Georgia Department of Early Care and Learning

Please write the school year in the box →

Pre-K Registration Form

2024-2025 **School Year**

PROVIDER LEGAL NAME: Meridian Education Resource Group dba Whitefoord, Inc.	(This section to be completed by the provider)
SCHOOL/SITE NAME: Whitefoord Early Learning Academy	

CHILD INFORMATION	**(Please print name exactly as it appears on the birth certificate.)**		
CHILD'S LAST NAME:			
CHILD'S FIRST NAME:			
CHILD'S MIDDLE NAME:	NAME SUFFIX:		(i.e. Jr, Sr, II, III)
CHILD'S SOCIAL SECURITY#:	D.O.B. (MM/DD/BY):	SEX:	M F
HOME ADDRESS (*Do not enter PO Box Info*):		COUNTY:	
CITY:	STATE: GA ZIP:	HOME PHONE:	

If the Student is transferring from another Pre-K, please provide the following:
Previous School Name: _____ Last Date in Attendance: _____

PARENT/GUARDIAN INFORMATION			
Parent/Guardian #1 - LAST NAME:	FIRST:		MIDDLE INITIAL:
Home Address *(If different from child)*:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email Address:			
Place of Employment:	Work Phone:		
Address:			
City:	State:	Zip:	
Parent/Guardian #2 - LAST NAME:	FIRST:		MIDDLE INITIAL:
Home Address *(If different from child)*:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Email Address:			
Place of Employment:	Work Phone:		
Address:			
City:	State:	Zip:	

EMERGENCY CONTACT INFORMATION	**(Persons to contact in the event that either parent/guardian cannot be contacted)**			
NAME	RELATIONSHIP	CELL PHONE	ALTERNATE PHONE	EMAIL
1.				
2.				

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.

Signature Parent/Guardian: _____ **DATE:** _____

CHILD MAINTENANCE				
CHILD'S LIVING ARRANGEMENTS:	☐]BOTH PARENTS	☐]MOTHER	☐]FATHER	☐ OTHER
CHILD'S LEGAL GUARDIAN:	☐]BOTH PARENTS	☐ MOTHER	☐ FATHER	☐ OTHER

THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:			
NAME	ADDRESS	RELATIONSHIP	CELL PHONE
1.			
2.			
3.			
4.			

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): _____.

DATE OF LAST FULL HEALTH SCREENING:_____ PHONE:

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:

MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:

GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

SIGNATURE (Parent/Guardian): _____

DATE: _____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child, _____, by photograph and/or videotape in connection with daily Pre-K activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PRE-K PROVIDER NAME/ADDRESS: Whitefoord Early Learning Academy/ 35 Whitefoord Ave, Atlanta, GA 30317

SIGNATURE (Parent/Guardian): _____

DATE: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

Georgia's Pre-K Program
Roster Information Form

This form is to be completed after school starts, not at the time of registration. **Please clearly print** the name as it appears on the birth certificate. *(Por favor escriba el nombre como aparece en el certificado de nacimiento.)*

TODAY'S DATE (M/D/Y): ____/____/____		
CHILD INFORMATION:		
Legal Last Name *(Apellido):*		Name Suffix (Sufijo) (Jr,II,III):
Legal First Name *(Primer Nombre):*		Name Child is Called:
Legal Middle Name *(Segundo Nombre):*		
Child's Social Security# _____-_____-_____	DOB *(Fecha de Nacimiento)* *(M/D/Y):* _____/_____/_____	Gender *(Sexo):* M ☐ F ☐
Date enrolled in Pre-K (M/D/Y): _____/_____/_____		
PARENT/GUARDIAN INFORMATION:		
Last Name:	First Name:	
Relationship: Mother ☐ Father ☐	Grandparent ☐ Guardian ☐	

1. Is your child's ethnicity **Hispanic/Latino/Spanish Origin,** regardless of race? *(¿Es Ud. **Hispano/Latino o de Origen Hispano,** sin importar la raza?)*

☐ **Yes** *(Si)* ☐ **No** *(No)* ☐ **Decline to Answer** *(negarse a contester)*

Please select **ONE OR MORE** of the following races regardless of how you answered question one. *(**TODOS** deben seleccionar **UNA O MAS** de las sigulentes razas sin importar cómo haya contestado la primera pregunta.)*

2. Is your child:

☐ a. **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. *(**Blanco** – Una persona que tiene orígenes en los pueblos provenientes de Europa, el Medio Oriente, o Africa del Norte).*

☐ b. **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *(**Asiática** – Una persona con orígenes en los pueblos provenientes del Lejano Oriente, Suroeste de Asia, o el subcontinente Hindú incluyendo, a Cambodia, China, India, Japón, Corea, Malasia, Pakistán, Las Filipinas, Tailandia, y Vietnam.)*

☐ c. **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. *(**Nativo de Hawaii u Otra Isla del Pacífico** – Una persona con orígenes en los pueblos provenientes de Hawaii, Guam, Samoa, u otra Isla del Pacifico.)*

☐ d. **Black or African American** – A person having origins in any of the Black racial groups of Africa. *(**Negro o Afro Americano** – Una persona con orígenes en los pueblos provenientes del Africa o en grupo racial Negro.)*

☐ e. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North and South America including Central America, who maintains a tribal affiliation or community attachment. *(**Indio Americano o Nativo de Alaska** – Una persona con orígenes en los pueblos provenientes de América Del Norte y del Sur, incluyendo América Central, que mantiene una afiliación tribal o comunitaria.)*

☐ f. **Decline to Answer** *(negarse a contester)*

3. What is your child's primary language? *(¿Cuál es el idioma primario de su hijo(a)?)*

☐ **English** *(Inglés)*

☐ **A language other than English** *(Un idioma diferente al Inglés)*

4. Was your child born as a: *(El parto en que Ud. tuvo a su hijo(a) fue de:)*

☐ **Single Birth (1)** *(Un sólo niño)*

☐ **Twin (2)** *(De mellizos)*

☐ **Triplet (3)** *(De trillizos)*

☐ **Quadruplet (4)** *(De cuatrillizos)*

☐ **Quintuplet (5)** *(De quintuples)*

5. Does your child have an Individualized Education Plan (IEP)? *(¿Tiene su hijo(a) un Plan de Educación Individualizada (IEP?))*

☐ **Yes** *(Si)* ☐ **No** *(No)*

6. Does your child receive any of the following services? *(¿Recibe su hijo(a) alguno de estos servicios?)*

☐ **Childcare and Parent Services (CAPS) (child care subsidy program)**

☐ **Food Stamps** *(Cupones de Alimentos)*

☐ **SSI**

☐ **Medicaid**

☐ **Temporary Assistance for Needy Families (TANF)**

7. Will the Pre-K center be providing transportation for your child? *(¿Recibirá su hijo(a) transporte en el Centro donde va a asistir a Pre-K?)*

☐ **Yes** *(Si)* ☐ **No** *(No)*

Parent/Guardian Signature **Date**

WHITEFOORD

Enrollment Form

Entrance Date_____ **Withdrawal Date**_____

Child's Name_____Sex___Age_____Date of birth_____

Home Address (Street)_____

City_____State_____Zip_____

Home Phone Number_____

Father's Name_____Home Phone Number_____

Father's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Father's Place of Employment _____Work Phone _____

Employer's Street Address_____City_____State_____Zip_____

Mother's Name_____Home Phone Number_____

Mother's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Mother's Place of Employment_____Work Phone #_____

Employer's Street Address_____City_____State_____Zip_____

Child's Living Arrangements: (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Child's Legal Guardian(s): (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other

The child may be released to the person(s) signing this agreement or to the following:

*Name_____ Address_____
(Street-City-State-Zip)
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

*Name_____ Address_____
(Street-City-State-Zip)
Telephone Number_____ Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name_____Telephone Number_____

Name_____Telephone Number_____

Name_____Telephone Number_____

Name of Public or Private School child attends, if any:_____

Child's doctor or clinic name_____

Doctor/clinic phone #_____

My child has the following special needs_____

_____

_____

The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:_____

_____

_____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns:_____

_____

_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name)_____ Date of birth_____ suffer an injury or illness while in the care of (Facility name) Whitefoord Early Learning Academy and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian:_____
Signature

Date:_____

Facility Administrator/Person-In-Charge_____
Signature

Date:_____

Parental Agreements with Child Care Facility

The Whitefoord Early Learning Academy agrees to provide child care for
(Name of Facility)
_____ on _____ _____ a.m. to _____ p.m.
(Name of Child) (Days of Week)
from _____ to _____.
(Month) (Month)

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast
Morning Snack
Lunch
Afternoon Snack
Evening Snack
Dinner
Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The _____ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for
_____.
(Name of Facility)

I understand that the facility will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Person-In-Charge)

Authorization to Dispense External Preparations

590-1-1-.20(1)

Student Name: _____

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____**Whitefoord Early Learning Academy**_____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

- ☐ Baby Wipes
- ☐ Band-aids
- ☐ Neosporin or similar ointment
- ☐ Bactine or similar first aid spray
- ☐ Sunscreen
- ☐ Insect Repellent
- ☐ Non-prescription ointment (such as A & D, Desitin, Vasaline)
- ☐ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*Center should maintain in child's file

WHITEFOORD

Dear Parent/Guardian:

This letter is intended for parents or guardians of children enrolled in a child care center. **Whitefoord Inc.** offers healthy meals to all enrolled children as part of our participation in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP). The CACFP provides reimbursements for healthy meals and snacks served to children enrolled in child care. Please help us comply with the requirements of the CACFP by completing the attached CACFP Meal Benefit Income Eligibility Form also known as the Income Eligibility Statement (IES). In addition, by filling out this form, we will be able to determine if your child(ren) qualifies for free or reduced-price meals.

1. **Do I need to fill out an Income Eligibility Statement (IES) for each of my children in day care?** You may complete and submit one [1] IES form for all children enrolled in child care in your household **only** if the children in child care are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: [NAME OF CENTER; ADDRESS; PHONE NUMBER].**
2. **Who can get free meals without providing income information?** Children in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR) benefits can get free meals. Foster children and children enrolled in Head Start are also eligible for free meals. Children in households participating in WIC may be eligible for free meals.
3. **Who can get reduced-price meals?** Your children can get reduced-priced meals if your household income is within the reduced-price limits on the Federal Income Eligibility Guidelines, shown on this application. Children in households participating in WIC may be eligible for reduced-price meals.
4. **May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center.
5. **Who should I include as members of my household?** You must include everyone in your household (such as grandparents, other relatives, or friends who live with you) who shares income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you.
6. **How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Eligibility Guidelines, the center will receive a higher level of reimbursement. Once properly approved for free or reduced-price benefits, whether through income or by providing a current SNAP, TANF, FDPIR case number, you will remain eligible for those benefits for 12 months. You should notify us, however, if you or

WHITEFOORD

someone in your household becomes unemployed and the loss of income causes your household income to be within the eligibility standards.

7. **What if my income is not always the same?** List the amount that you normally get. For example, if you normally get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 per month. If you normally receive overtime pay, include it, but not if you only work overtime on an occasional basis.
8. **What if I have foster children?** 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. Households may include foster children on the Income Eligibility Statement but are not required to include payments received for the foster child as income. Households wishing to apply for such benefits for foster children should contact **[NAME; ADDRESS; PHONE NUMBER].**
9. **We are in the military; do we include our housing and supplemental allowances as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, regarding deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.
10. **Will the information I give be verified?** ***(pricing program only)*** Maybe. We may ask you to send written proof to verify the information you submitted on the form.
11. **What if I disagree with the decision about the information I complete on this form?** You should talk to your Whitefoord Inc.

In the operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age, or disability.

If you have other questions or need help, call **404-431-1200**

Sincerely,

MG

WIC

A Special Food and Nutrition Education Program For Women, Infants and Children

WHO IS ELIGIBLE?

- A pregnant woman
- A breastfeeding woman
- A woman who has recently been pregnant
- An infant or a child less than 5 years old

SERVICES PROVIDED:

- Nutritious foods
- Nutrition counseling
- Breast feeding support
- Health care referral

TO BE ELIGIBLE, YOU MUST ALSO:

- Have a low or moderate income

AND

- Have a special need that can be helped by WIC foods and nutrition counseling

APPROVED WIC FOODS:

- Milk, cheese, eggs, cereals, peanut butter, fruit or vegetable juices, dry beans or peas, iron fortified formula

YOU DO NOT HAVE TO BE ON PUBLIC ASSISTANCE TO APPLY.

CALL YOUR LOCAL HEALTH DEPARTMENT FOR MORE INFORMATION.

Georgia WIC Program

Georgia WIC
Georgia Department of Public Health
2 Peachtree Street, NW
10th Floor
Atlanta, GA 30303
Telephone: 1-800-228-9173
Website: http://dph.georgia.gov/WIC

INCOME ELIGIBILITY GUIDELINES
(Effective from July 1, 2023 to June 30, 2024)

Household Size	Reduced Meal Income Limits				
	Annually	Monthly	Twice A 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
For each additional family member add	+ 9,509	+793	+ 397	+366	+ 183

Sources of Income Chart[1]

INSTRUCTIONS

Households that receive SNAP, TANF, FDPIR, SSI or Medicaid: Complete the following:

Part I: For family day care home and child care center, list participant's name and a SNAP, TANF, or FDPIR case number. For adult day care, list participant's name and a SNAP, TANF, FDPIR, SSI or Medicaid case number. **Note: foster children (children placed in the household by the court system) can be included in this section. A separate form is no longer needed for foster children. Note:** Children in Foster care, enrolled in Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Please refer to the Q&A section for a definition of each free categorical eligibility.
Part II: Skip this part.
Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.
Part IV: Sign the form. A Social Security Number is not necessary.
Part V: Answer this question if you choose to.

All other Households, including WIC households, complete the following:

Part I: For family day care home, child care center or adult day care, list participant's name.
Part II: To report total household income from last month, complete the following:
A- Child Income: Please indicate the TOTAL income received by **Child** household members listed in PART I. Please list any child income and how often it is received in this section.
B – Adult Income: List the first and last name of each **Adult** person living in your household as an economic unit. You must indicate yourself and all other adult members living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant should be listed here as well. Attach another sheet if necessary.
List Gross Income. Next to each person's name, list each type of income received last month, and how often it was received.
B-Column 1: List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).
B-Column 2: List the amount each person got last month from welfare, child support, alimony.
B-Column 3: List Social Security, pensions, and retirement.
B-Column 4: List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned businesses, farming, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.
Social Security Number: If income is listed or completed in Part II, the adult completing the form must also list the last four digits of his or her Social Security Number or mark the "I don't have a Social Security Number" box.
If no income: If the person does not receive income from any source, write "0". If "0" is entered or any income fields are blank, the person is certifying that there is no income to report. Please note that the last four digits of his or her Social Security Number is REQUIRED when/if **Part II B** is completed and household members are listed (with or without income).

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	▪ Social Security (including railroad retirement and black lung benefits) ▪ Private pensions or disability benefits ▪ Regular income from trusts or estates ▪ Annuities ▪ Investment income ▪ Earned interest ▪ Rental income ▪ Regular cash payments from outside household

C – Total Household Members. Please list the total number of all household members (children and adults) in this section.

Part III: Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

Part IV: An adult household member must complete this section completely and then sign the form. Please refer back to Part II to ensure the last four digits of his/her social security number have been recorded or the box has been marked if he/she does not have one.

Part V: Answer this question if you choose to.

Privacy Act Statement: This explains how we use the information you give us.

Bright from the Start: Georgia Department of Early Care and Learning
CACFP Meal Benefit Income Eligibility Statement*

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. **Note**: Do not use EBT numbers. Write case number and proceed to Part III.	**Children in Head Start, foster care and children who meet the definition of migrant, runaway, or homeless are eligible for free meals. Check (✓) all that apply. (See definitions in FAQs)**				
		Head Start	Foster Child	Migrant	Runaway	Homeless
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

PART II: Report income for ALL Household Members (Skip this step if participant is categorically eligible as documented in Part I.)
Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income[1] - Sometimes children in the household earn or receive income. Please indicate the TOTAL income received by child household members listed in PART I here.

Child Income/How often? (i.e., weekly, monthly, etc.)
$_____/_____

B. Other Household Members[1]. **List all household members even if they do not receive income. Also, list the adult participant if he/she did not meet eligibility in Part I. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only along the frequency i.e., twice a month, weekly, etc. If they do not receive income from any source, write '0'. If you enter "0" or leave any field blank you are certifying (promising) there is no income to report.**

Name of Other Household Members (First and Last)	1. Earnings from work before deductions / How often?	2. Subsidies, child support, alimony / How often?	3. Social Security, pensions, retirement / How often?	4. All other income / How often?
1. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
2. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
3. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
4. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
5. _____	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

C. Total Household Members (Adults and Children) listed in Part I and Part II _____

Social Security Number. If Part II B is completed and household members are listed (with or without income), the adult completing the form must also list the last four digits of his or her Social Security Number or check the "I don't have a Social Security Number" box below. (See Privacy Act Statement on next page). **Failure to complete this section, if income is listed, will result in the denial of free or reduced eligibility.**

Last four Digits of Social Security Number XXX-XX_____ ☐ I do not have a Social Security Number

PART III: Enrollment Information: *Children Only*
My child is normally in attendance at the facility between the hours of _____ [am/pm] to _____ [am/pm]. ☐ (✓) Check here if only before/after school care is provided.

Circle the days your child will normally attend the center: **Sunday Monday Tuesday Wednesday Thursday Friday Saturday**

Circle the meals your child will normally receive while in care: **Breakfast AM Snack Lunch PM Snack Supper Evening Snack**

PART IV: Signature
*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 purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child(ren) or adult listed on the form in Part I are enrolled for care. **If not completed fully and signed, the participant will be placed in the Paid category**.*

Signature: X _____ **Print Name:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

***This application is a revision of USDA's newly released meal benefit prototype and meets all legal requirements and reflect design best practices identified by USDA through focus testing and other research.**

PART V: Participant's Ethnic and Racial Identities: *The use of racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing information in Part V is voluntary. Your response or lack of response will not impact the participant's eligibility for meals.*

Check (✓) one ethnic identity:
☐ Hispanic/ Latino ☐ Not Hispanic/ Latino

Check (✓) one or more racial identities:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Multiracial

Official Use Only Section for Provider: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____ **Per**: ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Year **Household Size**: _____

Categorical Eligibility: check (✓) if applicable ☐ **Eligibility**: check (✓) one Free ☐ Reduced ☐ Paid ☐

Day Care Homes Only: check (✓) one Tier I ☐ Tier II ☐

When more than one person is performing CACFP duties, there must be at least two signatures on this form: one signature from the Determining Official (the official who determined initial income classification) and one signature from the Confirming Official (the official who verified the form's accuracy).

Determining Official's Signature: _____ **Date**: _____

Confirming Official's Signature: _____ **Date**: _____

Follow Up Official's Signature: _____ **Date**: _____

Georgia Dept of Early Care and Learning
BRIGHT FROM THE START

2 Martin Luther King Jr. Drive, SE, Suite 754, East Tower, Atlanta, GA 30334
(404) 656-5957

Child and Adult Care Food Program and Summer Food Service Program
Racial and Ethnic Data Individual Collection Form for Families

This form may be completed by a parent or guardian. Collection of the racial and ethnic data is to ensure compliance with USDA nondiscrimination requirements only. Providing this information is voluntary. Your response or lack of response will not impact the participant's eligibility for meals. The data is kept confidential, accessible only to authorized personnel, and may be protected by the Privacy Act of 1974.

Instructions for completion: (Please Print)

1) In Section I, input the number of children in the household based on the two ethnic categories: a) of Hispanic or Latino origin; or b) not of Hispanic or Latino origin.
2) In Section II, input the number of children in the household by racial category based on the six categories listed.
3) **The total number of children by ethnic category (Section I, Item C) and the total number by racial category (Section II, Item H) should be equal.**

After completion, the participant, parent and/or guardian may return this form in-person to the Program site.

Section I.

Ethnic Category	Number of Children
A) Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino)	
B) Not Hispanic or Latino	
C) TOTAL NUMBER OF CHIDREN BY ETHNIC CATEGORY	

Section II.

Racial Category	Number of Children
A) American Indian/Alaskan Native (A person having origins in any of the original peoples on North America, and who maintains cultural identification through tribal affiliation or community recognition [includes Aleuts and Eskimo)	
B) Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, for example Cambodia, China, India, Japan, Korea, the Philippine Islands, Thailand, Malaysia, Pakistan and Vietnam).	
C) Black or African American (A person having origins in the black racial groups of Africa. Terms such as "Haitian" can be used in addition to "Black or African American").	
D) Native Hawaiian or other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands).	
E) White (A person having origins in any of the original peoples of Europe, North Africa, or the Middle East).	
F) Multiracial (A person having origins in two or more of the original peoples of Africa, Asia, Europe, Middle East, North America, or Pacific Islands).	
G) Number of Unknown Responses (Parent/guardian did not advise of a racial category)	
H) TOTAL NUMBER OF CHILDREN BY RACIAL CATEGORY	

I certify to the best of my knowledge and belief that the above information is collected in accordance with USDA guidelines and is accurate and complete. ***A signature is not required for non-enrolled participants.***

_____ _____

Signature Date

WHITEFOORD

WHITEFOORD EARLY LEARNING
STUDENT HEALTH RECORD

Student Name:_____

SEX:_____ **BIRTHDATE:**_____/_____/_____

ADDRESS:_____

PHONE NUMBER: ( ) _____ - _____

ACCOMPANYING ADULT:_____ **RELATIONSHIP TO STUDENT:**_____

To Be Completed by Child's Doctor
RELEVANT INFORMATION: (from health history or parent observation):

SCREENING TESTS: Starred items (*) are required for children 3-5 years old. Enter date if done previously. When recording results, enter a minimum: Normal (N), Suspect (S), or Atypical/Abnormal (A)

TEST	DATE	RESULTS
PRESENT AGE		____YRS. _____Mos.
HEIGHT (no shoes, to nearest in.) *		
WEIGHT (light clothing, to nearest ¼ lb.)*		
BLOOD PRESSURE		
HEMATOCRIT OR HEMOGLOBIN*		
HEARING		
TEST	**DATE**	**RESULTS**
TYPE OF TEST:		
RESULTS:		
RESCREENING:		
VISION		
TEST	**DATE**	**RESULTS**
TYPE OF TEST:		
ACUITY		
RESCREENING		
STRABSIMUS		
COMMENTS:		

WHITEFOORD

WHITEFOORD EARLY LEARNING
STUDENT HEALTH RECORD

OTHER TESTS (If Indicated)		
	DATE	**RESULTS**
TB		
Sickle Cell		
Lead		
OVS		
Urinalysis		
Other		

PHYSICAL EXAMINATION ASSESSMENT:

	NORMAL FOR AGE	**ABNORMAL**	**NOT EVALUATED**
General Appearance			
Posture, Gait			
Speech			
Head			
Skin			
Eyes (1) External Aspect			
(2) Optic Fundoscopic			
(3) Cover Test			
Ears (1) External			
(2) Tympanic Membrane			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Genitalia			
Bones, Joints, Muscles			

WHITEFOORD

WHITEFOORD EARLY LEARNING
STUDENT HEALTH RECORD

	NORMAL FOR AGE	ABNORMAL	NOT EVALUATED
Neurological/Social (1) Gross Motor			
(2) Fine Motor			
(3) Communication			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
Glands			
Muscular Coordination			
Other			

GENERAL STATEMENT OF CHILD'S PHYSICAL STATUS:

SIGNATURE:_____ **DATE:**_____/_____/_____

FINDINGS, TREATMENTS AND RECOMMENDATIONS

Abnormal Findings/Diagnosis	Treatment Plan	Recommended Follow-Up Results (Initial when complete)	Date

Permission For Developmental Screening

School Year _____

_____
Child's Name

To meet the requirements of granting organizations, developmental screenings on all students are required from time to time during the school year. The appropriate staff will administer these screenings. Parent/legal guardian will be notified of the results. If further evaluation is needed, you will be notified and asked to accompany your child.

_____ _____
Parent/Legal Guardian Date

Proof of Insurance

School Year _____

In order for your child to receive services at Whitefoord, Inc. School Health Clinic, proper documentation of insurance must be received. The clinic is a part of several insurance plans including the Medicaid System of Georgia Better Health Care and PeachCare for Kids. Without proper documentation of insurance, you may be financially responsible for services rendered.

As a part of our program to work with the whole family, as insurance information changes, we ask that you bring this information to the administrative staff as soon as possible to make a copy and place in your child's file.

_☐_ I am Medicaid eligible. My Medicaid number is_____
_☐_ I have PeachCare. My PeachCare number is_____
_☐_ I have private insurance with_____. Group number_____
_☐_ I do not have insurance. I would like to talk with someone about getting insurance.
_☐_ I will be responsible for payment for all medical services.

Child's Doctor:_____ Telephone:_____

Address:_____

_____

Child's Doctor:_____ Telephone:_____

Address:_____

_____

_____
Child's Name

_____ _____
Parent/Legal Guardian Date

WHITEFOORD

Parent Contact Form

School Year _____

Date:_____

It is important that we have current daytime and evening telephone numbers and/or cellular phone numbers for a child's parent(s) or legal guardians at all times. There are times when it is imperative that we are able to speak with you immediately. Please inform us when any of this information changes. Please take a moment and fill out this form with current information.

Your child's name:_____

Your name: _____

Your relationship to the child:_____

Daytime telephone number at which you can be reached: _____

Cellular number at which you can be reached:_____

Any other number where we can reach you for emergency purposes only:_____

Please indicate change of address below if applicable

Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Your Signature:_____ Today's Date:_____

Parent/Guardian Email Address:_____

WHITEFOORD

Vehicle Emergency Medical Information

Child's Name _____ Date of Birth _____

Address _____

Parent Name _____

Home Phone _____ Work Phone _____

Parent Name _____

Home Phone _____ Work Phone _____

Person to notify in an emergency and parents cannot be reached:

Name _____ Phone _____

Child's Doctor _____ Phone _____

Medical facility the center uses _____

Address _____

Child's Allergies _____

Current prescribed medication _____

Child's special needs and conditions _____

In the event of an emergency involving my child, and if Whitefoord Early Learning Academy
Name of Facility
cannot get in touch with me, I hereby authorize any needed emergency medical care. I further agree to be fully responsible for all medical expenses incurred during the treatment of my child.

Child's Name _____

Signature (Parent/Guardian) _____

Witness By _____ Date _____

WHITEFOORD

SCHOOL-BASED PEDIATRIC CONSENT FORM

I understand that Whitefoord Inc. School Based Health Centers can provide comprehensive health services to my child. **I also understand that I have the right to withdraw this consent at any time upon written notice to the medical director.**

I authorize (check all that applies):

- ☐ **Release of information** from the child's medical record whenever necessary for payment, continued care or treatment, and healthcare operations.
    - o I further give consent for staff to examine the child's full school record, including attendance and other information that may assist staff in helping my son/daughter to accomplish the purposes described above.
- ☐ For my child to receive **medical care** through the School Based Health Center, including physical exams, drawing blood, evaluation of injuries, vaccinations, chronic disease management, referrals and other office minor procedures.
    - o **Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian**
- ☐ For my child to receive **dental care** through the School Based Health Center. This includes periodic dental examinations for my child, which may include screenings, photographs, radiographs, and any other acceptable methods for the dental evaluation and management of the child's dental health.
- ☐ For my child to receive **behavioral health and counseling services**, including one-on-one counseling, community resource referrals and outreach, and coordination of outside resources
- ☐ Participation in **health education** classes and the Fitness Program sponsored/coordinated by Whitefoord Inc. Health Education Department.
- ☐ That in the case of a medical emergency, I give permission to Whitefoord Inc. Health Centers to call **emergency transport** for my child.

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know basis" to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include the following; immunization records, class schedules, parental contact, address, phone number, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from the School Based Health Center may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed above to release information to the School Based Health Center staff members as needed. This information may include the following; medical records including lab results, office visits, hospital admissions, vaccinations and BMI (Body Mass Index) information entered into GRITS (Georgia Registry of Immunization Transactions and Services), dental and mental health records. I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, School Based Health Center staff members will use and share my Personal Health Information (PHI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives his/her health care services.

I have read and understand the above information and give permission for the child's care as described. *I understand that I have the right to OPT the child out of any medical testing or treatment.* This consent will last the duration of the child's time at this school location.

Name of Parent or Legal Guardian (please print):	**Name of Child (please print):**	
Signature of Parent or Legal Guardian:	**Relationship to Child:**	**Date:**

WHITEFOORD

SCHOOL-BASED PEDIATRIC CONSENT FORM

PRESENT HEALTH CONCERN/REASON FOR VISIT: _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____

Street Address/Apt #: _____ **County:**_____ **City:**_____ **Zip:** _____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Current Primary Care Provider (PCP): _____ ☐ Patient does not have one but would like to make Whitefoord PCP

Date of Birth (mm/dd/yyyy): _____ **Sex:** ☐ Male ☐ Female ☐ Transgender (M-to-F) ☐ Transgender (F-to-M)

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White **Race Cont. :** ☐ Hispanic ☐ More than one race ☐ Other: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Primary Language: _____ **Do you or the patient require a translator?** ☐ Yes ☐ No

Present Housing Situation (check any that apply): ☐ Migrant ☐ Seasonal ☐ Homeless ☐ Public Housing

Does this patient have an advanced directive (legal document stating patient's wishes regarding medical treatment if no longer able to communicate to doctor)? ☐ Yes ☐ No

How did you hear about Whitefoord? Please Specify:_____

Does Patient Attend School? ☐ Yes ☐ No **School Patient Attends:** _____ **Grade:** _____

PARENT/ GUARDIAN INFORMATION

Name: _____ **Relationship to Patient:** _____

Street Address/Apt # (If different from above): _____

Employer Name (if applicable): _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student **Email:** _____

If you are unavailable, do you authorize Whitefoord to discuss patient health information with anyone else?: ☐ Yes ☐ No

If yes, please provide: Name: _____ Relationship to Patient:_____ Phone #: _____

Emergency Contact (If different than Parent/Guardian):

Name: _____ **Relationship to Patient:** _____ **Phone #:** _____

Can Whitefoord discuss personnel health information with Emergency Contact? ☐ Yes ☐ No

INSURANCE AND FINANCIAL INFORMATION

Financially Responsible Party (financially responsible for payment or primary insurance holder): ☐ Self ☐ Other

If other, Name: _____ Relationship to patient: _____

Responsible Party's Date of Birth (MM/DD/YYYY): _____

We offer discount based on a sliding fee scale, giving us your household information would help us determine if you qualify for our sliding fee scale discount:

What is financially responsible party's number of household dependents?: _____

What is financially responsible party's household income? _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly

Are you covered by medical insurance?: ☐ Yes ☐ No If yes, what type?: ☐ Medicaid ☐ Private ☐ Other: _____

If Medicaid: Medicaid ID #: _____

If Private Insurance: Company Name:_____ Policy Holder Name: _____

Policy #:_____ Group #: _____

Do you have dental insurance? ☐ Yes ☐ No

Company Name:_____ Policy Holder Name: _____

Policy #:_____ Group #:_____

Preferred Pharmacy Name: _____ **Preferred Pharmacy Phone Number:** _____

Preferred Pharmacy Address: _____

MEDICAL HISTORY

Was patient born premature? ☐ Yes ☐ No If Yes, explain _____

Has patient been treated or received care in an Emergency Room in the past 6 months? ☐ Yes ☐ No

WHITEFOORD

SCHOOL-BASED PEDIATRIC CONSENT FORM

Does patient take any medications? ☐ Yes ☐ No *List all medications:*

Does he/she need to take any prescribed medications during school hours? ☐ Yes ☐ No *List all medications:*

Approximate date of last well check visit? Date:

Any surgery in the past? ☐ Yes ☐ No Explain:

Any hospitalization in the past? ☐ Yes ☐ No Explain:

Any implanted medical device such as shunts, catheters, pacemaker etc ? ☐ Yes ☐ No If Yes, explain:

Has patient started their menstrual period? ☐ Yes ☐ No Start date:

Is premedication with antibiotics needed prior to dental procedures? ☐ Yes ☐ No Explain:

HAS THE PATIENT HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?:

Systems Review	Name of the Condition	Yes	No	Age of Onset	Family member with condition? (please specify)
Neurological (Brain) **and Nerve disorders** (ex. Migraines, Seizures)		☐	☐		
Eye disorders		☐	☐		
Ear/Nose/Throat disorders		☐	☐		
Oral/Dental disorders		☐	☐		
Endocrine/gland disease/autoimmune disorders (ex. Diabetes, Hyperthyroidism)		☐	☐		
Lung Disease/Problems (ex. Asthma, Pneumonia)		☐	☐		
Heart Disease/ Problems (ex. Hypertension)		☐	☐		
Gastro-Intestinal disorders (ex. Gallstones, Ulcers)		☐	☐		
Urinary Tract Disease/Problems (ex. Kidney stone, over active bladder)		☐	☐		
Skin disorders (ex. Psoriasis, Eczema)		☐	☐		
Blood /Lymph disorders (ex. Anemia)		☐	☐		
Allergy/Immunology disorders		☐	☐		
Behavioral Health problems/Mental Illness (ex. Depression, Eating Disorder)		☐	☐		
Musculoskeletal/Joint disorders (ex. Scoliosis)		☐	☐		
Developmental Disorders (ex. Autism)		☐	☐		
School/Psycho-social problems (ex. ADD)		☐	☐		
Cancer/Malignancy		☐	☐		
Others (ex. TB, Hepatitis, Chicken Pox)		☐	☐		

ALLERGIES

Any allergies? ☐ Yes ☐ No If yes, list all allergies (food, medications, anesthetic, latex, other):

Does your child have an Epi-Pen at school? ☐ Yes ☐ No

DENTAL HEALTH

Would you like to enroll the patient in dental services? ☐ Yes ☐ No

Has patient had dental cleaning within the last 6 months? ☐ Yes ☐ No

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No

BEHAVIORAL HEALTH: Please complete ONLY if patient is in need of behavioral health services

Would you like to enroll the patient in behavioral health services? ☐ Yes ☐ No

All About Me and My Family

Dear Family,

We welcome you and your child to our classroom community! We are eagar to know you and your child better in the coming weeks. Please help us get started by sharing with us some important things about your child. We encourage you to talk with us at any time and to provide all information that may help us to teach and care for your child in a more complete way. We look forward to working together as partners in support of your child.

Date _____

Child's Name _____ First Language _____

Completed by _____ Relationship to child _____

In a few words, please describe your child

_____

_____

Who is part of your child's family? Please list names of family members and their relationships to the child.

_____

_____

What are some of your family traditions?

_____

_____

What are your child's favorites?

Favorite toys _____

Favorite songs _____

Favorite foods _____

Favorite activities _____

Other _____

Form Adapted from
www.coxcampus.org

All About Me and My Family

Are there situations or experiences that upset your child?

What do you do to comfort him/her when he/she is upset or afraid?

If already talking, can you understand the words he/she says?

Do you have any special concerns about your child's development that you would like to share with us?

What questions do you have about your child's upcoming school experience?

What do you hope your child gains from his/her experience at school?

How can we best support you in our role as parents?

How would you like t be contacted by your child's teachers? Also, please tell us the best times to reach you for non-emergency conversations?

Any additional thought you would like to share?

Thank you for completing this form and returning it!

Form Adapted from
www.coxcampus.org

Family Language and Culture Survey: Supporting Multilingual/Dual Language Learners

WHITEFOORD

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

Dear family: This survey is designed to help teachers gather important information about your child's language and culture background. It will help us plan ways to partner with you to support your child's first language and bring his/her culture into the classroom. Thank you for completing and returning the survey.

Does your child speak and/or hear a language/languages other than English at home? (Check one): No ☐ Yes ☐

IF YOUR CHILD ONLY SPEAKS AND HEARS ENGLISH AT HOME, is there anything you would like to share about your child's (or your family's) culture? Please do so in the space provided. **You do not need to fill out the rest of this survey.**

_____

_____

_____

_____

_____

IF YOUR CHILD SPEAKS AND/OR HEARS A LANGUAGE(S) OTHER THAN ENGLISH AT HOME, PLEASE FILL OUT THE REST OF THIS SURVEY.

1. What language(s) do family members speak at home?

List household members, relation to the child, and language in which each person speaks to your child:

Family member	Relationship to child	Language

Form adapted from

www.coxcampus.org

Adapted from: Espinosa, L. 2014. Getting it for Young Children from Diverse Backgrounds: Applying Research to Improve Practice with a Focus on Dual Language Learners (2nd Edition) 2nd Edition. Pearson

2. What language does your child use when speaking at home?

☐ Only English	☐ Mostly English but sometimes first language	☐ Both languages equally	☐ Mostly home language but also some English	☐ Only home language (not English)

If more than one language is spoken at home, please specify which language the child uses most or with what family member the child uses each language:

_____

3. How do you feel about your child continuing to learn his/her first language at the same time he/she learns English?

I really want my child to learn English and maintain our first language. ☐	I don't really know how I feel about this. ☐	I am concerned about my child learning our first language and English at the same time. ☐

4. What country is your child/family from? What is your child's cultural heritage and what parts of your culture are most important to you and your family?

_____

_____

5. How can you help your child's teachers bring your language and culture into the classroom?

_____

_____

6. How can your child's teachers support you?

_____

_____

Adapted from: Espinosa, L. 2014. Getting it for Young Children from Diverse Backgrounds: Applying Research to Improve Practice with a Focus on Dual Language Learners (2nd Edition) 2nd Edition. Pearson