NEW BEGINNING

NBL ACADEMY

LEARNING ACADEMY

# CHILD ENROLLMENT PACKET




LEARNING ACADEMY

543 Bream Street • Charleston, WV 25387

# New Enrollment Credentials & Information

- ☐ Parent/Guardian Identification (Parent ID)
- ☐ Birth Certificate (Child)
- ☐ Shot Records
- ☐ Well Child Check-up Report
- ☐ **If child is under 3 months old, a letter from doctor stating that your child can attend daycare is required.**
- ☐ Social Security Card (Child)
- ☐ Insurance Card (Child)
- ☐ Free & Reduced Meal Application
- ☐ Special Dietary Needs Medical Sheets - if this applies to your child (Form must be filled out & signed by your doctor)
- ☐ Child Emergency Sheet must have accurate **telephone numbers** and complete **physical addresses** for any person listed on the sheet. (P.O. Box is not acceptable) - needs to be signed & completed
- ☐ Connect Certificate/Private Pay
- ☐ Enrollment Fee $25.00 per family
- ☐ Need an active Email Address _____

**Everything above must be in all children's folders before your child/children can start attending New Beginning Learning Academy.**

**We Can't Wait to Teach Your Children!**

West Virginia Department of Health and Human Resources

# Emergency Information/Permission Form for Children in Child Care Settings

**A. Family Information**

1. Child's Name: _____ Birth Date: _____ Gender: ☐ Male ☐ Female

Home Address: _____

Child's School: _____ School Phone: _____

School Address: _____

Child's Doctor: _____ Doctor's Phone: _____

Doctor's Address: _____

Insurance Company: _____ Policy Number: _____

Preferred Hospital/Clinic for Emergency Care: _____

2. Parent/Guardian Name: _____ Phone: _____

Address: _____

Employer/School Name: _____ Work/School Phone: _____

Employer/School Address: _____

3. Parent/ Guardian Name: _____ Phone: _____

Address: _____

Employer/School Name: _____ Work/School Phone: _____

Employer/School Address: _____

**B. Emergency Contact:** Names and telephone numbers of individuals to contact in case parents cannot be reached in an emergency:

| Name | Physical Address | Telephone Number |
|---|---|---|
| | | |
| | | |
| | | |

**C. List of people with permission to pick child up from care (anyone <u>not</u> listed <u>cannot</u> pick up child without written permission from parent):**

| Name | Physical Address | Telephone Number |
|---|---|---|
| | | |
| | | |
| | | |

**Special Instructions**: Biological/custodial parents must be given access to their children unless there is a court order preventing contact. Individuals with court orders against them preventing child pick up:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Other restrictions on child pick-up: _____

**D. List any allergies, illnesses, regular medications, special needs and concerns:**

**E. Permission to Receive Medical Care:**

I, _____ give my permission for _____
(Name of Parent/Guardian) (Child Care Provider Name)

to consent for _____ to receive emergency medical, dental or surgical
(Name of Child)

treatment if I cannot be reached. I place the following restrictions on medical treatment : _____

**F. Permission to Transport:**

- ☐ I do not give the child care provider permission to transport my child for non-emergency reasons.
- ☐ I give the child care provider permission to transport my child for non-emergency reasons, such as to and from school or school activities, shopping, field trips, etc.
- ☐ In the event of an emergency, I prefer that the child care provider call an ambulance to transport my child.
- ☐ In the event of an emergency, I give permission for the child care provider to transport my child.

I place the following restrictions on transportation:

Enrollment Date: ____/____/____ Discharge Date: ___/___/___

Parent/Guardian Signature: _____ Date: ___ / ___ / ___

**State of West Virginia** **County of _____**

**The foregoing instrument was acknowledged before me on this _____ day of _____, 20_____,**

**By _____. My commission expires on _____.**
**Notary Public**

# Toddler/Preschool Social Resume

Child's Name _____

Does your child have a nickname? ☐ Yes ☐ No

If Yes, what is it? _____

## FAMILY

| Names of brothers & sisters | Birthdate |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| Names of others living in the home | Relationship to child |
|---|---|
| _____ | _____ |
| _____ | _____ |

What language is spoken in your home? _____

Does your child have pets? ☐ Yes ☐ No

If Yes, what are they? _____

## FOOD

Describe your child's appetite _____

What foods does your child dislike? _____

What foods does your child like? _____

Does your child feed him/herself? ☐ Yes ☐ No

Does your child have any food sensitivities? ☐ Yes ☐ No

If Yes, please identify _____

What time does your child eat? ☐ Breakfast ☐ Lunch ☐ Supper

## SELF-CARE

Is your child in diapers? ☐ Yes ☐ No Comment _____

Has training begun? ☐ Yes ☐ No Comment _____

Is your child trained? ☐ Yes ☐ No Comment _____

Does child need help? ☐ Yes ☐ No Comment _____

Does your child need any help with dressing? ☐ Yes ☐ No

If Yes, please list _____

## SLEEP

Describe your child's sleep routine (include naps & lengths of naps).

_____

_____

## SOCIAL/EMOTIONAL DEVELOPMENT

Does your child separate easily from you? ☐ Yes ☐ No

Please comment _____

Is your child afraid of anything? ☐ Yes ☐ No

Please comment _____

Does your child have a favorite toy, blanket or soother? ☐ Yes ☐ No

Please identify _____

Does your child spend time with other children? ☐ Yes ☐ No

Please comment _____

How does your child show feelings?

Affection _____ Fear _____

Frustration _____ Anger _____

Excitement _____

What activities does your child enjoy? _____

What activities does your child dislike? _____

How do you handle discipline in your home? _____

What characteristics in your child's development would you like...

Encouraged _____

Discouraged _____

Please provide any other information relating to your child that would be helpful in understanding and caring for your child.

_____

_____

Parent/Guardian Signature _____ Date _____

West Virginia Department of Health and Human Resources

# Child Health Assessment

Child's Name _____ Parent/Guardian _____

DOB ___/___/_____ Home Phone _____ Address _____

Child Care Facility/School _____ _____

Child Care Facility/School Phone _____ Work Phone _____

*Note: A copy of the HealthCheck exam report attached to a copy of the child's immunization record may be substituted for this form.*

Health history and medical information pertinent to routine child care and emergencies:

Date of Exam ____/____/_____

Allergies to food or medicine:

| Length/Height | Weight | Head Circumference | Blood Pressure |
|---|---|---|---|
| _____in/cm %ile _____ | _____in/cm %ile _____ | _____in/cm %ile _____ | _____in/cm %ile _____ |

| Physical Examination | Normal | Abnormal/Comments |
|---|---|---|
| Head/Ears/Eyes/Nose/Throat | | |
| Teeth | | |
| Cardiorespiratory | | |
| Abdomen/GI | | |
| Genitalia/Breasts | | |
| Extremities/Joints/Back/Chest | | |
| Skin/Lymph Nodes | | |
| Neurologic/Tone | | |
| Developmental (e.g. ddst) | | |

| Immunizations | Birth to 1 Month | 2 Month | 4 Month | 6 Month | 12-18 Month | 4-6 Years |
|---|---|---|---|---|---|---|
| DTP/DTaP | | | | | | |
| Polio | | | | | | |
| HIB | | | | | | |
| HEP B | | | | | | |
| MMR | | | | | | |
| Varicella | | | | | | |
| Other (PCV7) | | | | | | |

Note: Ages and number of boosters may vary when immunizations start at older ages.

| Screening Tests (If completed) | Date | Normal | Abnormal/Comments |
|---|---|---|---|
| Lead | | | |
| Anemia (HGB/HCT) | | | |
| Urinalysis (UA) | | | |
| Tuberculosis (TB) | | | |
| Hearing | | | |
| Vision | | | |

Date of Last Dentist's Exam

Note: Age-appropriate health services and immunizations must follow the schedule recommended by AAP.

**Health Problems or Special Needs**

**Recommended Treatment/Medications/Special Care** (attach additional sheets if necessary)

**Medical Care Provider**

**Address**

**Phone**

MD
DO PA
CRNP

_____

**Date** **Signature of Physician or CRNP**

Dear Parent or Guardian:

This center participates in the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP). Please help us comply with the requirements of the CACFP by completing, signing and returning the attached statement as soon as possible. The statement will be filed as confidential information. The names of the participants for which free or reduced price meals may be claimed shall not be published, posted or announced in any manner; this information is necessary to determine the amount of federal funding received by our center for the meal served to children. Higher reimbursement will contribute to the overall quality of care your provider maintains.

If you received Food Stamps or benfefits under the West Virginia Temporary Assistance to Needy Families (TANF) on behalf of your child, then please list either your 10 digit Food Stamp case number or your TANF case number in Section 2 and sign and date the statement in Section 5. This means that your child is " categorically eligible' and will automatically qualify for reimbursement.

If a Food Stamp or TANF case number is not reported, Section 4 must be completed. You must include your total current household income by source and the names of all household members. CACFP defines a household as a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses). The reported income should be what each member received last month. If last month's income does not accurately reflect your circumstances, provide a projection of your income using last year's income as a basis. Please remember to put the name and social security number of the primary wage earner underneath the chart. You must also sign and date Section 5.

If this application is for a foster child, please read carefully the directions found on the "Instructions For Applying' sheet. If you have a foster child and have further questions, please contact our office for additional information before completing the application.

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, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at https://www.usda.gov/oascr/how-to-file-a-program-discrimination-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:

(1) **MAIL:** U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or call (833) 632-9992

(2) **FAX:** (202) 690-7442; or

(3) **EMAIL:** program.intake@usda.gov.

This institution is an equal opportunity provider, employer, and lender.

Thank you for your cooperation:_____

Institution Representative

# 2026-2027 West Virginia Application for Free and Reduced Price School Meals

Complete one application per household. Please use a pen (not a pencil).

**RETURN TO (School/District Name):**
**ADDRESS:**

## STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

**List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.**

| Child's First Name | MI | Child's Last Name | Grade | Check all that apply: Foster Child | Migrant | Runaway | Homeless |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

## STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDPIR?

◯ **NO** → Go to STEP 3. ◯ **YES** → Write case number here and proceed to STEP 4.

**CASE NUMBER (NOT EBT NUMBER):**

Write only one case number in this space.

## STEP 3 List ALL household members and income for each member (before taxes and deductions)

**A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)**

List all Adult Household Members not listed in STEP 1 (including yourself ) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

| Name of Adult Household Members (First and Last) | Earnings from Work | How often received? Weekly | Every 2 Weeks | 2x Month | Monthly | Annual | Public Assistance, Child Support, Alimony | How often received? Weekly | Every 2 Weeks | 2x Month | Monthly | Pensions, Retirement, Social Security, SSI, VA Benefits , All Other | How often received? Weekly | Every 2 Weeks | 2x Month | Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | $ | ◯ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ |
| | $ | ◯ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ |
| | $ | ◯ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ |
| | $ | ◯ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ |
| | $ | ◯ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ | $ | ◯ | ◯ | ◯ | ◯ |

Total Household Members (Children and Adults) ☐

**Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (If Applicable)** ☐☐☐☐

**Check if no Social Security Number** ☐

**Please see application's back for list of income sources.**

**B. Child Income**

Sometimes children in the household earn or receive income.
Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

| Child Income | How often received? Weekly | Every 2 Weeks | 2x Month | Monthly | Annual |
|---|---|---|---|---|---|
| $ | ◯ | ◯ | ◯ | ◯ | ◯ |

## STEP 4 Contact information and adult signature. RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL: Insert school address here

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school ofcials ma y verify (confr m) the information. I am aware that if I purposely give false information, my children may lose meal benefts , and I may be prosecuted under applicable State and Federal laws."

| Print Name of Adult Signing the Form | Signature of Adult | Today's Date |
|---|---|---|
| | | |

| Mailing Address (if available) | City | State | Zip | Phone (optional) | Email (optional) |
|---|---|---|---|---|---|
| | | | | | |

## SOURCES AND EXAMPLES OF INCOME

**For additional information on income, please refer to the instructions that accompany this application.**

| Sources of Income | | | Examples of Income for Children |
|---|---|---|---|
| **Earnings from Work** | **Public Assistance/Alimony/ Child Support** | **Pensions/Retirement/ All other sources of income** | |
| • Salary, wages, cash bonuses, tips, commissions<br>• Net income from self-employment (farm or business)<br>**If you are in the U.S. Military:**<br>• Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances)<br>• Allowances for of-base housing , food, and clothing | • Unemployment benefits<br>• Workers' compensation<br>• Supplemental Security Income (SSI)<br>• Cash assistance from State or local government<br>• Alimony payments<br>• Child support payments<br>• Veterans benefits<br>• Strike benefits | • Social Security/Disability (including railroad retirement and black lung benefits)<br>• Private Pensions or disability benefits<br>• Income from trusts or estates<br>• Annuities<br>• Investment income<br>• Earned interest<br>• Rental income<br>• Regular cash payments from outside household | • A child has a regular full or part-time job where they earn a salary or wages<br>• A child is blind or disabled and receives Social Security benefits<br>• A parent is disabled, retired, or deceased, and their child receives Social Security benefits<br>• A friend or extended family member regularly gives a child spending money<br>• A child receives regular income from a private pension fund, annuity, or trust |

## OPTIONAL

**Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.**

**We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.**

**Ethnicity (check one):** ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

**Race (check one or more):** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacifc Islander ☐ White

**Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.**

## DO NOT FILL OUT

**For school use only.**

**Annual Income Conversion:** Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income

How often?

| Weekly | Every 2 Weeks | 2x Month | Monthly | Annual |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Household size

Categorical Eligibility ☐

Eligibility

| Free | Reduced | Denied |
|---|---|---|
| ○ | ○ | ○ |

Determining Official's Signature | Date | Confirming Official's Signature | Date | Verifying Official's Signature | Date

### Use of Information Statement

**The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms.** We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefts t o your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number.' Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

### The contact information below is solely to file a complaint of discrimination

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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 state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the **USDA Program Discrimination Complaint Form, AD-3027,** found online at How to File a Program Discrimination 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
EMAIL: program.intake@usda.gov

***Do not mail applications to this address, only complaints of discrimination.**

*USDA is an equal opportunity provider, employer, and lender.*

1900 Kanawha Boulevard, East, Building 6 • Charleston, WV 25305
wvde.us

# Children with Disabilities and Special Dietary Needs

Schools/Sites participating in a federal school meal program (National School Lunch Program, School Breakfast Program, Child and Adult Care Food Program, Summer Food Service Program, Fresh Fruit and Vegetable Program, Special Milk Program, and Afterschool Snack Program) are required to make reasonable accommodations for children who are unable to eat the school/site meals because of a disability that restricts the diet.

### 1. Licensed Medical Authority's Statement for Children with Disabilities

U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in school/site meals for children whose disabilities restrict their diets. School Food Authorities/Sponsors must provide modifications for children on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document **("Medical Plan of Care for School/Site Food Service")** may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in West Virginia includes a:

- Physician, (MD or DO)
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

**The written medical statement must include:**

- An explanation of how the child's physical or mental impairment restricts the child's diet;
- An explanation of what must be done to accommodate the child; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

### 2. Other Special Dietary Needs

School/Site food service staff may make food substitutions for individual children who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Schools/Sites are encouraged to have documentation on file when making menu modifications within the meal pattern.

### 3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008,* a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

*Major life activities* include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Steven L. Paine, Ed.D.
State Superintendent of Schools

Thomas W. Campbell
President, West Virginia Board of Education

**4. Individuals with Disabilities Education Act**

A child with a disability under Part B of the *Individuals with Disabilities Education Act* (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to ensure that food service staff is involved early in decisions regarding special meals.

**Nutrition Program Contact**
For more information about requesting accommodations to meals and the meal service for children with disabilities at (School or Site Name), please contact:
*(Name and contact information)*

**USDA Nondiscrimination Statement**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or

2. fax:
   (833) 256-1665 or (202) 690-7442; or

3. email:
   program.intake@usda.gov.

This institution is an equal opportunity provider.

# Medical Plan of Care for School/Site Food Service

*Please read pages 1 and 2 before completing this form.*

| Child's Name | Date of Birth | Grade Level/Classroom |
|---|---|---|
| Name of School/Site | WVEIS Number | |
| Name of Parent/Guardian | Phone Number of Parent/Guardian | |
| Signature of Parent/Guardian | Date | |

**1. Provide an explanation below of how the child's physical or mental impairment restricts the child's diet:**

**2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the child's needs:**

**3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.**
**Foods to be omitted:**
1-
2-

**Suggested substitutions:**
1-
2-
3-

**4. Indicate texture modifications, if applicable:**
- Chopped/Cut into bite-sized pieces
- Diced
- Finely Ground
- Pureed
- Other: _____

**5. List any required special adaptive equipment:**

| Name of Physician/Medical Authority & Title (Please Print) | Provider Phone Number |
|---|---|
| Signature of Physician/Medical Authority | Date |

***Signing the following section is optional, but may prevent delays by allowing the school/site to speak with the physician/medical authority.***

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (child nutrition program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school/site program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____

# SPECIAL DIETARY NEEDS MEDICAL STATEMENT

Student's Name _____ DOB _____

School _____ County _____ WVEIS# _____

Does this patient have a disability that affects her/his diet? ☐ Yes ☐ No

Diagnosis _____

Does this patient have a non-disabling medical condition that affects her/his diet? ☐ Yes ☐ No

Diagnosis _____

Did you refer this patient's family to receive diet education? ☐ Yes ☐ No

If Yes, to whom? ☐ MD ☐ RN ☐ RD ☐ CDE

Name _____ Phone _____

Diet information sent to:

☐ School Nurse ☐ School Cook ☐ Child Nutrition Director ☐ Principal ☐ Other

## PLEASE MARK ONLY THE AREAS THAT APPLY

Schools or sites may make substitutions for individuals with a non-disabling medical condition who are unable to consume the regular meal because of medical or other special dietary needs.

☐ FOOD ALLERGIES

_____

_____

_____

☐ SUBSTITUTIONS MUST BE LISTED

_____

_____

_____

☐ SODIUM RESTRICTION (Specify Milligrams) _____

☐ CARBOHYDRATES COUNTING (Specify Grams)

Breakfast _____ Lunch _____

☐ OTHER RESTRICTIONS

_____

_____

_____

☐ CALORIC REQUIREMENTS: please indicate the calories for each meal provided at school.

| Daily Total | Breakfast | Lunch | Snack |
|---|---|---|---|
| 1,200 | _____ | _____ | _____ |
| 1,500 | _____ | _____ | _____ |
| 1,800 | _____ | _____ | _____ |
| 2,000 | _____ | _____ | _____ |

☐ TEXTURE CONSISTENCIES: for swallowing or chewing difficulties.

**SOLIDS**

☐ Regular Chopped

☐ Mechanical soft with ground meat

☐ Mechanical soft with chopped meat

☐ Pureed

**LIQUIDS**

☐ Regular Consistency

☐ Honey Consistency

☐ Nectar Consistency

☐ Pudding Consistency

☐ NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE: (for Breakfast & Lunch only)

Oral Feedings/Tube Feedings _____

Specify amount & frequency of feeding _____

Additional Comments _____

## DISABILITY

If an individual with a disability requires a special diet, the United States Department of Agriculture requires a medical statement form completed and signed by a licensed physician; medical doctor (MD) or doctor of osteopathic medicine (DO). An updated medical statement must be provided annually or when any change is prescribed.

## NON-DISABLED MEDICAL CONDITION

If an individual has a medical condition requiring a special diet and is medically certified, the school food service may make substitutions to the regular diet on a case-by-case basis. A medical statement is required and must be completed by a medical doctor (MD), doctor of osteopathic medicine (DO), physician's assistant (PA), or nurse practitioner (ANP) and include substitutions to the regular menu. An updated medical statement must be provided annually or when any change is prescribed.

| | |
|---|---|
| Provider Name & Title (print) | Parent/Guardian Name (print) |
| Signature, Credentials Date | Signature Date |
| Provider Phone | Parent/Guardian Phone |

1900 Kanawha Boulevard, East, Building 6 • Charleston, WV 25305
wvde.us

July 17, 2025

Child and Adult Care Food Program (CACFP)
Sponsors and Institutions

**Obligation to Provide Infant Meals**

This letter serves as clarification of the obligation for centers and day care homes participating in the United States Department of Agriculture (USDA) CACFP to provide meals to infants. **Please use the attached infant meal pattern.**

**Centers and day care homes must:**

- Make available one type of formula for infants (creditable formula guidance is attached).
- Give parents the opportunity to accept or refuse infant formula and/or meals; and
- Provide special food or formula if a Special Dietary Needs form is provided.

**Centers and day care homes may not:**

- Require parents or guardians to bring their own formula or food; or
- Refuse to provide meals because of logistics or cost of food.

Attached is the *PARENT INFANT MEAL NOTIFICATION* that must be completed for each infant in care. This form will allow parents/guardians to accept or refuse infant formula or meals at centers and day care homes. A copy of this form must be on file at the centers and day care homes for all infants in care.

Questions regarding this policy should be directed to Tracy Sayre, trcsayre@k12.wv.us (centers) and Jamie Chapman, jamie.chapman@k12.wv.us (day care homes) at (304) 558-3396.

Sincerely,

Anthony Crago
Anthony Crago (Jul 17, 2025 11:11 EDT)

Anthony Crago, Director
Office of Child Nutrition

AC/TS/JC/ja
Attachments

07172025jaTSJC_Revised_OPIM

Michele L. Blatt
State Superintendent of Schools

Nancy J. White
President, West Virginia Board of Education

**WEST VIRGINIA DEPARTMENT OF EDUCATION**

**OFFICE OF CHILD NUTRITION**

**PARENT INFANT MEAL NOTIFICATION**

**To:** Parents and Guardians of infants under one year of age

**From:** Name of Center or day care home_____

**Subject:** Infant Meals

All children enrolled in this center or day care home, including infants, are eligible for meals through the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). Centers or day care homes that participate in this program are reimbursed by USDA to help with the cost of serving nutritious meals that meet CACFP guidelines to all enrolled children. To fully meet CACFP requirements, this site is required to provide formula and other required infant foods to enrolled infants.

You have a right to the benefits described in this letter. Any food provided must comply with the CACFP Infant Meal Pattern, which ensures that infants receive the appropriate nutrition for their developmental stage.

A copy of the CACFP Infant Meal Pattern is included with this letter. Please note that solid foods will be introduced according to your infant's developmental readiness and your input.

Parents or guardians may provide their own iron-fortified infant formula and/or breast milk **or** one solid meal component.

**PLEASE CHECK YOUR PREFERENCES:**

**Formula or Breast Milk (check one)**

_____ I want the center/day care home to provide formula for my infant (We offer_____)

_____ I will provide_____ formula for my infant.
**Note:** I understand that I will need to submit a Special Dietary Needs form if my infant requires special foods or formula.

_____ I will provide breast milk for my infant.

**Solid Food: (check one)**

_____ I want the center/day care home to provide solid food for my infant when he/she is developmentally ready.

_____ I will provide one solid meal component in place of a solid meal component provided by this center/day care home.

**Infant's Name:** _____ **Birth Date:** _____

This institution/day care home has not requested or required me to provide infant formula or food for my baby. I understand that I have the choice of having my baby participate in the CACFP.

**Parent/Guardian Signature:** _____**Date:** _____

**Authorized Representative Signature:** _____**Date:** _____

**This Institution is an equal opportunity provider.**

The following is an excerpt from the USDA memo, *CACFP 06-2025 – Feeding Infants and Meal Pattern Requirements in the Child and Adult Care Food Program: Questions and Answers*, issued on December 20, 2024:

## Creditable Infant Formulas

As part of offering a meal that is compliant with the CACFP infant meal pattern requirements, centers and day care homes with infants in their care must offer at least one type of iron-fortified infant formula (7 CFR 226.20(b)(2)). Centers and day care homes may purchase infant formula online or in person from retailers (e.g., local, regional or national vendors), pharmacies, and membership-based warehouses.

The Food and Drug Administration (FDA) defines iron-fortified infant formula as a product "which contains 1 milligram or more of iron in a quantity of product that supplies 100 kilocalories when prepared in accordance with label directions for infant consumption" (21 CFR 107.10(b)(4)(i)). The number of milligrams (mg) of iron per 100 kilocalories (calories) of formula can be found on the Nutrition Facts label of infant formulas.

The following criteria may be used to determine whether a formula is eligible for reimbursement:

1. Ensure that the formula is not an FDA Exempt Infant Formula. An exempt infant formula is an infant formula labeled for use by infants who have inborn errors of metabolism or low birth weight, or who otherwise have unusual medical or dietary problems, as defined in 21 CFR 107.3. The FDA webpage, Exempt Infant Formulas Marketed in the United States By Manufacturer and Category,https://www.fda.gov/food/infant-formula-guidance-documents-regulatory-information/exempt-infant-formulas-marketed-united-states-manufacturer-and-category provides more information and a list of FDA Exempt Infant Formulas.

2. Look for "Infant Formula with Iron" or a similar statement on the front of the formula package. All iron-fortified infant formulas must have this type of statement on the package.

3. Use the nutrition facts label as a guide to ensure that the formula is iron-fortified. The nutritive values of each formula are listed on the product's nutrition facts label. To be considered iron-fortified, an infant formula must have 1 mg of iron or more per 100 calories of formula when prepared in accordance with the label directions.

Additionally, to be creditable for reimbursement, infant formula must meet the definition of an infant formula in section 201(z) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(z) and meet the requirements for an infant formula under section 412 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350a) and the regulations at 21 CFR parts 106 and 107. Requiring an infant formula to be compliant with the FDA regulatory standards on infant formula is consistent with the Special Supplemental Nutrition Program for Women, Infants, and Children's (WIC) infant formula requirements and helps ensure that all infant formulas served in the CACFP meet nutrient specifications and safety requirements. If a formula is purchased outside of the United States, it is likely that the formula is not regulated by the FDA. Infant formulas that are not regulated by FDA are not creditable in the CACFP.




**LEARNING ACADEMY**

543 Bream Street • Charleston, WV 25387

# Parent Handbook Acknowledgment

Please sign to acknowledge receiving the Parent Handbook from New Beginning Learning Academy.

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

---

# Photograph & Video Permission

New Beginning Learning Academy has my permission to photograph, audio, & video my child during their attendance at New Beginning Learning Academy.

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____




**LEARNING ACADEMY**

543 Bream Street • Charleston, WV 25387

# Participation in Field Trips

I, _____ have given **New Beginning Learning Academy,**
Parent/Guardian Signature

permission for my child/children to participate in **FIELD TRIPS; (ex. MOVIES, NATURE WALKS, visits to area PLAYGROUNDS,** and other educational trips sponsored and supervised by New Beginning Learning Academy staff.

**NOTICE WILL BE GIVEN BEFORE ALL FIELD TRIPS!**

Child/Children's Name _____

_____

_____

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

LEARNING ACADEMY

543 Bream Street • Charleston, WV 25387

# End of School Day Transportation

**TO: Piedmont Elementary** - 203 Bradford Street, Charleston, WV - (304) 348-1910
**Mary C. Snow Elementary** - 100 Florida Street, Charleston, WV - (304) 348-1902
**Edgewood Elementary** - 550 Hawk's Ridge Road, Charleston, WV - (304) 348-6635

## PERMISSION SLIP

I, _____ have given **New Beginning Learning Academy,**
Parent/Guardian Signature

permission to receive my child/children at the end of the school day, whether early dismissal or regular school; to be transported to **New Beginning Learning Academy**, 543 Bream Street, Charleston, WV 25387.

Child/Children's Name _____

_____

_____

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

NEW BEGINNING

NBL ACADEMY

LEARNING ACADEMY

543 Bream Street • Charleston, WV 25387

## Weekly Schedule for _____

Child's Name

### Monday

_____ to _____

### Tuesday

_____ to _____

### Wednesday

_____ to _____

### Thursday

_____ to _____

### Friday

_____ to _____

# Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

**Meals** CACFP homes and centers follow meal requirements established by USDA.

| Breakfast | Lunch or Supper | Snacks (Two of the four groups: ) |
|---|---|---|
| Milk<br>Fruit or Vegetable<br>Grains or Bread<br>or may substitute<br>a meat/alternate<br>up to three times<br>a week | Milk<br>Meat or meat alternate<br>Grains or bread<br>Fruit<br>Vegetable | Milk<br>Meat or meat alternate<br>Grains or bread<br>Fruit or vegetable |

**Participating Facilities** Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed or approved private homes.
- **Afterschool Care Programs:** Centers in low-income areas provide free snacks to school-age children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.

**Eligibility** State agencies reimburse facilities that offer non-residential day care to the following children:

- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool care programs in needy areas.

**Contact Information** If you have questions about CACFP, please contact one of the following:

**Sponsoring Organization/Center**
**Stephanie Guerrant**

New Beginning Learning Academy
543 Bream Street,
Charleston, West Virginia 25387
(304) 610-8836

**State Agency Director**
**Amanda Harrison**

WV Department of Education
Office of Child Nutrition
1900 Kanawha Boulevard, East R-248 B
Charleston, West Virginia 25305
(304) 558-3396

USDA

USDA is an equal opportunity provider

English Version