



Authorization to Screen, Obtain, and Release Information

2899 Highway 47 • Lac du Flambeau • WI 54538 • 715-588-9291 Fax 715-588-9576

Name of Child _____ Date of Birth ____/____/____

HIPPA – Compliant authorization to screen, obtain, exchange, or release health, education information and/or use of child's photograph/video for ZHS activities:

Zaasijiwan Head Start 0 to 5 Program PO Box 67, Lac du Flambeau, WI 54538

- Health/Oral Health Screening and Results Other _____
- Mental Health and Developmental Screening and Results
- Blood/Lab Screening and Results

Peter Christensen Health Center PO Box 67, Lac du Flambeau, WI 54538

- Health Records and Examination Results Referral follow-up
- All Screening/Rescreening and Results Other _____

Peter Christensen Dental Clinic PO Box 128, Lac du Flambeau, WI 54538

- Dental Screening and Results Referral/follow-up
- Dental Examination/Treatment and Results Other _____

Marshfield Clinic – Minocqua Center and FHC 9601 Towline Road, Minocqua, WI 54548

- Health Records and Examination Results All Screening/Rescreening and Results
- Immunization records Other _____
- Referral follow-up

Human Service Center 705 E Timber Drive, Rhinelander, WI 54501

- Developmental screening and results Referral follow-up
- Individual Family Service Plans (IFSP) Other _____

Lac du Flambeau Public School 2899 Highway 47, Lac du Flambeau, WI 54538

- All official student records and reports All Health Records and Screening Results
- Individualized education plans (IEP) and related reports Other _____

Family Resource Center PO Box 67, Lac du Flambeau, WI 54538

- Psychological observation reports Behavioral observations
- Referral follow-up Other _____

GLITC PO Box 9, Lac du Flambeau, WI 54538

- Permission to share family information for referral of services.

Family Services PO Box 67, Lac du Flambeau, WI 54538

- Guardianship/Custodial/Placement Documents Other _____
- Referral follow-up

Parental / Guardian Authorization/Permission

This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. This authorization also gives permission for ZHS and community care partners to perform required screenings and observations of participants. I recognize that these records, once received by the agency, may not be protected by the HIPPA Privacy Act and may become educational records protected by the Family Educational Rights and Privacy Act-FERPA with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to participate in this program. I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the information I have authorized to be used or disclosed by this authorization form. Arrangements to inspect this information can be made by contacting the Zaasijiwan Head Start-ZHS Director.

_____/_____/_____
Signature of Parent or Guardian **Date**

(Fax or photocopy effective as original)(Copies to parent/guardian, physician or other health care provider releasing the protected health information, school official requesting/receiving the protected health information, student SpEd file. Information also to be used to maintain health status record for participants in a Federal program.)

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within 30 school days (6 calendar weeks) of admission to the child care center. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (✓) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

Yes year _____ (Vaccine is not required)

No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

Physician's Signature Required

For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge, this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian

Date Signed



PETER CHRISTENSEN DENTAL CLINIC

128 Old Abe Rd Lac du Flambeau, WI 54538 (715)588-4269

PCDC Fluoride Varnish and Field Trip Permission Slip

Dear Parent/Guardian,

The Peter Christensen Dental Clinic is offering preventative dental programs for the Zaasijiwan Head start. These programs are not meant to be a substitution of regular dental visits.

Fluoride Varnish Program (monthly at Head Start):

- Oral health education and tooth brushing supplies
- Oral health assessment by a licensed dental professional (dental hygienist or dentist)
- Fluoride Varnish application

***Notification of visitation to the PCDC dental campus will be announced when scheduled.**

- Oral health education and tooth brushing supplies
- Oral health assessment by a licensed dental professional (dental hygienist or dentist)
- Dental cleaning
- Dental exam
- Fluoride

If you elect to have your child participate in these programs, you will receive a letter describing your child's dental health status and what was completed. All procedures will follow recommendations from the American Dental Association and Centers for Disease Control and Prevention for school-based dental prevention programs.

Benefits: Fluoride varnish has a sticky consistency which helps adhere to tooth and allows fluoride to stay in contact with the tooth for several hours.

Fluoride helps with remineralization of hypocalcified areas that are susceptible to decay and/or cavities.

If you are interested in your child participating, please sign and return the permission slip



PETER CHRISTENSEN DENTAL CLINIC

128 Old Abe Rd Lac du Flambeau, WI 54538 (715)588-4269

PCDC Fluoride Varnish and Field Trip Permission Slip

YES! I give permission for my child to participate in both programs

NO. I do not want my child to participate.

(optional) Reason for declining? _____

Child's Last Name: _____ First: _____ DOB: _____

Teacher: _____ Grade: _____

Parent/Guardian Name: _____ DOB: _____

Responsible Party's Mailing Address: _____

Phone Number: _____ Email: _____

Your insurance will only be billed if applicable but no child will be refused services based on their insurance coverage.

What type of DENTAL insurance does your child have? Forward Health/Medicaid/BadgerCare Private Insurance (i.e. Delta, Cigna) No Insurance Other _____

Is your child a member of a Federally Recognized Tribe? YES or NO What tribe? _____
If Enrolled-Tribal Enrollment #: _____ If 1st Descendant: _____

Please answer the following questions about your child. Does your child:	
1. Take medicine prescribed by a doctor? Y/N If yes, what kind? _____	
What are these medications taken for? _____	
2. Any ongoing significant medical conditions that your child is being treated for? _____	Y/N
If yes what conditions? _____	
3. Have any allergies (i.e. medications, food, latex) _____	Y/N
4. Has your child ever been seen by a dentist?	
<input type="checkbox"/> Yes, within one year	<input type="checkbox"/> Yes, over one year ago
	<input type="checkbox"/> Never
5. Have a primary dental provider? Please list: _____	

PLEASE RETURN TO THE HEADSTART'S FRONT OFFICE

PRINTED PARENT/GUARDIAN NAME SIGNATURE DATE

Zaasijiwan Head Start 0-5

Nutrition Assessment

Name:

Date:

What types of fluids does your child usually drink?

Whole Milk 2% Milk 1% Milk Juice

Water Soft Drinks Other :

	Yes	No	Comments
Do you have concerns about your child eating habits?			
Does your child have a good appetite?			
Does your child enjoy meal time?			
Are you concerned about your child's weight?			
Have there been any changes in your child's appetite in the last month?			
Does your child take vitamin supplements?			
Does your child have trouble chewing or swallowing?			
Does your child eat or chew anything that isn't food?			
Does your child have any food allergies?			
Is your child on a special diet?			
Does your child often have diarrhea or constipation?			
Does your child still drink from a bottle?			

What are your child's favorite foods?

What are their least favorite foods?

How often does your child eat the following?

	Never or Rarely	Once A Week	Several Times A Week	Once A Day	Two or More Times A Day
Dairy (cheese, yogurt, milk)					
Meats (beef, chicken, fish, pork, etc.)					
Other Protein (dried beans, eggs, peanut butter, tofu)					
Grains (bread, rice pasta, cereal, tortillas; etc.)					
Fruits (bananas, oranges, apples, berries, etc.)					
Vegetables (corn, green beans, peas, carrots, etc.)					
Sweets (cake, cookies, candy, soda, etc.)					
Fats (butter, margarine, mayo, etc.)					

Parent's signature:

Date:



Privacy, Parental Rights, and Sharing of Directory Information

Zaasijiwan Head Start, with certain exceptions, will obtain your written consent prior to the disclosure of personally identifiable information (PII) from your child's records. As a parent/guardian, you have the right to request information from your child's records as well as the right to obtain copies of your child's records and information on certain disclosures. Please be advised that disclosure without parental consent may occur in situations where officials at a program, school, or school district in which the child seeks or intends to enroll or where the child is already enrolled so long as the disclosure is related to the child's enrollment or transfer in which case you will be notified and presented with the opportunity to refuse. Disclosure without consent may also occur in situations where the program is working with officials within the program or acting for the program, such as contractors, and officials from state, federal, or other entities if the officials are providing services for which the program would otherwise use employees, requesting information in connection with an audit, evaluation, or to conduct studies intended to improve outcomes. Additional disclosures without consent may occur to address a disaster, health or safety emergency, or a serious health and safety risk such as a serious food allergy, if the program determines that the disclosure is necessary to protect the health or safety of children or other persons or to address court orders and/or cases in which child maltreatment/abuse/neglect or child welfare is a concern.

Although, Zaasijiwan Head Start adheres to policies and procedures governing the dissemination and disclosure of personally identifiable information (PII), the program may disclose appropriately designated "directory information" without written consent, unless you have advised the program to the contrary. The primary purpose of directory information is to allow Zaasijiwan Head Start to include information from your child's education records in certain school publications and notices. Examples include:

- **Photos showing your child participating in program activities;**
- **Program publications;**
- **Attendance or other recognition lists;**
- **Graduation programs; and**
- **Social media pages**

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent.

If you do not want Zaasijiwan Head Start to disclose any or all of the types of information designated below as directory information from your child's education records without your prior written consent, you must notify the program in writing by September 30, 2019 or within 30 days of your child's enrollment into the program. You may also opt-out by Zaasijiwan Head Start has designated the following information as directory information:

- **Student and/or Parent/Guardian name**
- **Photograph**
- **Date of birth**
- **Dates of attendance**
- **Grade level**
- **Participation in activities**
- **Honors and/or awards received**

I, _____, have received information on Zaasijiwan Head Start's procedural approach to privacy, parent rights, and directory information. I am choosing to opt out of sharing the following directory information with regard to my child(ren): _____.

- Student and/or Parent/Guardian name
- Photograph
- Date of birth
- Dates of attendance
- Grade level
- Participation in activities
- Honors and/or awards received

Parent/Guardian Signature

_____/_____/_____
Date

Medication Consent Form
Zaasijwan Head Start 0 to 5

(For prescription and non-prescription medications)

Name of child: _____ Date of birth: _____

Name of parent / guardian: _____

Child's home address: _____

Name of Physician prescribing this medication: _____

Physician's phone #: _____

Name of medication & dosage:

Time(s) this med is to be given:

For how long: _____

The reason for this medication is:

I give my permission to the Head Start Health Service staff, or designee, to give the medication(s) to my child according to the directions written above and authorize them to contact the child's physician. I agree to hold the Head Start program and its employees who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication.

I agree to notify the Head Start program staff in writing when any change in the above order is necessary.

Signature of Parent / Guardian

Date



Zaasijiwan Head Start

Blanket Special Event and Field Trip Authorization

During the school year, your child's class may participate in special events such as family socials and field trips. Please fill out the authorization below so that your child can participate. This form will be kept on file for the duration of the school year.

Name of Special Event/Field Trip: Lac du Flambeau Zaasijiwan Head Start

Destination of Field Trip: School Year 2020-2021

Child's First and Last Name: _____

Child's Classroom Name: _____

Home Address: _____

Parent/Guardian Name: _____

Daytime Contact Number: _____

Emergency Contact Name: _____

Daytime Contact Number: _____

I, _____, the parent of _____, ("my child"), give permission for my child to attend family socials, field trips, and other special events sponsored by the Zaasijiwan Head Start program. In signing this agreement, I understand that I will be notified of planned events in advance and that I assume any risk associated with the activity. Should it be necessary for my child to receive medical treatment while participating in this activity/field trip, I give my permission for Zaasijiwan Head Start personnel to use their judgment to obtain medical services for my child and for the physician selected by Zaasijiwan Head Start personnel to render any medical treatment deemed necessary.

Parent/Guardian Signature

Date

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI) _____ Address - Home (Street, City, State, Zip Code) _____
 Telephone Number _____ Birthdate (mm/dd/yyyy) _____ Date - First Day of Attendance (mm/dd/yyyy) _____

PARENT / GUARDIAN INFORMATION

Name _____ Provide information where the parent(s) / guardian(s) may be reached while the child is in care.
 Telephone Number - Home _____ Telephone Number - Work _____ Telephone Number - Cellular _____
 Telephone Number - Home _____ Telephone Number - Work _____ Telephone Number - Cellular _____

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name - Physician _____ Address - Medical Facility _____ Telephone Number _____

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(2), authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(2) a., Authorizations shall be reviewed periodically and updated as necessary.

Yes No I authorize the center to apply sunscreen to my child. Brand Name _____ Ingredient Strength _____
 Yes No I authorize the center to allow my child to self-apply sunscreen. Brand Name _____ Ingredient Strength _____
 Yes No I authorize the center to apply repellent to my child. Brand Name _____ Ingredient Strength _____
 Yes No I authorize the center to allow my child to self-apply repellent. Brand Name _____ Ingredient Strength _____

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

- Check any special medical condition that your child may have:
 - No specific medical condition
 - Asthma
 - Cerebral palsy / motor disorder
 - Other condition(s) requiring special care - Specify. _____
 - Diabetes
 - Epilepsy / seizure disorder
 - Gastrointestinal or feeding concerns including special diet and supplements
 - Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
- Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
- Food allergies - Specify food(s). _____
- Non-food allergies - Specify. _____

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

- a.
- b.
- c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates:



CACFP ENROLLMENT FORM

Parent/Guardian Instructions:

This form can be used for up to three children per household. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. This form can be used for three years for the same child(ren), to meet the annual updating requirements.

Child Care Name:

Lac du Flambeau Zaasijiwan Head Start

HOURS AND MEALS WHILE IN CARE											
Child's Name:	Days Normally in Care (Check ✓)	From		To		Meals Normally Received While in Care (Check ✓)					
		From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Monday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Tuesday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of Birth:	<input checked="" type="checkbox"/> Wednesday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Thursday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Information (Year One):			Additional Information (Year Two):				Additional Information (Year Three):				

HOURS AND MEALS WHILE IN CARE											
Child's Name:	Days Normally in Care (Check ✓)	From		To		Meals Normally Received While in Care (Check ✓)					
		From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Monday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Tuesday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of Birth:	<input checked="" type="checkbox"/> Wednesday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Thursday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Information (Year One):			Additional Information (Year Two):				Additional Information (Year Three):				

HOURS AND MEALS WHILE IN CARE											
Child's Name:	Days Normally in Care (Check ✓)	From		To		Meals Normally Received While in Care (Check ✓)					
		From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	<input type="checkbox"/> Sunday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Monday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Tuesday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of Birth:	<input checked="" type="checkbox"/> Wednesday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/> Thursday	8:00 am	3:30 pm			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Friday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Saturday					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Information (Year One):			Additional Information (Year Two):				Additional Information (Year Three):				

PARENT/GUARDIAN SIGNATURE					
Parent/Guardian Signature (Year One):	Date Mo./Day/Yr.	Parent/Guardian Initials (Year Two):	Date Mo./Day/Yr.	Parent/Guardian Initials (Year Three):	Date Mo./Day/Yr.



Wisconsin WIC Program

Information & Income Eligibility Guidelines

Purpose:

The purpose of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is to promote and maintain the health and well-being of nutritionally at-risk pregnant, breastfeeding and postpartum women, infants and children. WIC provides nutrition education, breastfeeding education and support, supplemental nutritious foods, and referrals to other health and nutrition services.

- Health benefits of WIC have reduced premature births, low birthweight, and long-term medical expenses.

Who is Eligible for WIC?

To be eligible for WIC benefits in Wisconsin, a person must meet the following requirements:

- Be a pregnant, breastfeeding, or new mother; be an infant up to age one; or a child up to age 5;
- Be a resident of Wisconsin;
- Be income eligible (*income eligibility guidelines are on the next page*); and
- Have a health or nutrition need

Benefits Received by WIC Participants

All participants receive:

- Screening for nutrition and health needs
- Information on how to use WIC foods to improve health
- Benefits to buy foods that help keep you and your children healthy and strong
- Referrals to doctors, dentists, and programs like Wisconsin FoodShare, Medicaid, BadgerCare Plus, Wisconsin Works (W-2), and Head Start

Women receive:

- WIC approved foods (<https://www.dhs.wisconsin.gov/wic/approved-foods.htm>)
- Information on healthy eating during pregnancy and breastfeeding
- Help with starting or continuing breastfeeding

Infants receive:

- Help with starting or continuing breastfeeding
- Infant foods (<https://www.dhs.wisconsin.gov/wic/infant-foods.htm>)
- Infant formula, if needed
- Immunization referrals

Parents/caretakers receive information on taking care of babies

Children:

- WIC approved foods (<https://www.dhs.wisconsin.gov/wic/approved-foods.htm>)
- Immunization referrals

Parents/caregivers receive information on food shopping, recipes, and feeding your child

➤ To apply for WIC, go to Nutrition & WIC Area Contacts: <https://www.dhs.wisconsin.gov/wic/contacts.htm>

➤ For other health programs and referral services, contact the Well Badger Resource Center at:
1-800-642-7837 OR <https://wellbadger.org/>

Wisconsin WIC Program - Income Eligibility Table

The income levels are based on 185% of the US Dept. of Health and Human Services Nonfarm Income Poverty Guidelines for Gross Income (*before deductions*). Applicants exceeding 185% are not eligible.

July 1, 2020 – June 30, 2021

Family Size	Income Levels				
	Weekly \$	Every Two Weeks \$	Twice Per Month \$	Monthly \$	Annual \$
ONE	454	908	984	1,968	23,606
TWO	614	1,227	1,329	2,658	31,894
THREE	773	1,546	1,675	3,349	40,182
FOUR	933	1,865	2,020	4,040	48,470
FIVE	1,092	2,183	2,365	4,730	56,758
SIX	1,251	2,502	2,711	5,421	65,046
SEVEN	1,411	2,821	3,056	6,112	73,334
EIGHT	1,570	3,140	3,401	6,802	81,622
ADDITIONAL	160	319	346	691	8,288

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- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov
- This institution is an equal opportunity provider.

Good nutrition today means a stronger tomorrow!

Building for the Future

with CACFP

This program receives support from the Child and Adult Care Food Program to serve healthy meals to your children.



Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

Participating Agency Contact Information	State Agency Contact Information
<i>Contact Person</i> Tari Wolfe	Amanda Cullen, RDN, CD, Director
<i>Agency Name</i> Lac du Flambeau Zaasijiwan Head Start	Community Nutrition Programs
<i>Agency Address</i> P.O. Box 67, 2899 Hwy. 47.S. Lac du Flambeau, WI 54538	Wisconsin Department of Public Instruction
	P.O. Box 7841 Madison, WI 53707-7841
<i>Agency phone number</i> 715-588-9291	608-267-9129

Learn more about CACFP at USDA's website:

<https://www.fns.usda.gov/cacfp/child-and-adult-care-food-program>

USDA is an equal opportunity provider, employer and lender.

United States Department of Agriculture

Food and Nutrition Service FNS-317

November 2019

¡Buena nutrición hoy significa un mañana más saludable!

Construyendo para el Futuro

con CACFP

Este programa recibe ayuda del Child and Adult Care Food Program para servir comidas nutritivas a sus niños.



Comidas servidas aquí deben de seguir los requisitos nutricionales establecidos por USDA.

¿Preguntas? ¿Inquietudes?

Información de contacto de la agencia participante	Información de Contacto de la Agencia Estatal
<i>Persona de Contacto</i> Tari Wolfe	Amanda Kane, RDN, CD, Director
<i>Nombre de la Agencia</i> Lac du Flambeau Zaasijiwan Head Start	Community Nutrition Programs
<i>Dirección de la Agencia</i> P.O. Box 67, 2899 Hwy. 47 S. Lac du Flambeau, WI 54538	Wisconsin Department of Public Instruction
	P.O. Box 7841
	Madison, WI 53707-7841
<i>Número de teléfono de la Agencia</i> 715-588-9291	608-267-9129

Aprenda más información sobre CACFP en el sitio web del USDA: <https://www.fns.usda.gov/cacfp/child-and-adult-care-food-program>

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Noviembre 2019