



Enrollment fee: \_\_\_\_\_

Weekly Tuition: \_\_\_\_\_

Supply Fee: \_\_\_\_\_

Other: \_\_\_\_\_

Do you need childcare assistance?

CCA: 214-630-7911

City of Dallas: 214-670-8258

11421 Shiloh Road  
Dallas, TX 75228  
972-681-7545  
HcaKids4Christ@gmail.com

We welcome you and your child to our center!

We believe that the most important beginning of a child's life is the love they receive. We focus on teaching responsibility, developing socialization and self help skills needed to succeed while encouraging the talents in each child. We want to build a creative foundation for a lifetime of learning within your child. Your child will be given plenty of individual attention and love each day. Through trusting and believing in the Lord, we know that each day will be a blessing for your child.

"TRAIN UP A CHILD IN THE WAY HE SHOULD GO AND WHEN HE IS OLD HE WILL NOT DEPART FROM IT" Proverbs 22:6

- Monday – Friday 5:30 am – 6:30 pm
- Abeka Bible Curriculum
- 6 weeks – 12 years old
- Advance Prekindergarten / Prek 2 and 3yr old Program
- Security Cameras in each room
- Professional Christian Staff
- Texas Prekindergarten Readiness Program
- 25 years in business
- Physical Education Program
- To / From Public school transportation
- After School Tutoring

Go to [Heavenlychristianacademy.com](http://Heavenlychristianacademy.com) for more information!





# Heavenly Christian Academy Admission Statement

Director:

Child's Full Name:		Child's Date of Birth	Home or Work Landline Phone:
Child's Home Address:		Texas Zipcode:	
Date of Admission	Date of Withdrawal	Email for Correspondence:	
Parent's or Guardian's Name		Child Leaves with: Both Parents [ ] Only Mom [ ] Only Dad [ ] Guardian [ ]	
List telephone numbers below where parents/guardian may be reached while child will be in care:			
Mother's Cell Phone / Provider:	Father's Cell Phone / Provider:	Guardian's Cell Phone / Provider:	
Give the name, address and phone number of person to call in case of an emergency if parents / guardian cannot be reached:			Relationship
I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name & telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.			
Name / Phone	Name / Phone	Name / Phone	
TRANSPORTATION: I hereby Give [ ] Do not give [ ] - consent for my child to be transported and supervised by the operation's employees:			
For emergency care [ ] On field trips [ ] To and from home [ ] To and from school [ ]			
FIELD TRIPS: I hereby Give [ ] Do not give [ ]		- my consent for my child to participate in Field Trips:	
WATER ACTIVITIES: I hereby Give [ ] Do not give [ ]		- my consent for my child to participate in Water Activities:	
Sprinkler play [ ] Splashing/wading pools [ ] Swimming pools [ ] Water table play [ ]			
<b>MEALS:</b> I understand that the following meals will be served to my child while in care: - Breakfast [ ] Lunch [ ] Afternoon snack [ ]			
<b>DAYS AND TIMES IN CARE</b> My child is normally in care on the following days and times: Monday - Friday [ ] Times: _____ to _____			
Other Schedule:			

## AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached for emergency medical care, I authorize the person in charge to take my child to:		
Name of Physician:	Address:	Ph.#:
Name of Emergency Medical Care Facility:	Address:	Ph.#:
I give consent for the facility to secure any and all necessary emergency medical care for my child.		Signature - Parent or Legal Guardian

## Children attending Public School

My child attends the following school Name/ Address / Phone:	
My child has permission to: Walk to or from school or home, [ ] - Ride the Public bus [ ] and/or be released to the care of his/her sibling(s) under 18 years old. Name of sibling(s):	
School Hours / Special Instructions:	

## CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long- term continuous use, and any other information which caregivers should be aware of:	
Does your child have diagnosed food allergies? Yes No Plan submitted on:	
Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Line at (800) 514-0301 or (800) 514-0383 (TTY).	
Signature - Parent or Legal Guardian:	Date Signed:



**CONSENT INFORMATION**

I acknowledge receipt of the facility's operational policies, including those for:

Discipline and guidance [ ]	Procedures for release of children[ ]	Suspension and expulsion[ ]
Emergency plans [ ]	Illness and exclusion criteria [ ]	Procedures for dispensing medications[ ]
Procedures for health checks[ ]	Immunization requirements [ ]	Safe sleep[ ]
Meals and food service Practices [ ]	Procedures to visit the center without securing prior approval[ ]	Procedures for parents to discuss concern with the director[ ]
Procedures for parents to participate [ ]	Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website [ ]	

Special Notes / Concerns:

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. Please check only one.

1. HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he or she is able to take part in the day care program. [ ]

Health Care Professional's Signature:

Date Signed:

2. A signed and dated copy of a health care professional's statement is attached. [ ]

3. I have attached a signed and dated affidavit stating that I decline Immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90<sup>th</sup> day after the affidavit is notarized. I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of. [ ]

4. My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit to the child care operation.

Name and Address of Health Care Professional:

Signature - Parent or Legal Guardian:

Date Signed:

**VARICELLA (CHICKENPOX)**

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine. Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at [www.dshs.state.tx.us/immunize/public.shm](http://www.dshs.state.tx.us/immunize/public.shm).

**GANG FREE ZONE**

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

**PRIVACY STATEMENT**

DFPS values your privacy. For more information, read our Privacy and Security Policy online at <http://www.dfps.state.tx.us/policies/privacy.asp>.

**SIGNATURES**

Child's Parent or Legal Guardian:

Date Signed:

Center Designee:

Date Signed:



## Discipline and Guidance Policy for \_\_\_\_\_

Name of Operation

- ◆ Discipline must be:
  - (1) Individualized and consistent for each child;
  - (2) Appropriate to the child's level of understanding; and
  - (3) Directed toward teaching the child acceptable behavior and self-control.
- ◆ A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:
  - (1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
  - (2) Reminding a child of behavior expectations daily by using clear, positive statements;
  - (3) Redirecting behavior using positive statements; and
  - (4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.
- ◆ There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:
  - (1) Corporal punishment or threats of corporal punishment;
  - (2) Punishment associated with food, naps, or toilet training;
  - (3) Pinching, shaking, or biting a child;
  - (4) Hitting a child with a hand or instrument;
  - (5) Putting anything in or on a child's mouth;
  - (6) Humiliating, ridiculing, rejecting, or yelling at a child;
  - (7) Subjecting a child to harsh, abusive, or profane language;
  - (8) Placing a child in a locked or dark room, bathroom, or closet with the door closed;and
  - (9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

Texas Administrative Code, Title 40, Chapters 746 and 747, Subchapters L, Discipline and Guidance

My signature verifies I have read and received a copy of this discipline and guidance policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Check one please:

☐ parent

☐ employee/caregiver

☐ household member of child-care home



# Heavenly Christian Academy Child Assessment Form

Novel

Child Name (last, first, middle)	Class	Enrollment Date	Date of
Mother's Name? Cell Phone:	Email address for child reports and parent/teacher communication:		
Father's Name / Cell Phone:	Emergency contact / Cell / Relationship		

## 1. Health

Does your child have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any side effects we should be alerted to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## 2. Toileting:

Does your child need assistance with toileting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How can we best help?		
What are your ideas about toilet training?		

## 3. Behavior:

Does your child have any special fears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child communicate his/her needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did your child experience any difficulties at a previous center? Explain		
What did you like or dislike about your previous child care center?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		





## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:

- ☐ Hispanic or Latino  
☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ Asian ☐ American Indian or Alaska Native  
☐ White ☐ Native Hawaiian or Other Pacific Islander  
☐ Black or African American

### Part 7. Sharing Information With Other Programs: OPTIONAL

The above information may be disclosed for the purpose of enrolling children in the Children's Health Insurance Program (CHIP). Parents/guardians are not required to consent to such disclosure and electing not to allow disclosure will not adversely affect a child's eligibility.

- ☐ I do elect to allow my household information to be disclosed.  
☐ I do not elect to allow my household information to be disclosed.

### Don't fill out this part. This is for official use only.

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, ☐ Month, ☐ Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Denied \_\_\_\_\_ Tier I \_\_\_\_\_ Tier II \_\_\_\_\_

Reason: \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Privacy Act Statement:

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) eligibility number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

### Non-discrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;  
(2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.





## CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

### Part 1. All Household Members

Name of Enrolled Child(ren): \_\_\_\_\_

Names of all household members  
(First, Middle Initial, Last)

CHECK IF A FOSTER CHILD (THE  
LEGAL RESPONSIBILITY OF A  
WELFARE AGENCY OR COURT)  
\* IF ALL CHILDREN LISTED BELOW  
ARE FOSTER CHILDREN, SKIP TO  
PART 5 TO SIGN THIS FORM.

CHECK  
IF NO INCOME

**Part 2. Benefits:** If any member of your household receives SNAP, TANF, or FDPIR, provide the name and eligibility number for the person who receives benefits. If no one receives these benefits, skip to part 3.

NAME: \_\_\_\_\_ ELIGIBILITY NUMBER: \_\_\_\_\_

**Part 3. (Applies only to parents/guardians with children enrolled in a day care home)** If any member of your household receives benefits listed on the enclosed *List of Eligible Federal/State Funded Programs (H1660)*, provide the name of the program and eligibility number: NAME: \_\_\_\_\_ ELIGIBILITY NUMBER: \_\_\_\_\_

Check here if no eligibility number ☐

### Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	B. Gross income and how often it was received			
	Note: Self-employed report income after expenses in box 1			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$200/bi-monthly
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____
	\$____/____	\$____/____	\$____/____	\$____/____

### Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the next page.)

*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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Last four digits of Social Security Number: \* \* \* - \* \* - \_\_\_\_\_ ☐ I do not have a Social Security Number