TODDLERS NURSEY SCHOOL REGISTRATION FORM

Program times are Monday through Friday – 8:00 am to 2:00 pm. **Required:** Parent participation in student activities/projects; parent meetings prior to start of school; parent-teacher conferences two times a year; and attendance.

An after-hours care program (Kids Club) is available Monday – Friday (7:45 am – 8:00 am and 2:00 pm to 5:30 pm) for those who need extended hours. State subsidies are accepted.

Children must be between 24 and 36 months old.

WAITING LIST

Once capacity has been reached, children will be placed on a waiting list. As a spot opens, children will be chosen based on enrollment application date.

ATTENDANCE POLICY

Parents must agree to a 95% attendance rate. Excused absences must have a written doctor's excuse. Three days of unexcused absences = warning. Five days of unexcused absences = 2nd warning. Seven days of unexcused absences = dismissal from program. **Late arrivals/early dismissals count as absences. COVID guidelines have relaxed the attendance policy.**

The following is required for registration:

- Completed application form
- Proof of date of birth
- 1 Copy of Immunization Record and wellness exam signed by a physician
- Religious or medical exemptions to these requirements must be submitted to school officials in writing by State of New Mexico Health Department
- Custody papers (if applicable)
- Copy of the (IEPs) if applicable
- Signed permission for screening: ASQ screenings

Please initial and date:

1. **I agree to Ashley's Garden attendance policy with a 95% attendance rate and only excused absences. ________**
2. **I give permission for the following screening: ASQ ______**

Date Received:__________Initials _______
Age Eligible:________
Birth Certificate_________
Passport_______________

EMAIL:___________________________

PLEASE PRINT CLEARLY

The Village: Toddlers Nursey School 2022-2023

PART 1: PERSONAL INFORMATION – Please Print

AGE: Years______Months_____

CHILD'S NAME: ____ ☐ Male ☐ Female **DATE OF BIRTH**: _____________
LAST FIRST MIDDLE INITIAL

ADDRESS:____**PHONE**:_____________
STREET/APT # CITY, STATE, ZIP CODE

NAME(S) OF PARENT(S) OR GUARDIAN(S):

NAME:_____________________________**RELATIONSHIP:**_______________________**PHONE:**_____________
NAME:_____________________________**RELATIONSHIP:**_______________________**PHONE:** _____________
Mom's Occupation____________________________**Dad's Occupation** _________________________________

EMERGENCY CONTACT:
NAME:_____________________________**RELATIONSHIP:**______________________**PHONE:**_____________
NAME:_____________________________**RELATIONSHIP:**______________________**PHONE:**_____________
NAME:_____________________________**RELATIONSHIP:**______________________**PHONE:** _____________

PART 2: PERSONAL HISTORY Please check the items below that apply to your child

- **LANGUAGE SPOKEN AT HOME**:___________________Is your child fluent in English? ☐YES ☐NO
- **ETHNICITY: Hispanic**____**Caucasian**____**Asian**____**Black**____**American Indian**____**Middle Eastern**____
- **REFERRAL:** ☐YES ☐NO
  REASON(S) FOR REFERRAL______________________________AGENCY: _______________________________
- **KINDERGARTEN DISTRICT:** ____

PART 3: PRIOR CARE EXPERIENCE--Where your child spent the most time in the last 12 months?

☐ Home care ☐ Head Start ☐ Pre-Kindergarten ☐ Childcare Center ☐ Family Childcare

☐ Preschool special education program ☐ Parents ☐ Other___________________________________

PART 4: HEALTH INFORMATION--Please check the items below that apply to your child

☐Delayed speech/language ☐Hearing problems ☐Vision problems ☐Occupational therapy

☐ Concerns about child's development: ☐Asthma ☐Attention span ☐Use of medication

Please list any other therapy child is receiving: ______________________________________
Please list health problems: ____
Please list physical limitations: ____
Please list allergies (including food): ______________________________________
Please list regular medications (prescribed and over the counter): ____________________

Physician:_______________________Phone:________________Last checkup: ____________

Dentist:__________________________Phone:________________Last checkup: ___________

Optometrist:_____________________Phone:________________Last exam: ______________

Health Insurance:_________________________PHONE:______________________________

MEDICAID:______________________________PHONE: ______________________________

PART 5: AUTHORIZATION FOR PICK-UP (ID REQUIRED)

NAME:______________________________**RELATIONSHIP:**______________________**PHONE:**____________

NAME:______________________________**RELATIONSHIP:**______________________**PHONE:**____________

NAME:______________________________**RELATIONSHIP:**______________________**PHONE:**____________

The following people CANNOT or DO NOT have permission to pick up:

NOT AUTHORIZED____**Relationship**________________

NOT AUTHORIZED____**Relationship**________________

TO BE CONSIDERED FOR ENROLLMENT:

1. **YOU MUST ANSWER ALL QUESTIONS ON APPLICATION FORM**
2. **ESPECIALLY IMPORTANT -- INCOME ELIGIBILITY FORM.**

Signature of parent or guardian_________________________________**Date**___________________

GYM MAGIC, INC.
ASSUMPTION OF RISK, WAIVER OF LIABILITY, MEDICAL AUTHORIZATION

As legal guardian of (child's name) ____, I recognize that potentially severe injuries, including permanent paralysis or death can occur in sports or activities involving height or motion, including but not limited to gymnastics, dancing, tumbling, trampoline, tumble track, cheerleading, swimming, and adult fitness. In addition, swimming, or any activity in or around water can result in brain damage or drowning. I am also aware that participation in the after-school program can involve transportation to and from various field trips/after school programs and as a result my child could be injuredor killed in a vehicular accident. Being fully aware of these dangers, I voluntarily consent to the aforementioned person participating in any and all Gym Magic Inc. programs, camps and activities and I ACCEPT ALL RISKS associated with that participation.

In consideration for allowing my child or myself to use these facilities, I, on my own behalf and the behalf of my child and our respective heirs, administrators, executors and successors, hereby COVENANT NOT TO SUE and FOREVER RELEASE GymMagic, Inc., its officers, directors, shareholders, employees or agents from all liability for any and all damages or injuries suffered by my child or myself while under the instruction, supervision, or control of Gym Magic Inc., without limitation, those damages or injuries resulting from acts of negligence on the part of its officers, directors, shareholders, employees oragents.

In the event of an accident or emergency I would like my above-mentioned child to be taken to a hospital for medical treatment and I hold Gym Magic Inc. and its representatives harmless in their execution of this action. Additionally, I hereby agree to individually provide for all possible future medical expenses, which may be incurred by my child or myself as a result of any injury sustained while participating at or for Gym Magic Inc.

I have read and understand this ASSUMPTION OF RISK and WAIVER OF LIABILITY and MEDICAL AUTHORIZATION, and I VOLUNTARILY affix my name in agreement.

Parent, Legal Guardian's Signature___________________________________Date ______________________

Your participation in Gym Magic, Inc. gives Gym Magic permission to a photo, video tape or use a likeness in advertisements or promotions for Gym Magic.

Signed:____Date ______________________

Child and Adult Care Food Program
LETTER TO HOUSEHOLDS

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
GYM MAGIC KIDS: The Village	1532420	(575) 222 - 4717

Instructions: This letter must accompany the Income Eligibility Application.

Dear Parent / Guardian or CACFP Participant:

GYM MAGIC KIDS: The Village (Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial)) Participates in the Child and Adult Care Food Program (CACFP) administered by the United States Department of Agriculture. Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary to decide the level of CACFP reimbursement your center is eligible to receive for the meals served to children and/or adult participants in our program. This form will be treated as confidential information. All participants in our program receive their meal free of charge, but the determination of eligibility category affects the amount of federal funding we receive. Foster Children: A foster child enrolled in our program that is the legal responsibility of a welfare agency, or court may be certified as eligible for free meals regardless of your household income. Please refer to the instructions on how to complete the Income Eligibility Application form.

SNAP - Supplemental Nutrition Assistance Program (formerly the Food Stamp Program): If your household is currently receiving benefits under the Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservations (FDPIR) and your child is enrolled in a child care center you need only to list the case number sign and date the form.

If your household is receiving benefits under the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Medicaid or Food Distribution Program on Indian Reservations (FDPIR) and an adult in your home is enrolled in an Adult Daycare Center then you need only to list their case number sign and date the form. Otherwise, an adult household member must complete the form and disclose total current household income by source, and the names of all household members. The person completing the form must sign, provide a social security number, and date when completed.

The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide your annual income, or you may use last year's income if no significant changes have occurred. If your households' income is equal to or less than the amounts indicated for your households' size on the chart below, your provider may qualify for maximum reimbursement rates. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses).

INCOME ELIGIBILITY GUIDELINES - (EFFECTIVE FROM JULY 1, 2021 TO JUNE 30, 2022)

	FREE			REDUCED		
HOUSEHOLD SIZE	YEAR	MONTH	WEEK	YEAR	MONTH	WEEK
1	16,744	1,396	322	23,828	1,986	459
2	22,646	1,888	436	32,227	2,686	620
3	28,548	2,379	549	40,626	3,386	782
4	34,450	2,871	663	49,025	4,086	943
5	40,352	3,363	776	57,424	4,786	1,105
6	46,254	3,855	890	65,823	5,486	1,266
7	52,156	4,347	1,003	74,222	6,186	1,428
8	58,058	4,839	1,117	82,621	6,886	1,589
	5,902	492	114	8,399	700	162

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, audiotape, 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: How to File a Complaint, 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: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Gym Magic Kids/Sandra Graham	Sandra Graham (Digitally signed by Sandra Graham Date: 2021.07.27 11:39:37 -06'00')	July 27, 2021
Name of Sponsor / Center Representative	Signature of Sponsor / Center Representative	Date

Child and Adult Care Food Program
INSTRUCTIONS FOR COMPLETING THE INCOME ELIGIBILITY FORM

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
GYM MAGIC KIDS: The Village	1532420	575 222 4717

PARTICIPANT INFORMATION:

List name of all enrolled participants that you are applying for which are in care.

List each enrolled participant's date of birth.

If you are applying for a foster child, list only one foster child per form. A foster child may be eligible for free meals regardless of household income.

Child Care Centers: If the participant enrolled is in a Child Care Center and receives benefits through Supplemental Nutrition Assistance (SNAP), (*formerly food stamps or Food Distribution Program on Indian Reservation (FDPIR)*, please indicate the appropriate **case number** in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

Adult Day Care Centers: If the participant enrolled is in an Adult Daycare Center and receives benefits thru Supplemental Nutrition Assistance (SNAP) formerly, food stamps, Food Distribution Program on Indian Reservation (FDPIR), Supplemental Security Income (SSI) or Medicaid, please indicate the appropriate **case number** in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

If you do not receive benefits and have no case number for participants enrolled at the center, you must complete all parts of the IEA (Household and Income information).

HOUSEHOLD AND INCOME INFORMATION

Not required to be completed if case# is provided above.

List all household members. A household is a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses).

Provide the most current income by source for all household members. This can be based on the most recent information the month prior to completing the application.

Reported income needs to be reported on the same. The income reported on the application must include all income before taxes and before other deductions.

A foster child, defined as a ward of the court or welfare agency. Only the foster child's "personal use" income is listed.

Personal use income includes:

- Funds that are specified by the welfare agency as being for the personal use of the child. (If no funds are specified, the funds received from the welfare agency are not to be considered as income. Record "0" on personal income.)
- Money received from any source. This includes, but is not limited to, funds received from trust accounts, from the child's family, and earnings from the child's employment other than occasional or part-time jobs.

SIGNATURE

The adult family member completing the application must sign and date the application.

If the enrolled participant is not a recipient of benefits and has not provided a case number, the adult family member signing the application must provide a social security number.

If you do not have a social security number, check the "box" provided. Otherwise, failure to provide the social security number (if you have one) will make the Income Eligibility Application invalid and will reduce the level of CACFP reimbursement your family's Child Care Center receives for meals served to the children and/or adult participants enrolled for care in their center.

Child and Adult Care Food Program
INCOME ELIGIBILITY APPLICATION

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
GYM MAGIC KIDS: The Village	1532420	(575) 222 - 4717

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, audiotape, 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, 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. This institution is an equal opportunity provider.

Instructions: Complete this form and return to the Facility / Center / Site / Home Provider

(Check if applicable for Enrolled Participant)

ENROLLED PARTICIPANT INFORMATION:

First:	Last:	DOB:		Child Care Centers:		Adult Daycare Centers:				Case #:
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED	
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED	
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED	
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED	
			☐ Foster Child?	☐ SNAP	☐ FDPIR	☐ SNAP	☐ FDPIR	☐ SSI	☐ MED	

If Enrolled Participant is a Foster Child: Please list the amount of the child's "personal use" monthly income (if no personal income, record "0"): ____________

HOUSEHOLD INFORMATION:

List the first and last name of each person living in the household, related or not (such as grandparents, other relatives, or friends who live in the household). Include yourself and all children over the age of 13 living with you. (Please use additional forms if more lines are required).

First:	Last:	First:	Last:

Total Number in Household: ____________

HOUSEHOLD INCOME: Please indicate source and amount of current income for all members of your household. Please follow the definition of income specified in the standards for determining free and reduced-price eligibility in your parent letter. If you receive more than one check from any of these sources, please indicate the total ***monthly*** amount received.

Wages / Salary: $ ________ Child Support: $ ________ Social Security: $ ________ Pension/Retirement: $ ________
Unemployment: $ ________ Other Income: $ ________ **Total Income** $ ________ ☐ Monthly

PENALTIES FOR MISREPRESENTATION: I certify that all the above information is true and correct and that the food stamp or FDPIR number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature of Adult Family Member ________ Last Four Digits of Social Security Number* ________ ☐ Check if no SS# ________ Date

Privacy Act Statement

This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires that, unless the participant's food stamp or FDPIR number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of the information on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or FDPIR office to determine current certification for receipt of SNAP (food stamp) or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

FOR SPONSOR'S USE ONLY

☒ Child Day Care Center ☐ Adult Day Care Center ☐ Approved Free ☐ Approved Reduced ☐ Paid

☐ Home Provider Tier I Eligibility Verified by: ☐ Tax Return ☐ W-2 ☐ Pay Stubs ☐ Other Date Verified: ________

☐ Home Provider Child(ren) Tier I Eligibility Verified by: ☐ Household Income ☐ Categorically Eligible School Name / District: ________

☐ Home Provider or Child(ren) TIER I Ineligible

Sandra Graham (Digitally signed by Sandra Graham Date: 2021.07.27 11:44:00 -06'00')	Gym Magic Kids: The Village		
Signature of Facility / Center / Site Representative / Home Provider	Name of Facility / Center / Site Representative / Home Provider	Approving Date	Date Disenrolled

* Complete Social Security Number is not required for CACFP Participation, only the last four digits are required.