CERTIFICATE OF IMMUNIZATION
www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official immunization record for every student enrolled.

Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Each immunization date MM/DD/YY						**Titer date**
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
DT Diphtheria, Tetanus (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella date of disease	
Varicella positive screen date	

Recommended vaccines

	Each immunization date MM/DD/YY					
HPV Human Papillomavirus						
Rota Rotavirus						
MCV4/MPSV4 Meningococcal						
Men B Meningococcal						
Hep A Hepatitis A						
Flu Influenza						
Other						

Optional review signature by the school health authority or health care provider
I have reviewed this immunization record

Signature: _____ Date: _____

(Optional) TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT
I authorize my/my student's school to share my/my student's immunization records with state/local public health and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Signature: _____ Date: _____

General Health Appraisal Form

Parent: *Please complete*

Child's Name: _____ **Birthdate:** _____

Allergies: ❑ None ❑ Describe: _____

Type of Reaction: _____

Diet: ❑ Breast Fed ❑ Formula: _____ ❑ Age Appropriate

❑ Special Diet: _____

❑ **Preventive creams/ointments/sunscreen** may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: _____

_____ Date: _____

Parent or Legal Guardian Signature — Authorization expires 365 days after this date

Health Care Provider: *Please complete after parent section has been completed*

Date of Last Exam: _____ **Recent Weight:** _____ ****HCT:** _____ ** B/P:** _____ ****Lead Level:** _____

Physical Exam: ❑ Normal ❑ Abnormal *(see explanation of significant health concerns:)*

Significant Health Concerns: ❑ None ❑ Reactive Airways Disease ❑ Seizures ❑ Diabetes ❑ Developmental Delays

❑ Vision ❑ Hearing ❑ Hospitalizations ❑ Severe Allergies ❑ Other *(dental, nutrition, behavior, etc.)* _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

_____

Current Medications/Special Diet: ❑ None ❑ Describe: _____

_____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever ***(mark only one product: max. 3 consecutive days without additional medical authorization)***

❑ Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

OR

❑ Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

Immunizations: ❑ Up-to-date ❑ See attached immunization record ❑ Administered today: _____

_____

Signature:

Next Well Visit: ❑ Per AAP Guidelines* or ❑ Age: _____

This child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified on this form.

_____ _____

Signature of Health Care Provider (certifying form was reviewed) — Date

Office Stamp: *Or write Name, Address, Phone Number*

The Colorado Chapter of the American Academy of Pediatrics (AAP), Healthy Child Care Colorado, and Headstart have approved this form 04/04.

* The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

** Required by Head Start programs only per state EPSDT schedule

Immunization
Medical Exemption Form

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases as established by Colorado Board of Health rule 6 CCR 1009-2, unless an official exemption form is filed. This law applies to students attending child care facilities licensed by the Colorado Department of Human Services, public, private and parochial kindergarten, elementary and secondary schools through 12th grade, and colleges or universities. Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of disease and the circumstances of the outbreak.

Please complete all required fields below; incomplete forms will not be accepted. *All fields are required unless noted optional.*

Student Information:

Last Name:	First Name:	(optional) Middle Name:
Gender: □ Female □ Male	Date of Birth:	
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box:	
City:	State: CO	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

Parent/Guardian Completing This Form: □ Check if an emancipated student or student over 18 years old

Last Name:	First Name:	(optional) Middle Name:
Relationship to student: □ Mother □ Father □ Guardian		
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box	
City:	State: CO	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		□ Check if Not Applicable
Address:		
City:	State: CO	Zip Code:
Phone Number:		Grade of Student:

	Required Vaccines for Entering School: (Check each vaccine declined)	**List medical contraindication(s) for each vaccine declined**
□	Hepatitis B	
□	Diphtheria, tetanus, pertussis (DTaP, Tdap)	
□	Haemophilus influenza type b (Hib)	
□	Inactivated poliovirus (IPV)	
□	Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23)	
□	Measles-mumps-rubella (MMR)	
□	Varicella (chickenpox)	

The physical condition of the above named student is such that vaccination would endanger his/her life or health or is medically contraindicated due to other medical conditions.

Physician/Advanced Practice Nurse/delegated Physician Assistant Signature: _____ Date: _____

Under Colorado law, you have the option to exclude your child's/your information from CIIS. To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

Immunization

Non-Medical Exemption Form (Religious and Personal Belief)

Vaccines are one of the greatest public health achievements of the past century and save an estimated 3 million children's lives every year. The Colorado Department of Public Health and Environment strongly supports vaccination as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. For nearly all children, the benefits of preventing disease with a vaccine far outweigh the risks. Declining to follow the advice of a health care provider, or public health official who has recommended vaccines may endanger an unvaccinated child's health and others who come into contact with him/her. Some vaccine-preventable diseases are common in other countries and unvaccinated children could easily get one of these diseases while traveling or from a traveler.

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases as established by Colorado Board of Health rule 6 CCR 1009-2, unless an official exemption form is filed. This law applies to students attending child care facilities licensed by the Colorado Department of Human Services, public, private and parochial kindergarten, elementary and secondary schools through 12th grade, and colleges or universities. Prior to kindergarten, an official non-medical exemption form must be filed each time a student is due for vaccines according to the schedule developed by the Advisory Committee on Immunization Practices.[1,2] From kindergarten through 12th grade, an official non-medical exemption form must be filed every year during the student's school enrollment/registration process[1]. **Students with an exemption may be kept out of child care or school during a disease outbreak.**

Please complete all required fields below; incomplete forms will not be accepted. *All fields are required unless noted optional.*

Type of Non-Medical Exemption Claimed:
□ Personal Belief □ Religious

Student Information:

Last Name:	First Name:	(optional) Middle Name:
Gender: □ Female □ Male	Date of Birth:	
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box:	
City:	State: CO	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

Parent/Guardian Completing This Form: □ Check if an emancipated student or student over 18 years old

Last Name:	First Name:	(optional) Middle Name:
Relationship to student: □ Mother □ Father □ Guardian		
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box:	
City:	State: CO	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		□ Check if Not Applicable
Address:		
City:	State: CO	Zip Code:
Phone Number:		Grade of Student:

[1] Colorado Board of Health rule 6 CCR 1009-2: http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6437&fileName=6%20CCR%201009-2.

[2] 2016 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a non-medical exemption form would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

Vaccine Preventable Disease Information

The information provided below is to ensure parents/guardians/students are informed about the risks of not vaccinating.

Diphtheria, tetanus, pertussis (DTaP, Tdap) - Unvaccinated children may be at increased risk of developing diphtheria, tetanus and/or pertussis if exposed to these diseases. Serious symptoms and effects of diphtheria include heart failure, paralysis, breathing problems, coma, and death. Serious symptoms and effects of tetanus include "locking" of the jaw, difficulty swallowing and breathing, seizures, painful tightening of muscles in the head and neck, and death. Serious symptoms and effects of pertussis (whooping cough) include severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/dtap.pdf and http://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.pdf
Haemophilus influenza type b (Hib) – Unvaccinated children may be at increased risk of developing invasive Hib disease if exposed to this disease. Serious symptoms and effects include bacterial meningitis, pneumonia, severe swelling in the throat, permanent neurologic damage including blindness, deafness, and mental retardation, infections of the blood, joints, bones, and covering of the heart, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hib.pdf
Hepatitis B - Unvaccinated children may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects include jaundice, life-long liver problems such as liver damage, scarring, liver cancer, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf
Inactivated poliovirus (IPV) – Unvaccinated children may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects include paralysis of muscles that control breathing, meningitis, permanent disability, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ipv.pdf
Measles, mumps, rubella (MMR) - Unvaccinated children may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include pneumonia, seizures, brain damage, and death. Serious symptoms and effects of mumps include meningitis, painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include rash, arthritis, and muscle or joint pain. If a pregnant woman gets rubella, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmr.pdf
Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23) - Unvaccinated children may be at increased risk of developing pneumococcal disease if exposed to this disease. Serious symptoms and effects include pneumonia, lung infections, blood infections, meningitis and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/pcv13.pdf and http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ppv.pdf
Varicella (chickenpox) – Unvaccinated children may be at increased risk of developing varicella if exposed to this disease. Serious symptoms and effects include severe skin infections, pneumonia, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.pdf

Required Vaccines for School Entry - Place an "X" next to each vaccine you are declining.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diptheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenza type b (Hib)		Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23)
	Hepatitis B		Varicella (chickenpox)

I am the parent/guardian of the above-named student or am the student himself/herself (emancipated or over 18 years of age) and am declining the vaccine(s) indicated above due to a religious or personal belief that is opposed to vaccines. The information I have provided on this form is complete and accurate.

- I may change my mind at any time and accept vaccination(s) for my child/myself in the future.
- I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, or www.ImmunizeforGood.com for additional information on the benefits and risks of vaccines and the diseases they prevent.
- I can contact the Colorado Immunization Information System (CIIS) at www.ColoradoIIS.com or my health care provider to locate my child's/my immunization record.[3]

I acknowledge that I have read this document in its entirety.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

COLORADO
Department of Public Health & Environment

Notice of Immunization Requirement & In-Process Form
Immunizations Needed for School or Child Care

Dedicated to protecting and improving the health and environment of the people of Colorado

This notification is being sent to you by your student's school/childcare to inform you of a required immunization(s) not documented on the student's immunization record provided to the school/childcare. **Please respond directly to your school/childcare regarding this notice.**

To the parent/guardian of: _____

Your student will need an up-to-date immunization record that includes required immunizations in order to attend this school/child care. Colorado law allows your student to attend school/child care while he/she is getting up-to-date on immunizations and is considered in-process. ** Please present an immunization record to your school/childcare after each immunization.

The following shot(s) is/are required and due by the following date: _____

_____ **DTaP** (Diphtheria/Tetanus/Pertussis)

_____ **Tdap** (Tetanus/Diphtheria/Pertussis)

_____ **Td** (Tetanus/Diphtheria)

_____ **IPV** (Polio)

_____ **MMR** (Measles, Mumps, Rubella)

_____ **Hib** (*Haemophilus influenzae* type b)

_____ **PCV13** (Pneumococcal Conjugate)

_____ **Hep B (Hepatitis B)**

_____ **Varicella *** (Chickenpox)

***** All reporting of Chickenpox disease must be documented by a health care provider (MD, DO, APN -Advanced Practice Nurse or PA – Physician's Assistant) or a chickenpox disease screening can be done by the school nurse who is a RN - registered nurse). **As of 7/1/2015, 2 doses of Varicella vaccine are required for all students K – 12th grades.**

Please note If your child cannot receive an immunization for *medical reasons*, an MD, DO, APN or PA must sign a Medical Exemption. Colorado also allows parents to submit a Non-Medical exemption (religious or personal belief) with a parent/guardian signature. Please go to www.colorado.gov/vaccineexemption to obtain an exemption form and for

Dear Health Care Provider,

The Colorado Board of Health (CBOH) incorporates by reference the Advisory Committee on Immunization Practices (ACIP) immunization schedule. Colorado child cares and schools can only accept immunizations as valid if they meet both the **minimum age and minimum intervals** as defined by ACIP: ACIP Immunization Schedules for Persons Aged 0 Through 18 Years of Age

There are 3 ways a school/student can meet the compliance requirements directed by the Colorado Board of Health rule:

1. **A student is considered fully immunized if they have received school-required immunizations according to the ACIP schedule**: DTaP, Tdap, IPV, Hep B, MMR, Varicella, Hib, PCV13. (Note: Students entering Kindergarten are required to receive their final doses of DTaP, IPV, MMR and Varicella. Students entering 6th grade, regardless of age, are required to receive Tdap) OR

2. **A student is "in-process" of getting up-to-date on required immunizations** (a written plan is provided to the school by the parent) OR

3. **The student's parent/guardian has submitted a signed non-medical exemption** (based on religious or personal belief) or **the health care provider (MD, DO, APN or delegated PA) has signed a medical exemption** due to a condition that precludes a patient receiving vaccine(s).

If students do not meet one or more of the above compliance criteria, they are not permitted to attend school as stated in the School Immunization Law and the Colorado Board of Health Rules. If you have questions about the student's school immunization requirement, please communicate with the student's school nurse/school representative.

It is strongly recommended that additional vaccines that are recommended but not required be administered to best protect the student from vaccine preventable diseases (i.e., MenACWY, HPV, etc.).

If you have questions about the ACIP immunization schedule, or a dose of vaccine that is marked as invalid in your patient's immunization record, the Colorado Immunization Branch provides a **Nurse on-call Monday through Friday, 8:30 a.m. through 5 p.m. at 303-692-2700.** Additionally, there are

The Colorado Immunization Branch
303-692-2700

Medication Administration in School or Child Care

The parent/guardian of _____ ask that school/child care staff give the
(Child's name)
following medication _____ at _____
(Name of medicine and dosage) (Time(s))
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: _____ **Birthdate:** _____

Medication: _____

Dosage: _____ **Route** _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ **Ending Date:** _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____
Phone Number **Date**

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.
Thank you!

RESPIRATORY HEALTH CARE PLAN

Infants through preschool age

Child's Name_ _____ **DOB**__ _____

School/Center_ _____

Triggers: (check those which apply to this child)

☐Weather changes ☐Colds ☐Cold air ☐Exercise

☐Pollens (trees, weeds) ☐Molds ☐Animal dander- Type_____

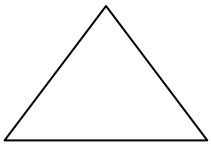
☐Dust and dust mites ☐Strong odors ☐Other:_____

List all routine daily meds (Name, Dose, Time)*: include all meds taken at home

Health Care Provider circle:
Baseline breaths per minute(circle)

18-30 **20-40**

Staff will be trained in taking accurate respiratory rate by nurse.



Yellow Zone
Warning

Steps to Take During an Asthma Episode:

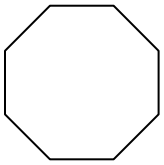
1. Count breaths per minute.
2. Observe for:
   - -Frequent cough, runny nose, stuffy nose.
   - -Increased cough with rapid breathing.
   - -Some decrease in play and/or appetite.
   - -Occasional wheeze you can hear.
   - -Other: _____

Health Care Provider circle/fill in:
Greater than

30 **40** _____**breaths/min**

Treatment @ child care:

1. Give medicine: _____ Dose: _____ Time: _____ End Date: _____
   Special instructions: _____
2. Encourage child to sit up right, relax and take deep even breaths.
3. Give sips of warm water.
4. Notify guardian if: _____
5. Stay with child and recheck breaths per minute 15 minutes after treatment.
6. If no improvement with medication, call parents to pick up child for further evaluation.
7. Notify nurse consultant and document.



RED ZONE
DANGER

Seek Emergency care if :

- -Continuous coughing, wheezing,
- -Shallow rapid breathing
- -Pale or blueness of fingernails and/or lips
- -Loss of consciousness
- -Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone
- -For infants: extremely fussy and /or difficulty sucking or eating.

Health Care Provider circle/fill in:
Greater than:

50 **60** _____**breaths/min**

Treatment @ child care/school:

1. **Call 911**
2. Call Parent and nurse consultant.
3. Other: _____

Health Care Provider's Signature_____Start date_____End date_____

Please attach completed medication authorization: _____yes _____ not needed.

RESPIRATORY HEALTH CARE PLAN (Page 2)

Child's Name: _____ **School/Center**: _____

Emergency Contact Information

Guardians' names: _____
Guardians' daytime phone numbers: _____
Guardians' address: _____

Alternative person if unable to contact guardians: _____
Alternative persons' relationship to the child: _____
Alternative persons' phone number(s): _____

Health care provider who should be called regarding emergency care due to a severe asthma episode:
Name: _____
Phone: _____
Fax: _____

Hospital Preference: _____

Field Trips: Medication must accompany student on all field trips. (spacer if at school/center)
A copy of this health care plan and current phone numbers must be with a staff member.
Teacher must be instructed on the correct use of the medication.

Parent's signature indicates permission to contact child's health care provider(s) listed above as needed. I understand that the School Nurse Consultant may delegate this care plan to unlicensed school personnel. I also understand this plan may be shared with school personnel if it is determined that the information may impact the student's educational experience and/or safety.

Health Care Providers signature: _____ Date: _____

Parent signature: _____ Date: _____

Nurse's signature: _____ Date: _____

Administrator's signature: _____ Date: _____

COLORADO
Department of Public Health & Environment

Child and Adult Care Food Program
Income Eligibility Form (IEF) 2016- 2017

Part 1 - List name and age of each child enrolled. Indicate each child's race and ethnicity. If this information is left blank, the institution representative may complete it based on visual identification. This information is for statistical reporting requirements and does not affect eligibility. **Note: A** =Asian; **AI/AN**=American Indian or Alaskan Native; **B/AA**=Black or African American; **H/PI**=Native Hawaiian or other Pacific Islander; **W**=White.

First Name	Last Name	Age	Ethnicity (select one) and Race (select one or more)
			Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Race:** ❑ A ❑ AI/AN ❑ B/AA ❑ H/PI ❑ W
			Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Race:** ❑ A ❑ AI/AN ❑ B/AA ❑ H/PI ❑ W
			Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Race:** ❑ A ❑ AI/AN ❑ B/AA ❑ H/PI ❑ W

Participation in some programs allows automatic eligibility for free meals in the CACFP with required documentation. If applicable, please check one of these boxes if one or more children listed above is:

❑ A **foster child** who is the responsibility of the State or was placed by the court. ❑ An **Early Head Start**, or **Head Start child or pregnant mother** or an **Even Start** enrolled child. ❑ A **homeless, migrant, or runaway child.** Refer to the back of this page for required eligibility documentation.

Please note: If you marked one of the boxes listed above and it applies to ALL children listed above, *SKIP TO PART 5 – Signature*.

Part 2 - Assistance Programs: Does anyone in your household receive benefits from any of the programs listed below? **If no**, go to **Part 3**. **If yes**, please mark which assistance program (only one is required), write the case number, and ***SKIP TO PART 5 – Signature***.

☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Temporary Assistance for Needy Families (TANF) **CASE NUMBER**_____
☐ Food Distribution Program on Indian Reservations (FDPIR) (Quest Card or Social Security numbers are not acceptable)

Part 3 - Income to report: List the names of all household members who are not listed in Part 1, regardless of age. Write the amount of income received by each household member for the current month, projected income for the first month of this application, or the month prior to this application. Indicate if income is weekly (W), monthly (M), or annually (A). If you enter '0' or leave any fields blank, you are stating there is no income to report. **Refer to the back of this page for definitions of income.**

First and Last Name	Gross Income/ Salary/Wages	Other Income	TOTALS Center Use Only
	$ W M A	$ W M A	$ W M A
	$ W M A	$ W M A	$ W M A
	$ W M A	$ W M A	$ W M A
	$ W M A	$ W M A	$ W M A

Total number in Household	**Note:** If necessary, convert multiple income schedules to annual income. Multiply weekly income by 52, bi-weekly by 26, monthly by 12.	**Total Income:** $ W M A

Part 4 – Social Security Number (SSN): If the adult household member completing this form does not provide a TANF, SNAP, or FDPIR number in Part 2, the person completing this form must provide the last four digits of his/her Social Security Number (SSN).

X	X	X	-	X	X	-				

☐ **Check if no SSN**

Part 5 - Signature: I certify that all of the information on this form is true and correct and is given in connection with the receipt of Federal Funds. Information may be verified. Deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes. Note: If the child is a foster child, an official of a court or other agency with responsibility for the child may sign this form.

Signature of Adult Household Member _____ Street Address _____

Printed Name _____ City _____ State _____ Zip Code _____

Date _____ Home Telephone _____ Work Phone _____

Gross Income/Salary/Wages includes, but is not limited to:

- Gross earned income or cash income before deductions.
- Monetary compensation for services, including wages, salary, tips, strike benefits, commissions, fees, withdrawals from savings, investments, trust accounts, and other accounts.
- Net income from self-owned businesses and farms.
- Social Security, public assistance or Welfare payments (e.g. TANF, General Assistance/General Relief), alimony, child support payments, and unemployment and worker's compensation.
- Private pensions or annuities, retirement benefits, disability benefits, veteran's benefits, dividends or interest, income from estates, trusts or investments, net rental income, cash withdrawals from savings, and net royalties.
- Student financial assistance (grants or scholarships) not used to meet education expenses.
- Regular contributions from persons not living in the household or any other money that may be available to pay for child (ren)'s meals.
- Child's income: The current earnings of a child or student grade 12 or below, regardless of age, who is a full-time or regular part-time employee, or who receives income from other sources, such as SSI or social security. Infrequent earnings, such as income from occasional baby-sitting or mowing lawns, are not counted as income and should not be listed on the application.

The following documentation is required for automatic eligibility:

- Documentation from the placement agency verifying the child is a foster child.
- One of the following documents from the Head Start program: 1) An approved Head Start or Even Start application; 2) A statement of Head Start or Even Start enrollment; 3) A list of participants from the Even Start or Head Start official; 4) Documentation from the Even Start official that confirms the child has not entered Kindergarten.
- Documentation verifying the status of a homeless, migrant or runaway child from the director of the homeless shelter, Migrant Education Program Coordinator or an official of the Runaway and Homeless Youth program.

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Income Category (check one): ❑ **Free** ❑ **Reduced** ❑ **Paid** (Ineligible for Free or Reduced Priced meals)

This form expires 12 months after the month in which the institution makes the determination. Example: If the determination is **July 2016, the form is valid from July 1, 2016 through July 31, 2017.** The institution may use the date the parent/guardian signs the Income Eligibility Form, **OR** the date the institution's official makes the determination and signs the Income Eligibility Form. **The same approval method selected must be used for all forms approved by the institution.**

Signature of Center's Eligibility Official

Determination Date: **Month** **Year**