A Place for Kids
Early Childhood Academy

Date Child Enter Care	Date Child Left Care

Child's name Last	First	Middle	Other name used	Birthdate

Street address	City	Zip code

Child's parent/guardian's name	Home phone with area code	Work phone with area code

Email address

Parent/guardian's street address (if different from above)	City	Zip code
Work address (or where you can be reached while child is in care)	**City**	**Zip code**

Child's parent/guardian's name	Home phone with area code	Work phone with area code

Email address

Parent/guardian's street address (if different from above)	City	Zip code
Work address (or where you can be reached while child is in care)	**City**	**Zip code**

Other people to notify in case of emergency

Name	Relationship	Address	Phone number
			Work:
			Home:
			Work:
			Home:
			Work:
			Home:
			Work:
			Home:

Other than you, who has permission to pick up your child?

Name	Relationship	Address	Phone number
			Work:
			Home:
			Work:
			Home:
			Work:
			Home:

Who does NOT have permission to pick up your child?

Name	Reason

Child's health information		
Date of child's last physical examination	Child's health care provider's name	Phone number with area code
Street address	City	Zip code

Special health problems:	Allergies, including drug reactions:
Regular medications:	Other pertinent data:

Child's dentist's name	Phone number with area code

Street address	City	Zip code

Child's medical insurance coverage	
Insurance company's name	Member/Policy number
Policy holder's name	Employer's name
Insurance company's name	Member/Policy number
Policy holder's name	Employer's name

Consent to medical and treatment of minor children

I hereby give permission that my child, ______________________________, May be given emergency treatment by a qualified child care provider at

A Place for Kids Early Childhood Academy .

Name and/or address

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Parent/Guardian's Signature	Date	Parent/Guardian's Signature	Date

Street Address	City	Zip code	Phone number with area code

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (MM/DD/YY):	**Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.	I certify that the information provided on this form is correct and verifiable.
Parent/Guardian Signature Required **Date**	**Parent/Guardian Signature Required** **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP / DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV / MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	________
Hepatitis B	Rubella	________
Hib	Tetanus	
Measles	Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guides below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade names in alphabetical order

https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/us-vaccines.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

A Place for Kids Childcare
Oral Health Non-Participation Form

Washington State WAC 110-300-0180 requires that licensed childcare providers offer tooth-brushing activities to children each day. This brushing is not intended to replace home brushing in the morning or evening, rather it is an additional brushing. Parents may choose that their child/ren not participate in tooth brushing while present at A Place for Kids. Our goal will be to include developmentally appropriate daily oral health activities in a variety of forms: read books, sing songs, and discuss healthy eating habits to promote awareness of dental health.
As the parent/guardian, you can opt in or opt out of tooth brushing. Please complete the applicable section on this form and let us know if you have any questions or comments.
If you "Opt-Out", tooth brushing activities will occur at home.
If you "Opt-In" A Place for Kids requires the following: A single use disposable toothbrush and a single use disposable cup must be brought in each day as there will be no storage of toothbrushes on site, and all used tooth brushes will be disposed of immediately. The tooth brushing will only be performed upon arrival at the center, with the parent/guardian present, near a designated waste receptacle. The cup (for spitting) and toothbrush will be disposed immediately following tooth brushing, to prevent cross contamination. Activity will occur without use of toothpaste.
A separate form must be filled out for each child. This form will be kept in your child's file. Should you change your mind you may fill this form out again.

I do not wish to have my child participate in tooth brushing while in care at

I wish to have my child participate in tooth brushing while in care at

A Place for Kids Childcare Center.

Child's Name: ____

Parent/Guardian's Name: ____________________________________

Signature: ______________________________Date:______________

Parent Acknowledgements:

Upon enrollment of my child/children at A Place For Kids Early Childhood Academy, the following center operating policy and procedures were discussed with me:

√ Disaster Plan
√ Fire Drill/ Earthquake Records
√ Health Policy
√ Center Policy & Procedures
√ Use of pesticides
√ Location of licensing information
√ Educational Programs Offered
√ Facility Layout
* Including where information is posted

Parent Initials____________

Date ________________

Upon enrollment of my child/children at A Place For Kids Early Childhood Academy, I received written information for the following center policies and operational procedures contained in the parent handbook.

√ Enrollment and Admission Requirements
√ Tuition Rates and Payment Procedures
√ Sample Daily Schedule
√ Center Operating Hours including School Closures
√ Sample Menu *including the policy on food brought from home
√ Open Door Policy (Free Access)
√ Sign In and Out Procedures
√ Child Abuse Reporting Requirements
√ Behavior Management Philosophy
√ Nondiscrimination Statement
√ Policy on Religious and Cultural Activities
√ Transportation and Field Trips
√ Sick Child Procedures
√ Medication Policies and Practices
√ Diapering
√ Toilet Learning
√ Infant Feeding Practices

Parent Initials____________

Date ________________

I have received, read, understand, and agree to adhere to the policies contained in the A Place For Kids Early Childhood Academy parent handbook.

Parent/Guardian Signature ____ Date ____________________________

Administration Signature ____ Date ____________________________

CHILD CARE AGREEMENT

Child's		
First name	**Middle name**	**Last name**
Parent or Guardian's name:		
First name	**Middle name**	**Last name**

Days and times my child will receive care:					
Check day(s) of care	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday
Arrival time					
Departure time					

Fee: $_________________per:	☐ Hour ☐ Day ☐ Week ☐ Month	Date payment due: Source of payment: ☐ Parent ☐ Other
Overtime Rate: $	Per	Late Fee: $ Per

I agree to promptly notify the child care provider of any changes of the above information. I understand that I am fully responsible for the terms of this agreement as stipulated.

I have read, understand, and agree to comply with the policy and procedures, information for parents given to me by

A Place for Kids Early Childhood Academy.

NAME OF PROVIDER

Parent or Guardian's Signature	Date	Parent or Guardian's Signature	Date

I agree to provide child care services according to the above plan, I agree to promptly notify the parent(s) or guardian(s) of any changes to the above information.

PROVIDER'S SIGNATURE **A Place For Kids**	**DATE**		
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**
919 NE 185TH ST.	**SHORELINE**	**WA**	**98155**

COMMENTS

1. What are your long range expectations for your child? ____

____

____

2. What would you like your child to get out of the Early Childhood program? __________________________

____

____

3. What would you as a parent like to get out of this program? ______________________________________

____

____

4. Describe a typical day activities for your child. ____

____

____

5. List the kind of things your child likes to do. ____

____

____

6. List those things your child does not like to do. ____

____

____

7. What celebrations are important to your family? ____

____

____

8. Other Comments. ____

____

____

____

A Place For Kids Early Childhood Academy

PHOTO PERMISSION

(Optional)

Full permission and authority is hereby granted to A Place for Kids Early Childhood Academy for my child's photo to be used for internal and external publicity. I understand this includes both print and electronic publishing including the Internet. Photographs and information which may be used for educational, public relations and other publication purposes related to A Place for Kids Childcare. Please note that any images of your child will not be accompanied by your child's name, address or phone number that may be used to identify your child.

Child's Name ____

Parent/Guardian Signature: _____________________________________

____

Street Address City State Zip Code

Phone: _______________________________ Date: _________________

A Place For Kids

DSHS AGREEMENT FORM

The Child Care Subsidy Programs (CCSP) ONLY

As a participant in the DSHS childcare program, I understand the following conditions are placed on my child's enrollment at

A Place for Kids:

1. I am responsible to know the status of my contract with DSHS. Any questions should be directed to my caseworker.
2. I am responsible for all co-payments as stipulated by DSHS. Failure to pay the current months co-pay by the 5th of the month may result in loss of childcare and late fees as outlined in the parent handbook. If you have any questions about your co-pay, please contact your caseworker.
3. A Place For Kids is only paid for the days my child attends. If my child is absent for more than 5 days per month, my childcare may be terminated. (Note: If extenuating circumstances exist, please contact the Director immediately.)
4. If DSHS terminates my benefits, I become responsible for the tuition at the current rate for my child's usage.

Child (ren)'s Name: ____

Parent/Guardian's Signature: ____

Date ___________________________ Case # __________________________________

Child and Adult Care Food Program

Dear Parents/Guardians:

Providing child care and early childhood programs at rates that parents can afford is a growing challenge and requires taking advantage of all available funding resources. One of these resources is the cash reimbursement program for meals and/or snacks from the United States Department of Agriculture (USDA) and the Office of Superintendent of Public Instruction (OSPI). This benefits you because it helps us keep the charge for childcare at a lower rate.

We can keep our fee schedule low and provide excellent food service for children; we need the information requested on the income eligibility application. Please complete, sign, and return this application today or as soon as possible. This information will be kept strictly confidential. Your cooperation is appreciated.

It is required by the USDA food program that all children who require an alternate diet due to allergies or food preference must have a doctor's note.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Please fill out the attached Enrollment/Income-Eligibility Application. If you have any questions or need any assistance, please don't hesitate to ask.

Sincerely,

Barbara Sun

Executive Director

Child and Adult Care Food Program
ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD/TANF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the SSN is not needed.

"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 CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	Today's Date	Print Name of Adult Signing
X______________________________________	__________________	**Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN
Address	**City/State/Zip Code**	**Daytime Phone**

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

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 receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Multi-Racial
☐ Native Hawaiian or Pacific Islander ☐ White

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, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Basic Food, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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

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

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on Basic Food/TANF/FDPIR.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free
☐ Reduced-Price
☐ Above-Scale

Total Income: $____________________
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X____ ____________________________
Signature of Institution's Representative **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.

EIEA Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the EIEA within these guidelines, the institution representative's signature date must be used as the effective date.