WORLD OF COLOR DEVELOPMENT CENTER

780 PINCHBACK RD
BEAUMONT TEXAS 77707
PHONE: (409) 866-7164 FAX (409) 866-0076
EMAIL: ARLENECOLEMAN50@YAHOO.COM
Hours 6am – 6 pm (M-F)
Cut off Time: 9:00 am (M –F)

Parent Email: _____

- Parent DL's____
- Child's Social Security____
- Birth certificate____
- Signed Physician Statement____
- Updated Vaccination record____

APPLICATION

TEXAS Health and Human Services

Form 2935
October 2023

Admission Information

Use this form to collect all required information about a child enrolling in day care.

Directions: The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

General Information

Operation's Name: World of Color Development Center		Director's Name: Kourtney Lynch	
Child's Full Name:		Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian
Child's Home Address:		Date of Admission:	Date of Withdrawal:
Name of Parent or Guardian Completing Form:		Address of Parent or Guardian *(if different from the child's)*:	
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Phone No.:	Parent 2 Phone No.:	Guardian's Phone No.:	Custody Documents on File? ◯ Yes ◯ No
In case of an emergency, call:			
Name of Emergency Contact:		Relationship:	Area Code and Phone No.:
Address:			
I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:
Name:			Area Code and Phone No.:

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees (Check all that apply).

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance: ◯ Yes ◯ No

If no, what type of assistance is needed: _____

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Signature — Parent or Legal Guardian **Date Signed**

School Age Children

My child attends the following school:	School Area Code and Phone No.:

My child has permission to *(check all that apply)*:

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

- ◯ 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 90th 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.

Vision Exam Results

Right Eye 20/ ´ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

Admission Requirement

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. *(Select **only one** option.)*

- ◯ 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.
- ◯ A signed and dated copy of a health care professional's statement is attached.
- ◯ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.
- ◯ 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 it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

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.

Signature **Date Signed**

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

◯Positive ◯Negative Date: _____

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

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature **Date Signed**

Texas Dept of Family and Protective Services

Child Assessment Form

Form 7293
November 2012

Child Name (last, first, middle)		Social Security No.*	Enrollment Date	Date of Birth
Street Address (if rural, attach directions)		City	County	Zip
Mailing Address (if different) – Street or P.O. Box		City	County	Zip
Telephone No. (include A/C)				

* If applicable.

1. Health

Does your child have any allergies?	☐ Yes	☐ 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?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ 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?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

3. Behavior:

Does your child have any special fears?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
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?		

Child Assessment Form

What position is most comfortable for your child when he/she is napping?	

4. Eating Preferences:

What are your child's favorite foods?			
Does your child use utensils, eat with fingers, feed self?			
Does your child choke easily while eating?		☐ Yes	☐ No

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	

I verify that the above assessment was discussed with the parent(s) of _____

_____

_____

_____ _____

Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

_____ _____

Signature of Parent Date Signed

Additional Comments:

Children with special care needs:

Any limitations or restrictions on the child's activities?_____

Any adaptive equipment provided for the child; If so please provide the instructions for how to use the equipment_____

Symptoms or indications of potential complications related to physical, cognitive, or mental condition that warrant prevention or intervention while the child is in care?_____

_____

Any medications prescribed for continuous, long term use?_____

Provide a copy of IEP/IFSP

World of Color Daycare Center

780 Pinchback Road

Beaumont, Texas 77707

409.866.7164

Parent Agreement Form

RELIGIOUS PARTICIPATION

At World of Color Daycare, we believe in thanking God for all he has given us. We thank God by praying daily. We understand that there may be children of all denominations that attend WOC. However, we will make special accommodations for those children whom are not religious.

HOLIDAY CELEBRATIONS

WOC celebrates all national holidays and multiple celebrations to include but not limited to Birthdays, Mothers Day, Fathers Day, Labor Day, Veterans Day, Thanksgiving, Christmas, Martin Luther King Day, Presidents Day, Black History Month, Valentine's Day, St. Patrick's Day, Easter, Cinco De Mayo, Memorial Day, Independence Day, and other various holidays that our parents of diverse cultures share with our school.

MEDICAL TREATMENT

In the case of on emergency or treatment of minor injuries/rashes, WOC has permission to use the following items unless otherwise noted in the allergy section of your Admission Information Form. Topical applications may include; Antibiotic Cream or Ointment (Neosporin), Solarcaine, Hydrocortisone Cream (Benadryl), Caladryl Lotion, Hydrogen Peroxide, Alcohol, and Adhesive Bandages. Caregivers will apply Diaper Rash Ointments provided by the parents for infants and toddlers.

MOSQUITO SPRAY/SUNSCREEN

WOC staff do not apply Mosquito Spray or Sunscreen prior to spending time outside each day. We do spray for insects whiles outside but even with

spray, there may be occasional incidents where insect bites may occur. If your child is allergic to a particular spray, please note it on your Admission Information Form.

CONTRACTOR SERVICES

WOC allows Contractors to utilize the facility for the benefit of the children. Individual contracts are signed by the parents for these services releasing liability from WOC. The children are not under supervision of WOC staff during these services. Contractor will be allowed to access your child with your permission Early Childhood Intervention, CPS, Speech Therapist, and Hearing and Vision Programs. WOC is not in charge of these services, and a parent must notify the office if visitors will be seeing your child with a health contractor.

PHOTO PERMISSION

WOC caregivers take photos for projects in the classroom and will be displayed in programs during their Pre-Kindergarten Graduation. WOC will also use video and photos from the center for early education training and advertisement. If you refuse for your child to be included in any of these opportunities, then a written, dated, and signed request must be on file at the center.

NUTRITION REQUIREMENTS

The Department of Family and Protective Services (DFPS) have amended Minimum Standards in regards to the nutrition requirements for children in child care. The meals at our center comply with all state guidelines to make sure your child gets the appropriate amount of nutrients during the day. If you choose to send a lunch with your child, please be aware that you are responsible for the nutrients for that meal. WOC does not allow the following items to be brought to the center for breakfast, lunch, and/or snacks;

For all ages;

- *Candy, Carbonated drinks, Sweet or Un-sweet tea, Flavored Teas, or Energy Drink.*

For children under 4;

- *Hot dogs, Corndogs, Whole Grapes, String Cheese, Nuts, Seeds, Dried Fruit, Pretzels, Chips,*

Peanuts, Popcorn, Marshmallows, Chunks of Meat larger than a child can swallow in one bite at a time, More than 4oz. of 100 percent juice.

FINANCIAL RESPONSIBILITIES REQUIREMENT

1. *A$ 95.00 non-refundable registration fee and must be paid upon submission of completed enrollment form.*
2. *Monthly for supplies, curriculum, technology fees and playground maintenance $25*
3. *Parents of 4 year olds will be responsible for providing a state required Vision and Hearing screening for their child.*
4. *Children enrolled in the center pay for the entire week whether they attend or not. This holds your place in our classrooms. NO EXCEPTIONS*
5. *Summer program is $300.00 per child this is in addition to weekly/monthly childcare fees*
6. *Non-payment of tuition fees will result in termination of services. Payments are due on Tuesdays.*
7. *A $5 late fee per child will be assessed for any child picked up after 6 pm and an* additional fee of $1 per minute thereafter.
8. *All fees will be paid on Brightwheel app/ Credit card at facility NO CASH/NO CHECKS.*
9. *An unpaid balances will be sent to small claims court we will attempt to collect debt*

OPERATIONAL POLICIES/PARENT AGREEMENT ACKNOWLEDGEMENT

By signing below, I confirm that I have received and read completely the WOC Operational Policies and the Parent Agreement. I recognize that the policies, information, and rules expressed in relation to the Parent Agreement and Operational Policies are subject to change. Policies may be revised, superseded, or withdrawn at any time without notice. In addition, I understand that I am enrolling my child in a state licensed and regulated childcare center through The Department of Family and Protective Services. I

Understand that failure to comply with WOC policies and procedures can lead to dismissal of my child.

In addition, I will complete an update form at the beginning of each year, as provided by the Center, at the beginning of each

school year and/or when information changes. I will provide any changes in address, contact information, and pertinent information to the facility when change occurs so that proper care of my child can be conducted. I have read and accepted the above financial terms and agree to pay my weekly child care fees on the following schedule: Weekly-Bi-weekly-Monthly.
Failure to pay tuition will result in termination of services without allowance for readmission,

At any time enrollment can be refused or terminated for any reason seen fit by the Director/Owner

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Signature of Parent or Guardian Date

World of Color Development Center
780 Pinchback Road
Beaumont, Tx 77707
(409)-866-7164

RE: School Closures/Early Dismissal

Dear Parents/Guardians,

Unfortunately, due to the numerous unforeseen (full-day/ half day) BISD closures, we are being forced to change our availability. BISD has made numerous unexpected changes to their original calendar. On days that BISD adds in unexpected closures, it impacts our staffing tremendously because our employees may or may not be able available to come in at the last minute.

Going forward, if BISD closes on a day that is not included on their posted calendar; we reserve the right to notify the parents 24 hours in advance if we can or cannot accommodate the unexpected closure and pick up of your child/ren.

BISD early dismissal due to inclement weather:

The parent will be responsible for picking up their student/s from school. World of Color afterschool staff does not arrive to the center until designated time of 3 pm. Therefore, your student/s will not be allowed to be dropped off until 3pm.

Thanks for your cooperation and understanding!

Warmest Regards,

Mrs. Kourtney

Child/ren name:_____

_____

_____

I, _____, acknowledge that I have received and read the notification regarding early dismissal, closure and inclement weather from World of Color Development Center and I will make arrangements to pick up my child promptly.

Parent Signature:_____ Date:_____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

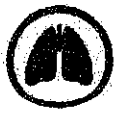
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

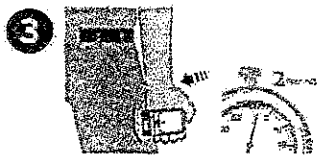
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

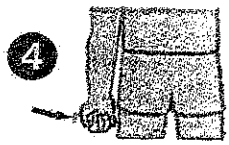
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



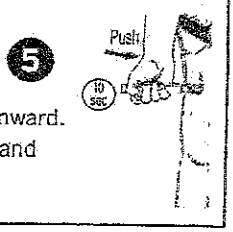
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

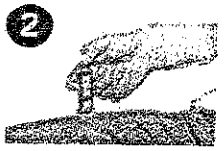


HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

212 therapy
pediatric therapy

Date:

Dear Parent(s),

Your daycare facility is partnering with 212 Therapy to participate in a facility wide free pediatric therapy screening opportunity for the following indicated therapy disciplines:

Speech Therapy Occupational Therapy Physical Therapy

We are requesting your permission to screen your child for any possible delays within your child's communication, fine or gross motor skills. It is our goal to help children overcome any concerning communication or motor development delays to prepare them for a strong future. If you would like your child to participate in the screening(s) mentioned above, please fill out the information below and return it to your daycare facility.

Child's name: _____

Date of birth: _____

Parent's Name: _____

Phone number: _____

Insurance Type: _____

Thank you!

212 Therapy LLC
1846 IH-10 South, Suite 102
Beaumont, TX 77707
Ph: (409) 292-3434
Fax: (409) 866-7255
www.212therapy.com

*if applicable

212 Therapy

INTERDISCIPLINARY SCREENING

Patient Name: _____ Date of Birth: _____

PCP: _____ Medicaid #: _____

SPEECH THERAPY SCREENING

Is child's speech difficult to understand?	Yes	No
Does child have feeding/swallowing difficulties?	Yes	No
Does child show any weakness in lips, tongue or jaw?	Yes	No
Is child able to follow simple directions?	Yes	No
Is child's speech dysfluent and/or does child struggle to communicate?	Yes	No
Is child able to ask and/or answer questions appropriately?	Yes	No
Is child's voice too soft, too loud, high pitched, low pitched, hoarse or nasally?	Yes	No
Does child understand how to use basic concepts appropriate for their age?	Yes	No

OCCUPATIONAL THERAPY SCREENING

Is child able to complete self-care tasks appropriate for their age?	Yes	No
Does child show difficulties with handwriting tasks?	Yes	No
Is child able to successfully stack blocks?	Yes	No
Does child exhibit sensory processing issue (complains of how clothing feels, sensitive or under-sensitive to smells and sounds, etc.)?	Yes	No
Is child impulsive or distractible?	Yes	No
Is child able to grasp small objects with his/her fingers?	Yes	No
Is child able to tolerate foods of all consistencies (smooth, crunchy, etc.)?	Yes	No
Does child enjoy bath time, sandboxes, swinging, car rides, etc.?	Yes	No
Does child have difficulty with gross motor skills?	Yes	No
Are child's fine motor skills adequate for the child's age?	Yes	No

PHYSICIAL THERAPY SCREENING

Does child seem clumsy or uncoordinated (taking longer than expected to learn motor skills, bumps into other people or objects in the environment, falls often, etc.)?	Yes	No
Does child avoid movement activities such as swings, slides, hesitates on curbs or uneven surfaces, etc.?	Yes	No
Does child use more movements and more time than necessary to accomplish a task consistently?	Yes	No
Does child appear to be in constant motion, fidgety, or have a difficult time sitting still?	Yes	No
Is child overly rough when playing?	Yes	No
Does child have difficulty imitating actions?	Yes	No
Is child seemingly unsafe in community or at home?	Yes	No
Does child fall more than peers or constantly have bruises, scrapes or injuries?	Yes	No
Does child look or tilt head always to one side and/or have flattening of back or side of the head?	Yes	No
Does child walk in a way that is different from other kids their age?	Yes	No

Patient would benefit from further evaluation for: (Circle all that apply)

SPEECH THERAPY OCCUPATIONAL THERAPY PHYSICAL THERAPY

Screening Therapist Name: _____ Date: _____

Screening Therapist Signature: _____

Parent Acknowledgement

I have read the following in the parent handbook and I understand that I must follow all aspects of this manual. Our handbook is reviewed annually and is updated as needed <Please initial and sign>

_____Motto
_____Open door policy
_____Non-discriminatory policies
_____Forms/Medical requirements
_____Tuition/Registration and supply fee
_____Hours of operation
_____Late pick up fee
_____Late payment fees
_____Sign-in and out
_____Discipline
_____Naptime
_____Outdoor play
_____Clothing and personal belongings
_____Persons authorized to pickup children
_____School closing for bad weather
_____Communication
_____Hearing/Vision
_____Illness
_____Moonlighting
_____Injuries
_____Medication
_____Transportation
_____Fire drills
_____Field trips
_____Holidays
_____Photography
_____Nurturing
_____Animals
_____Parent Participation/Volunteers
_____Reporting abuse and Neglect
_____Parent acknowledgement
_____CCCS

Signature:_____Date:_____
Director signature:_____Date:_____

Parent Orientation

TRS - P-PE-01

Name of facility: _____

Name of parent/guardian: _____

I have received information on the following:

- Tour the facility
- Introduction to teaching staff
- Parent visit with the classroom teacher
- Overview of parent handbook
- Policy for arrival & late arrival
- Opportunity for an extended visit in the classroom by both parent and child for a period of time to allow both to be comfortable.
- An explanation of Texas Rising Star Quality Certification is provided.
- Encouraging parents to inform the center/provider of any elements related to their CCS enrollment that the provider may be of assistance.
- An overview of family support resources and activities in the community
- Child development and developmental milestones provided
- Parents are informed of the significance of consistent arrival time. Children should arrive before the educational portion of the program begins to limit disruption. Consistent routines prepare children for the transition to kindergarten.
- Statement is shared with parents regarding limiting technology use on-site (e.g. refrain from cell phone use). In order to facilitate better communication between the parents and caregiver and the parents and child, it is best if parent are not distracted by use of electronic devices while at the center/home.
- Statement is shared with parents reflecting the role and influence of families.

I acknowledge receipt of the above information.

Parent signature _____ Date: _____

Director signature _____ Date: _____

World of Color Development Center

"What you need to Know"

We are a uniform facility; kids must be in uniform at all times. Uniforms must be purchased within 30 days of enrollment.

- If you are on catholic charities your payments are due by the 5th of each month. You will pay $10.00 weekly until payment is made in full.
- Private pay must pay Monday of each week NO EXCEPTION! Your child/ children will be automatically dropped after 1 week. $10 late fee applied every Tuesday
- Weekly payments are due rather your child attend childcare or not to hold his/her spot.
- Un-enroll student we require a 2 week notice in writing
- Challenging behaviors are handled case by case
- All school age children between the ages 2-4 need to be in a class setting at 8:30 a.m. **Breakfast end @ 8 am NO EXCEPTIONS!!!**
- NO child can be left here more than 11 hours daily. Any child left past 11 hours is considered child negligence & will be treated as such. A call to CPS will be made.
- World of Color is not responsible for children's personal items left, stolen or broken. All valuables should be left at home, that includes cell phones, tablets, jewelry, etc.
- Kids must be checked in daily on sign-in sheet and Brightwheel app
- If your child has a special diet or medication the director must be notified in writing with a doctor's excuse.
- Your child will need a complete change of clothing weather appropriate.
- Check with the front office for your child's school supply list.
- Drop off cut time is 9:00 a.m. NO EXCEPTIONS unless the child has a Dr.excuse.
- You will receive an invite to register for Brightwheel for general communication, announcements and billing.
- **Riding daycare transportation van/bus driver leave @ 7:15 am promptly**

X_____ X_____

Parent/ Guardian Signature Date

X_____ X_____

Director Signature Date

Photography Consent Form

Dear Parent/Guardian

As the parent of a child/children at **World of Color Development Center,** I agree to the following: I understand that my child*(ren)* whose name(s) are listed below may be photographed at **World of Color Development Center** during normal daycare hours, field trips, or activities. I understand that these photographs may be used in promoting child care services, either in print or on the internet.

Parent/Guardian Name:		Relationship To Child
Address		
City	State	Zip
Name (Child 1)		
Name (Child 2)		
Name (Child 3)		
I give permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting our child care serve. I understand that it's my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation.		
Parent/Guardian Signature:		Date

TEXAS
Health and Human Services

Form 2550
October 2019-E

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at World of Color Daycare Center and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Safe Sleep Policy

All staff, substitute staff, and volunteers at World of Color Daycare Center will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415(b) and §747.2315(b)]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415(b) and §747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing Sleepers & Footed Pajamas (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415(b) and §747.2315(b)].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2428 and §747.2328].

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

Signatures

This policy is effective on: _____ Child's name: _____

Arlene Coleman
Signature — Director/Owner

Date Signed

Kourtney Lynch, RN
Signature — Staff member

Date Signed

Signature — Parent

Date Signed

World of Color Development Center, LLC

780 Pinchback Rd

Beaumont, Texas 77707

(409)866-7164

Fax (409) 866-0076

Acknowledgment of receipt of new Operational Policy and Procedures Handbook. My signature below indicates that I have received a copy of World of Color's Operational policy and procedure manual. This handbook supercedes any and all prior practices, oral or written representations. This handbook will be amended throughout the year. Parent/ Guardian you will receive addendum's as they occur.

Parent Signature _____ Date _____

Witness signature Kourtney Lynch, RSL Date _____

World of Color Daycare COVID-19 RELEASE AND WAIVER OF CLAIMS ADDENDUM ("Release")

The undersigned, in my capacity as parent or legal guardian, hereby acknowledge the health risks and dangers associated with the transmission of the COVID-19 virus, and other communicable diseases, and recognize that exposure to the COVID-19 virus, or other communicable diseases, could occur while my child is in the care of the World of Color Daycare Center.

As such, and in consideration for child care services to be provided by the World of Color Daycare Center, the undersigned, for myself and my minor children enrolled in the Program **fully assume all of the risks associated with participation in the Program, including the possibility of COVID-19 (or the novel corona-virus) community spread.**

I, AS PARENT AND/OR LEGAL GUARDIAN, HAVE READ AND FULLY UNDERSTAND AND ACKNOWLEDGE THE CONTENTS OF THE RELEASE AND AGREE THAT I AM VOLUNTARILY WAIVING, RELEASING, INDEMNIFYING AND DISCHARGING World of Color Daycare Center AND ITS DIRECTORS, EMPLOYEES AND VOLUNTEERS FROM ANY AND ALL LIABILITY, DAMAGES, AND EACH AND EVERY ACTION (COLLECTIVELY, "CLAIMS") BY PARTICIPATION IN AND/OR ASSOCIATED WITH THE PROGRAM INCLUDING, BUT NOT LIMITED TO EXPOSURE OR TRANSMISSION OF THE COVID-19 VIRUS.

I represent that I have full authority to sign on behalf of my child(ren) and that my signature binds each other person having authority to make decisions on behalf of the child(ren).

MY SIGNATURE BELOW IS CONFIRMATION THAT I HAVE READ AND FULLY UNDERSTAND AND ACKNOWLEDGE THE CONTENTS OF THE RELEASE AND AGREE THAT I AM VOLUNTARILY WAIVING, RELEASING, INDEMNIFYING AND DISCHARGING World of Color Daycare Center AND ITS DIRECTORS, EMPLOYEES AND VOLUNTEERS FROM THE CLAIMS.

_____

Parent Signature Date

Child(ren) Names:_____

_____

_____

_____

Provider's Guide to Parent's Rights

Senate Bill 1098 from the 88th Legislative Regular Session added Section 42.04271 to the Human Resources Code and states that a parent or guardian of a child at a child care facility has the right to:

- Enter and examine the child-care facility during its hours of operation and without advance notice;
- File a complaint against the child care facility;
- Review the child care facility's publicly accessible records;
- Review the child-care facility's written records concerning the parent's or guardian's child;
- Receive inspection reports and information about how to access the child care facility's online compliance history;
- Have the facility comply with a court order that prevents another parent or guardian from visiting or removing the child;
- Be given the contact information for the child care facility's local Child Care Regulation office;
- Inspect any video recordings of an alleged incident of abuse or neglect involving their child provided that:
    - Video recordings of the alleged incident are available;
    - The parent or guardian does not retain any part of the video depicting a child that is not their own; and
    - The parent or guardian of any other child in the video receives prior notice from the facility;
- Obtain a copy of the facility's policies and procedures handbook;
- Review the facility's staff training records and any in-house training curriculum; and
- Exercise these rights without receiving retaliatory action by the facility.

By signing this form, I acknowledge that I have received a copy of the policy currently in effect for my childcare center as of 9/1/2023, and I understand my childcare facility parent's rights policy.

Parent Signature _____Date_____

Director Signature _____Date_____

TEXAS Health and Human Services

Food & Nutrition Solutions

CACFP ENROLLMENT FORM

Please complete the following information:

Center Name: World of Color

Phone Number: 409-866-7164

Child 1:

Name:_____ Date of Birth:_____ Enrollment Date:_____

Days in care: □Monday □Tuesday □Wednesday □Thursday □Friday □Saturday □Sunday

Times in care: Start time _____□AM □PM End time_____□AM □PM

Meals Served to child while in care: □Breakfast □AM Snack □Lunch □PM Snack □Supper □ EV Snack

Withdrawal Date (office use only): _____

Child 2:

Name:_____ Date of Birth:_____ Enrollment Date:_____

Days in care: □Monday □Tuesday □Wednesday □Thursday □Friday □Saturday □Sunday

Times in care: Start time _____□AM □PM End time_____□AM □PM

Meals Served to child while in care: □Breakfast □AM Snack □Lunch □PM Snack □Supper □ EV Snack

Withdrawal Date (office use only): _____

Child 3:

Name:_____ Date of Birth:_____ Enrollment Date:_____

Days in care: □Monday □Tuesday □Wednesday □Thursday □Friday □Saturday □Sunday

Times in care: Start time _____□AM □PM End time_____□AM □PM

Meals Served to child while in care: □Breakfast □AM Snack □Lunch □PM Snack □Supper □ EV Snack

Withdrawal Date (office use only): _____

Child 4:

Name:_____ Date of Birth:_____ Enrollment Date:_____

Days in care: □Monday □Tuesday □Wednesday □Thursday □Friday □Saturday □Sunday

Times in care: Start time _____□AM □PM End time_____□AM □PM

Meals Served to child while in care: □Breakfast □AM Snack □Lunch □PM Snack □Supper □ EV Snack

Withdrawal Date (office use only): _____

Part 5. Signature (Adult must sign) An adult household member must sign and date this form.

I certify that all information on this form is true and correct. I understand that the center 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: _____ Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Meals will be provided to all children without charge. This center's CACFP is operated in accordance with the USDA's policies and does not permit discrimination on the basis of race, color, sex, disability, national origin, age, religion, or political belief. 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

Part 6. Participant's ethnic and racial identities (optional) Mark one of the following:

□Hispanic or Latino	□Asian □Black/African American □American Indian/Alaska Native □White
□Not Hispanic/ Latino	□Native Hawaiian / Other Pacific Islander

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

Join Texas WIC

We're here for you

"Thanks to WIC, I now have the tools I need to make sure my family stays on the path to a healthy lifestyle."

–Roxie, WIC Client

As a WIC Client, you'll get:

- Delicious food
- One-on-one counseling with nutritionists
- Easy recipes
- Nutrition classes
- Breastfeeding support
- Health and immunization screenings
- Cooking demonstrations
- Personalized support
- Children's activities

Are you eligible?

Eight million women, infants, and children get WIC benefits. WIC is for pregnant women, new parents, infants, and children under five. If you are on Medicaid, TANF, or SNAP you already qualify.

Texas WIC Income Guidelines

Number of people in the home*	Monthly Income	Annual Income
2	$2,658	$31,894
3	$3,349	$40,182
4	$4,040	$48,470
5	$4,730	$56,758
6	$5,421	$65,046

Effective July 1, 2020

* A pregnant woman's household is increased by the number of infants she is expecting. If you have any income questions, call 1-800-942-3678.

Start now. Call 1-800-942-3678 or visit TexasWIC.org

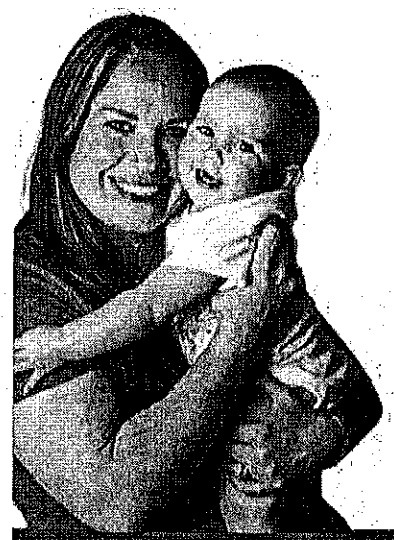
TEXAS Health and Human Services | TEXAS WIC This institution is an equal opportunity provider.

Ven a WIC de Texas

Estamos aquí para servirte

"Gracias a WIC, ahora tengo las herramientas que necesito para asegurar que mi familia siga el camino hacia un estilo de vida saludable."

–Roxie, cliente de WIC



Como cliente de WIC, recibirás:

- Alimentos deliciosos
- Asesoramiento individualizado con nutricionistas
- Recetas sencillas de preparar
- Clases sobre nutrición
- Apoyo para la lactancia
- Evaluaciones médicas y sobre las vacunas
- Demostraciones de cocina
- Apoyo personalizado
- Actividades para niños

¿Calificas?

Ocho millones de mujeres, bebés y niños reciben beneficios de WIC. El Programa WIC va dirigido a mujeres embarazadas, nuevos padres, bebés y niños menores de cinco años. Si ya recibes Medicaid, TANF o SNAP, es posible que califiques.

Requisitos de ingresos de WIC de Texas

Número de personas en el hogar*	Ingresos mensuales	Ingresos anuales
2	$2,658	$31,894
3	$3,349	$40,182
4	$4,040	$48,470
5	$4,730	$56,758
6	$5,421	$65,046

Vigente a partir del 1 de julio de 2020

* El número de personas en el hogar de una mujer embarazada aumenta de acuerdo con el número de bebés que espera. Si tienes alguna pregunta relacionada con los ingresos, llama al 1-800-942-3678.

Empieza hoy mismo. Llama al 1-800-942-3678 o visita TexasWIC.org

TEXAS Health and Human Services | TEXAS WIC Esta institución es un proveedor que ofrece igualdad de oportunidades.

World of Color Daycare Center Uniform

Dear Parents/Guardian

The School year is upon us all full-time students must be in full uniform . **NO EXEPTION**!!!!**FULL UNIFORM** must have **W.O.C LOGO** to upper left chest .You can purchase logo @ Cocomo Joes located at 2024 Calder St, Beaumont, Texas 77701 409.860.5448 Fee $7.50+ tax. It will take approximately **TWO WEEKS for turnaround** to put the logo on. Here are the classes that need to be in full uniform **Infant II, Toddler II, Reg 5/ Clubhouse**. If you have any question please feel free to call at anytime 409.866.7164. Uniforms can be purchased on Amazon.com, Walmart.com and French Toast.com. Design of the new uniforms for 2020-2021 will be located in front of sign-in book.

Thanks Management

Parent signature:_____

Date:_____

Childcare Rate Sheet

Name:	World of Color Development Center			
Address:	780 Pinchback Road			
City:	Beaumont	**State:**	Texas	**Zip:** 77707
Phone # :	(409) 866-7164	**Email:**	arlenecoleman50@yahoo.com	

Provider Effective Rate Change 12/1/2023

AGES	FULL TIME DAILY RATE (more than 6 hours a day)	Max Reimbursable FULL TIME RATE	PART TIME DAILY RATE (less than 6 hours a day)	Max Reimbursable PART TIME RATE
Infant (0-17 months)	$ 39.00	$195	$ 39.00	$195
Toddler (18 – 35 months)	$ 35.00	$175	$ 35.00	$175
3-5 year olds	$ 32.00	$160	$ 32.00	$160
6-12 year olds	$ 26.00	$130	$ 26.00	$130
	$		$	
	$		$	
	$		$	

Additional Fees:

Item:	Amount:	Frequency (daily, weekly, monthly, annually, on occurrence)
Transportation Fee	$ 15.00	Weekly per child
Administrative Fees	$ 95.00	One time non-refundable fee per family
Curriculum fee	$ 25.00	Monthly fee
Summer fees	$ 50.00	Additional per week

PRINT SAVE