drop off: _____ : _____ Pick up: _____ : _____
What meals will your child eat?	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack

Child Background Form

Please describe your child's eating, sleeping, toileting, communication and comforting habits and methods.

Does your child have special needs or receive special services?

Please provide information on your child's family, race, religion and language spoken in your home to have a better understanding of your cultural beliefs. Are there cultural or religious holidays, or traditions that your family observes that you would like to share?

Parent Authorization Form

Name Release:	<p>I give my permission to have my child's name printed on the class roster to be distributed to parents of children in the class and staff. (i.e. Valentines list etc.)</p> <p>Parent Signature: _____ Date: _____</p>
Media Release:	<p>I give my permission for my child to be photographed/videoed in/video recorded/for the program, at program functions, field trips, and for the photography/videos to be displayed and/or used on the Mi Familia Child Care Website, Facebook page, Instagram Page, Snapchat Page, Tik-Tok page, any type of promotion or advertising. I understand that the photographs or videography may be taken by school staff, professional photographers, news media and other people.</p> <p>Parent Signature: _____ Date: _____</p>
Impromptu Walks:	<p>I hereby give permission for my child to go on impromptu walking field trips in the neighborhood and/or to Seidels Lake Park, weather permitting. (1415 Fourth St S, SSP, MN 55075)</p> <p>Parent Signature: _____ Date: _____</p>
Permission to Administer:	<p><i>All over-the-counter (OTC) products need parental permission for administration. However, some of these external products do not need to be documented every time they are used. The following is a list requiring parental permission only.</i></p> <p>I hereby give Mi Familia permission to apply any of the following preparations except those that are circled, in accordance with directions for use on the appropriate container:</p> <p> <input type="checkbox"/> Sunscreen <input type="checkbox"/> Insect Repellent <input type="checkbox"/> Baby/Diaper Wipes <input type="checkbox"/> Diaper Creams/Ointments <input type="checkbox"/> Soap <input type="checkbox"/> Lip Balm <input type="checkbox"/> Hand Sanitizer <input type="checkbox"/> Skin Lotion/Creams/Vaseline Other – please specify: _____ </p> <p>Parent Signature: _____ Date: _____</p>

HEALTH CARE SUMMARY

MUST BE COMPLETED BY HEALTH CARE SOURCE

Date of Enrollment: _____

NAME OF CHILD _____

Birth Date _____

ADDRESS _____

Telephone _____

PARENT(S) or GUARDIAN _____

Date of last physical examination _____ How long have you been seeing this child? _____

How frequently do you see this child when he/she is not ill? _____

Does this child have any allergies (including allergies to medications)? _____

Is a modified diet necessary? _____

Is any condition present that might result in an emergency? _____

What is the status of the child's... Vision _____

Hearing _____

Speech _____

Please list below the important health problems

<u>Important Health Problems</u>	<u>Followed By You</u>	<u>Followed By Other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
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Other information helpful to the child care program _____

Phone _____

Signature of Health Source _____

Address _____

Date _____

Annual Family CACFP Enrollment Form

Center Name: *Mi Familia Childcare #163*

List all children ages 0-17 years old living in your household, even if they are not related. If more space is needed, attach another sheet.

Step	Child's First Name	Child's Last Name	Birthdate (mm/dd/yyyy)	Enrolled at this center?	In Foster Care?	Enrolled in Head Start?	Hours in Care		Normal Days in Care							Normal Meals Received					Ethnicity*	Race**
							Arrive Time	Leave Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Breakfast	AM Snack	Lunch	PM Snack	Dinner		
1				<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"/>			<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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>						

OPTIONAL TO COMPLETE - Ethnicity* (Select one) H: Hispanic or Latino N: Not Hispanic or Latino I: American Indian or Alaskan Native A: Asian
 H: Hispanic or Latino B: Black or African American P: Native Hawaiian or other Pacific Islander W: White

Infants Under 12 Months Only: The iron-fortified infant formula this center offers is: _____
 Parent/guardian accepts center formula Parent/guardian will provide breastmilk
 Parent/guardian declines center formula and will provide _____
 Parent/guardian will provide more than 1 food item per meal/snack and decline the CACFP

Step 3 If any household members currently participate in SNAP*, MFIP*, or FDPIR*, provide the case number. *If no, skip to step 4.* MFIP Case Number: _____ SNAP Case Number: _____ FPIR Case Number: _____

Step	Adult Income - List the full name and gross income (before taxes) for each adult household member (living with you, sharing income and expenses, related or not), including yourself. If any adult household members do not receive income from any source, write '0'.	Gross Pay from Work			Farm or Self-Employment		Public Assistance, Child Support, Alimony			All other Incomes							
		Weekly	Every 2 weeks	Twice per month	Monthly	Yearly	Payments received	Weekly	Every 2 weeks	Twice per month	Monthly	Yearly	Weekly	Every 2 weeks	Twice per month	Monthly	
4	\$	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child Income - Sometimes children in the household earn or receive income. Include the TOTAL income (before taxes) received by ALL children listed in STEP 1 here.
 Total Income: \$ _____ Weekly Every 2 weeks Monthly Yearly

I certify (promise) that all information provided is true and that all income is reported. I understand this information is given in connection with the receipt of Federal funds and officials may verify (confirm) the information. I am aware that I may be prosecuted under applicable State and Federal laws if I provide false information.

Step 5 Print Name: _____ Signature: _____ Date (mm/dd/yyyy): _____
 Last four numbers of signer's Social Security Number (SSN): _____ or I do not have a Social Security Number (Required if completing Step 4)
 Address (include street, city, state, zip code): _____
 Phone: _____ Email: _____

Sponsor Use Only - Do Not Write Here Effective Dates: From _____ TO _____ 1st Approval Signature: _____ Date: _____ 2nd Check Initials: _____
 Free (A) - Head Start Free (A) - Foster Free (A) - Case Number Free (A) - Income Reduced (B) - Income Paid (C) Total Income: \$ _____ How often: _____ HH Size: _____
 If Children qualify differently - Head Start Child (ren): _____ Child (ren) in Foster Care: _____ Free/Reduced/Paid Child (ren): _____