QUEST - School Year 2023-2024 ***Before / After School and Full Day Program*** **Registration Form** *Monday-Friday, 6:00 am - 6:00 pm* ***Registration/Activity Fee : $30.00 per enrollment***	*(For Staff Use Only)* ***Non-Refundable Registration Fee*** *Paid: $_____, Date: _____* ***Child's Name:*** _____

Select your QUEST site (check only one):

☐ Balls Creek	☐ Banoak	☐ Blackburn	☐ Catawba	☐ Claremont
☐ Clyde Campbell	☐ Lyle Creek	☐ Maiden	☐ Mt. View	☐ Webb Murray
☐ Oxford	☐ Sherrills Ford	☐ Snow Creek	☐ St. Stephens	☐ Startown
☐ CH Tuttle				

Select ONE Standard Contract Choice:

NOTE: *Before and After School care will be offered at all 16 sites. Full Day (workday/holiday) care will only be offered at 6 designated sites. (please see below)*

Check ALL contract Options Needed:

Registration Fee of $30.00, plus the 1st weekly payment is required BEFORE enrollment. ALL students enrolling in QUEST are required to complete a Free & Reduced Meal Application with Catawba County Schools. (www.lunchapplication.com)

☐	**Before School only**	$35.00 per week		
☐	**After School only**	$50.00 per week		
☐	**Before and After School**	$85.00 per week		
☐	**Full Day Care (teacher workdays/holidays)**	$26.00 per day		
☐	**Drop in Care Only** ** Requires a credit/debit card on file with Tuition Express	☐ Before School $11.00	☐ After School $16.00	☐ Full Day $32.00

NOTE: *Parents will be billed for the week based on the CCS Calendar. You cannot just pay for the days attended, with the exception of "Drop In" care. All other contracts will be billed based on contracted weeks.* ***Accounts will be charged for Legal Holidays as designated on the CCS Calendar.***

Will your child attend Full Day Care? YES _____ NO _____, If yes, what is your site preference?(check only one)

☐ Blackburn	☐ Catawba	☐ St. Stephens	☐ Lyle Creek	☐ Snow Creek	☐ Startown

NOTE: Accounts are billed based on contracts. If you sign up for Full Day care, you will be billed regardless of attendance.

Are you an employee of Catawba County Schools? YES _____ NO _____

If yes, What is your position? _____ At what school? _____

Are you a classified or certified employee? (please circle one)

==========

Are there custody arrangements that we need to be aware of?

(Custody agreements MUST be given to the Program Coordinator BEFORE the child enrolls.)

YES_____ NO_____ Date Copy received:_____

==========

Child to Enroll:

_____

Name Age Date of Birth Sex

*Other siblings enrolled in QUEST (including other schools): _____

(Separate registration form is required for each child)

Is your child a current student of Catawba County Schools? YES _____ NO _____

If yes, what school does your child currently attend? _____

Parents / Guardians responsible for the child listed above:

_____

(1) Name Relationship to the child Cell Phone #

_____

Address City Zip Code Home Phone #

_____

Parent Email Employer Work Phone #

==========

_____

(2) Name Relationship to the child Cell Phone #

_____

Address City Zip Code Home Phone #

_____

Parent Email Employer Work Phone #

Authorized Pick-Up and Emergency Contacts:

**** If parents cannot be reacher, the facility has permission to contact the people you authorize.***

	Name	Relationship to Child	Phone #	Pick-Up	Emerg.
1.					
2					
3					
4.					

Authorized Pick-Up or Emergency Contact

==========

Do you give permission for photographs of your child to be publicized? Yes _____ No _____

Do you give permission for your child to have access to the internet? Yes _____ No _____

==========

HEALTH CARE NEEDS: For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Please get this form from your QUEST Program Specialist.

==========

List any allergies and the symptoms and type of response required for allergic reactions:

_____

List any health care needs or concerns, symptoms of, and the type of response for these health care needs or concerns:

_____

List any particular fears or unique behavior characteristics the child has:

_____

List any types of medication taken for health care needs:

_____

Share any other information that has a direct bearing on assuring safe medical treatment for your child:

_____

EMERGENCY MEDICAL CARE INFORMATION:

Name of Health Care Professional: _____ Phone: _____

Hospital / /emergency Room Preference: _____ Phone: _____

HEALTH CARE INFORMATION: Health insurance coverage (a family / individual plan or school accident insurance) is required for enrollment in the QUEST program. Catawba County Schools and QUEST programs will not be responsible for expenses related to any accident / incident.

_____

Name of Provider Date:

EMERGENCY MEDICAL RELEASE: If emergency medical care is deemed necessary and I cannot be reached, I hereby authorize QUEST staff to call 911 services if necessary. My child may also leave with the people noted above for medical care.

_____

Signature of Parent / Guardian Date:

FIELD TRIP / PLAYGROUND PERMISSION:

I give permission for my child, _____, to leave the school site to attend field trips and/or aquatic activities arranged by the QUEST Program Coordinator. Students will travel only in approved Catawba County Schools Activity / Yellow Buses. Parents will be notified prior to all field trips. In addition, I give my permission for my child to play on school grounds outside the fenced area when properly supervised by QUEST staff. ** You will be given a calendar of Summer QUEST events / trips **

_____

Signature of Parent / Guardian Date:

PARENT HANDBOOK, NC LAWS & RULES, LATE PAYMENT AND EXPECTATIONS INFORMATION:

I have received, read, and acknowledged the QUEST Parent Handbook including Discipline Policies, Fees and Payment Policies, Late Pick-Up Policies, the NC Child Care Laws and Rules, and the Parent Participation Plan.

_____

Signature of Parent / Guardian Date:

NOTIFICATION OF SMOKING AND TOBACCO RESTRICTION: I understand all forms of smoking and tobacco use and/or products including: vapes, e-cigarettes, pipes, cigarettes, etc. are prohibited on school grounds and QUEST sites.

_____

Signature of Parent / Guardian Date:

DISCIPLINE POLICY AND PROCEDURES:

I have read and understand the Discipline Policy and Procedures for the QUEST Program. Additionally, notice has been given that if any changes are made to these policies and/or procedures - parents will be given a 2-week notice before implementation.

_____

Signature of Parent / Guardian Date:

PAYMENT POLICY:

I have read and understand the QUEST Payment Policy. I will maintain my account paid one full week ahead. I understand my account will be charged for the following legal holidays as listed on the Catawba County Schools calendar - Sept. 4; Nov. 10, 23, 24; Dec. 22; Jan. 1, 15; Mar. 29. I understand if I am contracted for full day care - I will be charged regardless of attendance.

_____

Signature of Parent / Guardian Date:

FOR OFFICE USE ONLY:

Date / Application Received:	
Date / Application Recorded on Enrollment Count Spreadsheet:	
Date / Application Copied and Sent to Full Day Site Coordinator:	
Date / Application / Information Updated/Entered in ProCare:	
Signature of Program Coordinator:	

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Child Development and Early Education

Nutrition Opt Out Form

Child Care Rules .0901(d) and .1706(c) state:

When children bring their own food for meals and snacks to the program, if the food does not meet the nutritional requirements specified in Paragraph (a) of this Rule, the operator must provide the additional food necessary to meet those requirements unless the child's parent or guardian opts out of the supplemental food provided by the operator as set forth in G.S. 110-91(2) h.1. A statement acknowledging the parental decision to opt out of the supplemental food provided by the operator signed by the child's parent or guardian shall be on file at the facility. Opting out means that the operator will not provide any food or drink so long as the child's parent or guardian provides all meals, snacks, and drinks scheduled to be served at the program's designated times. If the child's parent or guardian has opted out but does not provide all food and drink for the child, the program shall provide supplemental food and drink as if the child's parent or guardian had not opted out of the supplemental food program.

I _____ plan to provide all meals, snacks and
(Parent/Guardian Print Name)
drinks for my child and do not want his/her meals, snacks or drinks supplemented to meet the Meal Patterns for Children in Child Care Programs from the United States Department of Agriculture (USDA), which are based on the recommended nutrient intake judged by the National Research Council to be adequate for maintaining good nutrition.

Since I opted out, if I do not provide all the meals, snacks or drinks for my child, I understand that the program will provide supplemental food and drink.

_____ _____
Parent/Guardian Signature Date

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Child Development
and Early Education

Forma de Opción para no Participar en el Programa de Nutrición
Nutrition Opt Out Form

A partir de Julio 1, 2012, hay cambios en el Estatuto General 110-91(2)h.1 para dar alternativas a los padres o guardianes de niños inscritos en servicios de guardería infantil para: (i) proveer comida o bebidas a sus hijos que pueden no cumplir con los estándares de nutrición adoptados por la Comisión de Cuidado Infantil de Carolina del Norte y (ii) no participar en programas suplementarios de alimentos provistos por el servicio de guardería infantil.

A partir de Diciembre 1, 2012, las reglamentaciones de cuidado infantil fueron ratificadas e implementadas a la ley. La Reglamentación de Cuidado Infantil .0901(d) y .1706(c) establecen:

Cuando los niños traen su propia comida y bocadillos (snacks) a el programa, si la comida no cumple con los requerimientos especificados en el Párrafo de esta Reglamentación, el operador de la guardería infantil debe de proporcionar comida adicional para cumplir con estos requerimientos a menos de que el padre o guardián escoja no participar en el programa de comida suplementaria proporcionada por el operador, tal y como se establece en G.S. 110-91(2) h.1. Se debe de archivar (en la guardería infantil) una declaración de conocimiento firmada por el padre o guardián donde se da a conocer que no se desea participar en el programa suplementario de comida. El no participar en el programa suplementario de comida quiere decir que el operador no proporcionará ninguna comida o bebida y por lo tanto el padre o guardián proporcionará todas las comidas, bocadillos (snacks) y bebidas de acuerdo a las horas de alimento designadas en el programa. Si el padre o guardián ha decidido no participar en el programa, pero no proporciona toda la comida o bebida para el niño, el programa proporcionará comida y bebida suplementaria como si en padre o guardián no hubieran optado no participar en el programa suplementario de comida.

Yo _____ planeo proporcionar todas las
(Nombre de Padre/Guardián. Use letra de molde)
Comidas, bocadillos, y bebidas para mi hijo y no deseo que sus comidas, bocadillos o bebidas cumplan con los requerimientos del Programa de Alimentos en Guarderías Infantiles del Departamento de Agricultura de los Estados Unidos (USDA), que está basado en la recomendación para mantener una buena nutrición de acuerdo al Concilio Nacional de Investigación.

Como he decidido no participar en el programa, yo proporcionaré todas las comidas, bocadillos y bebidas para mi hijo (niño). Entiendo que el programa proporcionará comida y bebida suplementaria.

_____ _____
Firma Padre/Guardián Fecha

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

Infant and Child Enrollment Form

INSTITUTION NAME: Catawba County Board of Education FACILITY NAME: QUEST @ AGREEMENT#: 9457

Dear Parent/Guardian,
This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program. Be sure to sign and date in the space below.

The information below must be completed by the parent or guardian.

Infant/Child's First Name	Infant/Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			3:15 pm to 6:00 pm	M T W Th F ~~Sat Sun~~	~~B AM L~~ PM ~~S LPM~~
			3:15 pm to 6:00 pm	M T W Th F ~~Sat Sun~~	~~B AM L~~ PM ~~S LPM~~
			3:15 pm to 6:00 pm	M T W Th F ~~Sat Sun~~	~~B AM L~~ PM ~~S LPM~~
			3:15 pm to 6:00 pm	M T W Th F ~~Sat Sun~~	~~B AM L~~ PM ~~S LPM~~
			3:15 pm to 6:00 pm	M T W Th F ~~Sat Sun~~	~~B AM L~~ PM ~~S LPM~~

Normal/Typical Hours of Care: Write in each infant/child's usual arrival and departure time. Indicate a.m. or p.m.
Normal Days of Care: Circle the days of the week each infant/child is usually in attendance at the facility.
(M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)
Meals Normally Eaten – Circle the meals each infant/child usually eats at the facility.
(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature:____________________ **Date:** ________

Print Name: ____________________

Address: ____________________________

City:____________________State:_____Zip Code: ________

Home Telephone Number: (   )____________Work Telephone Number: (   ) ____________

For Facility/Provider Use Only:
Signature of Facility Representative/Provider:____________________Date: ________
Date each infant/child withdrew:____________________

For State Use Only: Complete:______Incomplete______ Reason:______________ Verified by:__________Date:______

Departamento de Salud y Servicios Humanos de Carolina del Norte
División de Bienestar Infantil y Familiar, Sección de Servicios de Nutrición Comunitaria
Programa de Alimentos para Cuidado de Niños y Adultos

Formulario para Inscripción de Infantes y Niños

CACFP Child & Adult Care Food Program

INSTITUTION NAME: Catawba County Board of Education

FACILITY NAME: QUEST @

AGREEMENT#: 9457

Estimado Padre/Tutor,

Este centro/programa recibe fondos de los Estados Unidos Departamento de Agricultura (USDA) Programa de Alimentos para Niños y Adultos (CACFP). CACFP necesita prueba de inscripción para **todos** los niños. Por favor complete la tabla de abajo para cada niño de su familia que esté inscrito en este centro/programa. Asegúrese de firmar y fechar en el espacio de abajo. Gracias.

La siguiente información debe ser completada por el padre o tutor.

Primer Nombre del Participante	Apellido(s) del Participante	Fecha de Nacimiento	Horario normal/típico de atención	Días normales/típicos de atención (marque todos los que corresponden)	Comidas habituales (Marque todos los que corresponden)
			3:15 pm a 6:00 pm	L M X J V ~~S~~ ~~D~~	~~B~~ ~~AM~~ ~~L~~ PM ~~S~~ ~~LPM~~
			3:15 pm a 6:00 pm	L M X J V ~~S~~ ~~D~~	~~B~~ ~~AM~~ ~~L~~ PM ~~S~~ ~~LPM~~
			3:15 pm a 6:00 pm	L M X J V ~~S~~ ~~D~~	~~B~~ ~~AM~~ ~~L~~ PM ~~S~~ ~~LPM~~
			3:15 pm a 6:00 pm	L M X J V ~~S~~ ~~D~~	~~B~~ ~~AM~~ ~~L~~ PM ~~S~~ ~~LPM~~
			3:15 pm a 6:00 pm	L M X J V ~~S~~ ~~D~~	~~B~~ ~~AM~~ ~~L~~ PM ~~S~~ ~~LPM~~

Horario normal/típico de atención**:** Por favor, escriba la hora habitual de llegada y salida de cada niño. Indique a.m. o p.m. (tarde).

Días normales de cuidado: Por favor, marque con un círculo los días de la semana en que cada niño asiste habitualmente al centro.

(L-Lunes; M-Martes; X- Miércoles; J-Jueves; V-Viernes; S-Sábado; D-Domingo)

Comidas habituales: Marque con un círculo las comida que cada niño habitualmente come en el Centro.

(B-Desayuno; AM-Merienda AM; L-Almuerzo; PM-Merienda PM; S-Cena; LPM-Merienda de noche)

Firma de Padre/Tutor: ______________________ **Fecha:** ____________

Imprima el Nombre: ______________________

Dirección: ______________________

Ciudad: ______________ Estado: ______________ Código Postal: ____________

Teléfono del hogar: **(   )** ______________ Teléfono del trabajo: **(   )** ______________

For Facility/Provider Use Only:
Signature of Facility Representative/Provider: ______________________ Date: ____________
Date each child withdrew: ______________________

For State Use Only: Complete: _______ Incomplete _______ Reason: ______________ Verified by: ____________ Date: __________

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

INFANT AND CHILD INCOME ELIGIBILITY APPLICATION

INSTITUTION NAME: Catawba County Board of Education FACILITY NAME: QUEST @ AGREEMENT#: 9457

1. PARTICIPANT'S NAME & DATE OF BIRTH:

First Name Last Name Date of Birth First Name Last Name Date of Birth

2. SNAP, TANF or FDPIR case number:

SNAP #_____ **TANF#:** _____ **FDPIR #** _____

If you have provided the case number; DO NOT complete #3 and #4. **Skip to complete #5 and #6.**

3. Is this application for a:
Foster Infant/Child? ☐ Yes ☐ No Homeless Infant/Child? ☐ Yes ☐ No Infant/Child from a migrant family? ☐ Yes ☐ No

~~4. HOUSEHOLD MEMBERS MONTHLY INCOME:~~

~~Names of All Other Household Members~~	~~Monthly Wages/ Salaries~~	~~Monthly Social Security~~	~~Monthly Public Assistance / Child Support~~	~~Monthly Retirement/ Pension~~	~~Other Monthly Income~~
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
	$				

5. ETHNIC IDENTITY: (Check one). ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (Check one or more): ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

6. **SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:** I certify that all of the above information is true and correct; that the application is being made in connection with the receipt of federal funds, that Program officials may verify the information on the application; and that deliberate misrepresentation of any of the information on the application may subject me to prosecution under applicable State and Federal criminal statutes.

Signature of Adult Household Member (Required) Date

~~Last Four Digits of Social Security Number (Required only if qualifying by income)~~ ~~Check if no SSN~~ ☐

Printed Name Home Telephone # Work Telephone #

Address City Zip Code

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your infant/child for free or reduced-price meals. You must include the last four digits of the social security number or check the "no SSN" box of the adult household member who signs the application if qualifying by income. The last four digits of the social security number is not required when you apply on behalf of a foster infant/child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your infant/child or other FDPIR identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your infant/child is eligible for free or reduced-price meals and for administration and enforcement of the Program.

To be completed by Institution/Sponsor

TOTAL HOUSEHOLD SIZE _____ TOTAL HOUSEHOLD MONTHLY INCOME $ _____

Approved: ☐ Free ☐ Reduced-Price ☐ Denied

Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other: _____

Withdrew on (Date): _____

For state use only:
Verified by: _____ Date: _____
Verified classification:
☐ Free ☐ Reduced-Price ☐ Denied
Reason for classification change: _____

Signature of Eligibility Official (Individual at the Institution Level) – Required **Date – Required**

Departamento de Salud y Servicios Humanos de Carolina del Norte
División de Bienestar Infantil y Familiar, Sección de Servicios de Nutrición Comunitaria
Programa de Alimentos para Cuidado de Niños y Adultos

APLICACIÓN DE ELEGIBILIDAD DE INGRESOS PARA INFANTE Y NIÑO

INSTITUTION NAME: Catawba County Board of Education FACILITY NAME: QUEST @ AGREEMENT #: 9457

1. Nombre del Participante y Fecha de Nacimiento:

Primer Nombre	Apellido(s)	Fecha de Nacimiento	Primer Nombre	Apellido(s)	Fecha de Nacimiento

2. Número de caso de SNAP, TANF o FDPIR:

SNAP # _____ **TANF #** _____ **FDPIR #** _____

Si ha dado el número de caso, NO complete los números 3 y 4**. Llene sólo los números #5 y #6.**

3. ¿Es éste application para un:
Menor de crianza temporal (*foster*)? ☐ Sí ☐ No ¿Sin hogar? ☐ Sí ☐ No ¿De una familia migrante? ☐ Sí ☐ No

~~4. INGRESO MENSUAL DE LOS MIEMBROS DEL HOGAR:~~

~~Nombres de Todos los Demás Miembros del Hogar~~	~~Sueldos/ Salarios Mensuales~~	~~Seguro Social Mensual~~	~~Asistencia Publica Mensual/ Manutención de Niños~~	~~Pensiones Mensuales de Jubilación~~	~~Otros Ingresos Mensuales~~
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$
		$	$		

5. IDENTIDAD ÉTNICA: (Marque uno) ☐ Hispano o Latino ☐ Ni Hispano o Latino
RAZA: (Marque uno o más) ☐ Blanco ☐ Negro o Afroamericano ☐ Indio Americano o Nativo de Alaska
☐ Asiático ☐ Nativo de Hawai'i o de otras islas del Pacífico

6. **FIRMA Y LOS ÚLTIMOS CUATRO DIGITOS DE NÚMERO DE SEGURO SOCIAL:** Certifico que toda la información anterior es verdadera y correcta; que la aplicación se realiza en relación con la recepción de fondos federales, que los funcionarios del Programa pueden verificar la información en la aplicación; Y esa tergiversación deliberada de cualquier información en la aplicación puede someterme a procesamiento bajo leyes penales Estatales y Federales aplicables.

Firma del Miembro Adulto del Hogar (Requerido)	Fecha	~~Últimos Cuatro Dígitos del Número de Seguro Social (Requerido solo si califica por ingresos)~~ ~~Marque si no tiene SSN~~ ☐

Nombre Impreso

Teléfono del hogar

Teléfono del trabajo

Dirección

Ciudad

Código Postal

La Ley Nacional de Almuerzo Escolar Richard B. Russell requiere la información en esta aplicación. Usted no tiene que dar la información, pero si no lo hace, no podemos aprobar a su infante/niño para comidas gratis o a precio reducido. Usted debe incluir los últimos cuatro dígitos del número de seguro social o marcar la casilla "NO SSN" del miembro adulto del hogar que firma la aplicación si califica por ingreso. Los últimos cuatro dígitos del número de seguro social no son requeridos cuando usted aplica en nombre de un infante/niño de crianza temporal o usted lista un Programa de Asistencia de Nutrición Suplementaria (SNAP), Programa de Asistencia Temporal para Familias Necesitadas (TANF), o Programa de Distribución de Alimentos en Reservaciones Indígenas (FDPIR) número de caso para su infante/niño u otro identificador FDPIR, o cuando usted indica que el miembro adulto del hogar que firma la solicitud no tiene un número de seguro social. Utilizaremos su información para determinar si su infante/niño es elegible para recibir comidas gratuitas o a precio reducido y para la administración y cumplimiento del Programa.

To be completed by Institution/Sponsor

TOTAL HOUSEHOLD SIZE _____ TOTAL HOUSEHOLD MONTHLY INCOME $ _____

Approved: ☐ Free ☐ Reduced-Price ☐ Denied

Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other: _____

Withdrew on (Date): _____

For state use only:
Verified by: _____ Date: _____
Verified classification:
☐Free ☐Reduced-Price ☐Denied
Reason for classification change: _____

Signature of Eligibility Official (Individual at the Institution Level) – Required **Date – Required**

North Carolina Department of Health & Human Services
Division of Child & Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

Medical Statement for Meal Modification

Institution Name: _____ **Agreement Number:** _____

This document does not apply to meal modifications made for dietary preferences or religious reasons.

The information collected below is required for CACFP participants with medical conditions (i.e., physical or mental impairments) requiring meal modifications. Reasonable modifications *must* be made to accommodate children and adults with medical conditions (e.g., diabetes, lactose intolerance, food allergy, etc.) restricting their diet. **Meals that do not meet CACFP meal pattern requirements must be supported by this medical statement or comparable documentation signed by a North Carolina (NC) licensed healthcare professional authorized to write prescriptions under state law.**

Child/Adult Participant Information

Name: _____ DOB: _____

Parent/Guardian Name (if applicable): _____

CACFP Facility Information

Facility Name: _____ Facility Phone: _____

Facility Representative Name: _____ Facility Address: _____

To be completed by licensed healthcare professional

Describe the Physical or Mental Impairment Restricting the Diet:

Examples: Sara is allergic to cow's milk and soy milk; Ben does not tolerate strawberries and they cause hives, itchy skin, gastrointestinal distress and diarrhea; Julian has a food allergy and cannot drink cow's milk.

Beverages and/or Foods to Omit:	Beverages and/or Foods to be Substituted:

Other Special Dietary Needs or Modifications Needed

Textural modification, caloric modification, adaptive equipment or other modifications (describe, if applicable):

Authorized Signature

_____ _____

Name of Licensed Healthcare Professional **Title**

_____ _____

Signature **Date**

Reference: CACFP 17-09(a) Modifications to Accommodate Disabilities in the CACFP

This institution is an equal opportunity provider.
Medical statements are confidential and are securely maintained.

Catawba County Schools QUEST Program -

DSS Contract Acknowledgement Form

Note: Families with DSS vouchers are responsible for the Full Day costs if your child is absent on the Full Days.

(DSS will cover the cost when your child attends Full

Days, but not when a child is absent.)

If you are contracted for Teacher Works Days and Annual Leave and your child does not attend QUEST your account will be charged for the Full Day cost $26.00 per Full Day.

List of Teacher Work Days and Annual Leave Days

September 22

October 20

November 9, 22

December 22

January 2, 3, 4, 5, 26

February 16, 19

March 14, 15

April 1, 2, 3, 4, 5

Parent Signature: _____

Date: _____

PC Signature: _____

Programa QUEST Escuelas del Condado de Catawba

Formulario de Admisión de Contrato del DSS

Nota: Las familias con cupones de DSS son responsables de los costos del día completo si su hijo está ausente durante los días completos.

(DSS cubrirá el costo cuando su hijo asista el día entero, pero no cuando el niño esté ausente).

Si se le contrata para trabajar en los Teacher Works Days -Días de Trabajo para Maestros y Annual Leave- Días de Ausencia y su hijo no asiste a QUEST, se le cobrará a su cuenta el costo del Día Completo $ 24.00 por Día Completo.

Lista de los Días de Trabajo de Maestros y Días de Ausencia

22 de septiembre

20 de octubre

9, 22 de noviembre

22 de diciembre

2, 3, 4, 5, 26 de enero

16, 19 de febrero

14, 15 de marzo

1, 2, 3, 4, 5 de abril

Firma del padre: _____

Fecha: _____

Firma PC: _____

Fecha: _____

QUEST
Catawba County Schools
Safe Pick - Up / Delivery Procedures

==========

- ➢ **Safe Arrival / Delivery of children is very important.**
- ➢ **Children MUST be escorted inside the QUEST entrance by a parent or guardian.**
- ➢ **Parents / guardians are required to sign students in/out. Both time and parent initials are required.**
- ➢ **At NO time should children be left unattended.**
- ➢ **At NO time should a student exit the building without a parent or guardian.**
- ➢ **Failure to comply with these requirements will result in your child being suspended / or unenrolled from the QUEST program.**

I, _____, parent of

(parent name)

_____ have read and understand the

(student name)

QUEST Pick-up / Drop-off Policy. I agree to follow the policy as stated above.

_____ / _____

Signature: **Date**

QUEST Payment Policy

Revised June, 2023

QUEST is establishing an updated Payment Policy. The following guidelines are now REQUIREMENTS:

- **Payment of registration fee and first two (2) weeks tuition are due at the time of enrollment. Your child's slot is not secure without this payment.**
- ALL accounts MUST maintain payment a full week ahead.
- For example, payment for the weeks of August 28 and September 4 are DUE at the time of enrollment. Payment for the week of September 11 is DUE September 1. Payment for the week of September 18 is DUE September 8, etc.
- If your account gets behind, your CONTRACT will be SUSPENDED and your child CANNOT attend any future days until the account is paid in full.
- Payments can be made online at tuitionexpress.com - your program coordinator can assist you in setting up your online payment account or you can call 828 466-7047 for assistance
- Money Orders, Cashiers Checks, and Credit/Debit Cards are also accepted, however, we prefer you pay using the online payment center.
- NOTE: Weekly contracted accounts will be charged for 11 legal holidays, as indicated on the Catawba County Schools Calendar.
- NOTE: Full Day contracted accounts will be charged for Full Day care attendance regardless of actual "prior sign-up or attendance".

Parent Signature required:

I have read and understand the above stated payment / account requirements. I understand that if my child's account fails to comply with the above requirements - the account will be suspended and my child cannot attend until the account is paid in full and paid one full week ahead.

Parent Name (print): _____ **Date:** _____

Parent Signature: _____

Student Name: _____ **QUEST Site:** _____

QUEST Payment Policy

Revised June, 2023

Parent Payment Schedule School Year - 2023-2024

To complete a child's enrollment in the QUEST program for the 2023-2024 School year, **the Registration Fee plus two (2) weeks of tuition are due along with the completed Enrollment Forms.**

Example of Fees:

Before School Tuition Cost: $35.00 weekly

- $30.00 registration fee
- $35.00 for current week of care
- $35.00 for week in advance
- Total DUE to enroll: $100.00
- *weekly payments start the first Friday enrolled

After School Tuition Cost: $50.00 weekly

- $30.00 registration fee
- $50.00 for current week of care
- $50.00 for week in advance
- Total DUE to enroll: $130.00
- *weekly payments start the first Friday enrolled

Before / After School Tuition Cost: $85.00

- $30.00 registration fee
- $85.00 for current week of care
- $85.00 for week in advance
- Total DUE to enroll: $200.00
- *weekly payments start the first Friday enrolled

(Detailed payment calendars can be obtained from your site Program Coordinator)