ENROLLMENT APPLICATION

Child's Name: _____ DOB: _____

Your Child's History

What was your child's birth weight? _____ lbs. _____ oz.

My child was:
- ☐ Full-term
- ☐ Premature

My child was/is fed:
- ☐ Formula
- ☐ Breast Milk
- ☐ Both

What did/does your infant do to self-soothe?

Apgar Score at birth: _____

Gestational Age at birth: _____ weeks

My child:
- ☐ Uses/used a pacifier
- ☐ Sucks/sucked his/her thumb
- ☐ Neither

Who is your child's physician? _____ ☐**Pediatrician** ☐**Family Doctor**

At what age did your child:

Smile _____

Roll over from front to back _____

Roll over from back to front _____

Crawl _____

Stand while holding on_____

Walk _____

Feed himself/herself _____

Say his first word _____ which was _____

Build a tower of four blocks _____

Say a sentence of two to four words _____

Ride a tricycle _____

Complete a four-piece puzzle _____

Your Child

Please describe your child in five words.

Are there any personality or behavioral traits that it would be helpful for us to know?

Is there anything that frightens your child? How does s/he react to being frightened? How do you respond?

Your Child (continued)

What comforts your child?

What angers or frustrates your child?

How do you respond to your child's negative behavior?

Does your child have any comfort items to help him/her sleep?

On a typical day, what is your child's mood upon waking?

What time does your child go to bed? _____ What time does your child wake up? _____

What is your child's nap schedule? (if any)

Does your child typically have trouble sleeping (night terrors, trouble getting to sleep)?

Is your child toilet-trained? If not, what method will you be using for toilet training?

Does your child need any assistance when using the toilet? What type of help does s/he need?

How does your child let you know when s/he needs to use the restroom?

Your Child's Home and Family

Who is in your child's family? Please list the name of each person in the family and his/her age. For the adults in the family, please include the highest level of education achieved and current occupation. (This information is for demographic purposes only.)

Who lives in the family home?

What is the primary language spoken in the family home? Please share a list of familiar words and phrases with your child's teacher.

Does your family have any cultural or religious practices that we should be aware of, such as dietary restrictions? Does your family cultural beliefs incorporate any special celebrations?

Would you be willing to come in to your child's classroom and teach the children about your family's celebrations? Do you have any suggestions as to the best way for Kids Country to incorporate your family's culture into our classrooms?

Are there any special custody arrangements and/or shared parenting arrangements for this child? If yes, please share these arrangements with us.

Is your child currently going through any major transitions, such as divorce, death in the family, new sibling, moving from crib to bed, or a new home?

Do you have any pets at home? If yes, what types of pets and what are their names?

What have your childcare arrangements been thus far?

Food and Fun

How often does your child drink milk, juice or water during the day at home?

Does your child have any favorite foods? What are they?

Does your child have any foods s/he doesn't care for? What are they?

Are there any foods your child should not eat? (Please see your Center Director for a "Child Care Plan for Health Conditions" form if your child has any food allergies or dietary restrictions.)

Where does your child sit at the table (high chair, booster seat, dining chair)?

Expectations

What are your goals for your child this year?

What are you and your child most excited about as you begin our program?

Are you or your child anxious about any part of our program?

Is there any other information about your child that would be helpful for us to know?

Parent Signature:_____ **Date:** _____

BRIGHTPATH

CONNECT WAIVER

I, _____ (Parent Name) am the parent or guardian of _____ (Child's Name) and have chosen to participate in The The Children's House *Connect* (the "Engagement Program").

Participation Agreement

In consideration for The Children's House, its subsidiaries and affiliates providing Connect (Engagement Program), accepting my application to participate in *Connect* (Engagement Program), and providing me access to *Connect* (Engagement Program), I hereby understand, acknowledge, and agree that:

(a) Our child will be participating in *Connect* (Engagement Program) and undertaken at my own and my child's risk.

(b) I have read the *Connect Parent Engagement Information Letter* attached hereto and I have had all my questions in relation to the *Connect* Engagement Program answered to my satisfaction prior to deciding to sign this Participation Agreement.

(c) I understand that I am prohibited from sharing photos and/or video of any children (other than my child), including any group photos/video, that I may have to access through my participation in the *Connect* Engagement Program. Should any photos and/or videos of children other than my child be distributed in violation of this covenant, I agree to indemnify and hold harmless The Children's House and its agents, employees, affiliates, and/or assigns for all claims, liabilities, damages, losses, and expenses (including legal fees on a solicitor and own client full indemnity basis) arising by reason of my unauthorized distribution in breach of this covenant.

BRIGHTPATH

CONNECT WAIVER

(d) I understand and acknowledge that the Connect Engagement Program relies on the use of a third-party provider (the "Developer") that utilizes the internet and cloud computing technology. Accordingly, I acknowledge that the Developer will have access to information, photos, and videos of and about my child and may create and hold electronic copies of this information for the purposes of back-up. The Developer may also monitor, for its internal use only, my access and use of the Connect Engagement Program. I understand and acknowledge that there are inherent privacy and confidentiality risks when using an internet-based service and cloud computing technology upon which the Connect Engagement Program relies. I understand and accept that The Children's House will have no liability in the event of any breach of confidentiality of any information collected and copied from the Connect Engagement Program, whether or not such breach resulted from the actions of the Developer of The Children's House, its agents, employees, assigns, or of any other parents who also participate in the Engagement Program. My participation in and use of the Connect Engagement Program is an acceptance of this limitation of liability.

(e) For greater certainty, I hereby release and forever discharge and agree not to make any claim against The Children's House, its board of directors, officers, agents, employees, affiliates, and/or assigns, for any and all claims, resulting from my participation and my child's participation in the *Connect* Engagement Program; and

(f) I understand and acknowledge that the terms of this waiver shall apply equally to me, and to my child.

BRIGHTPATH

CONNECT WAIVER

Approval for Photos/Videos

_☐_ I hereby grant permission to The Children's House and its representatives to photograph and video my child, and otherwise capture my child's image and to make recordings of my child's voice for the purposes of sharing information about my child with me under the *Connect* Parent Engagement Program.

_☐_ I further grant permission to The Children's House and its representatives to reproduce, use, exhibit, display, post or distribute any images and recordings of my child when such images or recordings are taken in a group, or in a multiple child setting, to other parents who are also participating in the *Connect* Parent Engagement Program.

_☐_ I hereby confirm and covenant that I will not share photos of any child (including group photos), other than my own, that I receive through the *Connect* Parent Engagement Program with anyone other than The Children's House and its employees.

I hereby release, defend, indemnify and hold harmless The Children's House, its board of directors, officers, employees, or agents from and against any claims, damages, or liability arising from or related to the use of images, recording or materials of my child, whether individually or in a group setting.

_____ _____

Child's Name Parent/Guardian's Name printed

_____ _____

Parent/Guardian Signature/date Director Signature /date

_____

The Children's House Location

Cot Waiver

It is time for your child to transition from a crib to a cot at 15 months.

Date_____

My child _____has permission to sleep on a cot during nap time.

Child's Date Of Birth_____

Parent Signature_____

INFANT CARE INFORMATION

Child's Name:	Nickname:
Child's Date of Birth:	Siblings:
What are you feeding your infant? ☐ Formula-Brand: _____ ☐ Breast Milk	
Number of Daily Feedings:	Frequency of Feedings: Amount for each Feeding:
Bottle should be warmed to: ☐ Room Temperature ☐ Warm ☐ Very Warm	Formula Preparation :
Solid Foods (Please list food, brand, type, amount, frequency and special instructions) Are foods served room temperature or warmed?	Table Food (Please list food, brand, type, amount, frequency and special instructions) Does your child drink from a cup yet?
How often should your infant's diaper be checked?	Security Items (i.e. pacifier, blankets, stuffed animals)
Nap Schedule:	Hints for getting baby to sleep: (You must secure a "Sleep Position Waiver Form" from your infant's physician if your baby is to sleep on his tummy or side. See the Center Director for this form.)
Allergies:	Special Precautions:
Is there any additional information about your infant that would be helpful for the caregivers to be aware of?	
Parent Signature/Date:	Caregiver Signature(s)/Date:
Form updated on :	Form updated on:

CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child _____ Birthdate _____ Sex _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name _____ Name _____

Relation to child _____ Relation to child _____

Home address _____ Home address _____

_____ _____

Phone Number _____ Phone Number _____

Place of employment _____ Place of employment _____

_____ _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Working hours _____ Working hours _____

OTHER PERSON TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____ Address _____

Phone Number _____ Hospital or Clinic _____

PROGRAM

Days per week _____ Hours of care _____

Rate of pay (optional) _____

_____ _____ _____

Signature of parent or other person placing child **Signature of caregiver** **Date**

A completely filled in form must be kept by the licensee for each child not related to the licensee. Please have this form available at all times to licensing representatives of the Department of Children and Family Services. Contact the Area Office for supplies of this form.

If the child has any of the following, please explaining:

Medical problems _____

_____

Physical handicaps _____

_____

Restrictions for play—outdoors _____

_____

Restrictions for play—indoors _____

_____

Allergies _____

_____

Food likes _____

_____

Food dislikes _____

_____

Fears _____

_____

Does the child take a nap? _____ Time _____ Length _____

Is the child toilet trained? _____

Does the child have special names for objects? (potty, cookies, drinks, etc.) _____

_____

Does the child regularly take medication? _____ If so, what kind and directions _____

_____

If the child is an infant, what are the feeding instructions? _____

Time _____ Amount _____ Temperature _____

Diaper changes: Powder _____ Ointment _____

Other information that will help in caring for the child _____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

_____

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY

CFS 593
Rev 7/2007

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES.

Parent(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes _____
to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. _____ is the preferred doctor/clinic/hospital.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize _____ to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER OVER-THE-COUNTER MEDICINE

(Administer only in accord with the appropriate standards for licensure)

I/we authorize _____ to administer over-the-counter medicine to my/our child as specified in written instructions.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

- over -

CHILD PICKUP

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize _____
Name Address Phone

and/or

_____
Name Address Phone

and/or

_____
Name Address Phone

to pick up my/our child when I am/we are unavailable.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

I/we authorize _____ to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above-named person(s). I/we understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

SWIMMING

I/we consent to my/our child using the swimming pool of _____
Name of Provider

at _____.
Address

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

																					Code:
Date																					
Age/ Grade																					**P = Pass** **F = Fail**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**U = Unable to test** **R = Referred**
Vision																					**G/C = Glasses/Contacts**
Hearing																					

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION (**List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**
Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

Bright Path
The best start in life

Week 1

	Monday	Tuesday	Wednesday	Thursday	Friday
AM Snack	Whole Grain Cheerios, Seasonal Fresh fruit and Milk	French Toast Stick and Applesauce	Yogurt Parfait with Vanilla Yogurt, Seasonal Fresh fruit, and Granola	Whole Grain Waffle and Seasonal Fresh Fruit	Rice Cakes and Seasonal Fresh Fruit
	Water	Water	Water	Water	Water
Lunch	Mac & Cheese Broccoli Peaches	Chicken Patty Sandwich Sun Butter and Jelly Sandwich Peas Seasonal Fresh Fruit	Cheese Ravioli with Marinara Sauce Green Beans Pineapple	Fish Taco Black Bean Taco Rice Pilaf Cucumber Slices Apples	Whole Grain Pizza Garden Salad Pineapple
	Milk	Milk	Milk	Milk	Milk
PM Snack	Sweet Potato Crackers Seasonal Fresh Fruit	Pita Wedges and Cucumbers with Hummus	Sun Butter and Apple Slices with Graham Crackers	Blueberry Muffin with Cream Cheese and Seasonal Fresh Fruit	Cherry Tomatoes and Red Pepper Sticks with Tzatziki Dip
	Water	Water	Water	Water	Water

- **V=Vegetarian option listed in green**
- **Infants will be offered the same as older children when developmentally appropriate**

Bright Path
The best start in life

Week 2

	Monday	Tuesday	Wednesday	Thursday	Friday
AM Snack	Rice Crispy Cereal with Seasonal Fresh Fruit and Milk	Whole Wheat Bagel and Cream Cheese	Whole Wheat Pancakes with Seasonal Fresh Fruit	Corn Muffin and Seasonal Fresh Fruit	Low Fat Cottage Cheese and Peaches
	Water	Water	Water	Water	Water
Lunch	Sun Butter and Jam Sandwiches Carrots Pineapple	Chicken Tacos or Black Bean Tacos with Cheese and Lettuce Seasonal Fresh Fruit Sweet Potato Fries	Veggie Nuggets Garden Salad Whole Wheat Dinner Rolls Seasonal Fresh Fruit	Black Bean Burger with Cheese Cucumbers Ranch Dressing Peaches	Toasted Cheese Sandwich Tomato Soup Green Beans Orange Wedges
	Milk	Milk	Milk	Milk	Milk
PM Snack	Yogurt and Seasonal Fresh Fruit	Avocado Toast with Tomatoes	Cheese Cubes and Applesauce	Pita Wedges, Pepper Sticks and Guacamole	Apple Slices and Sun Butter
	Water	Water	Water	Water	Water

- **V=Vegetarian option listed in green**
- **Infants will be offered the same as older children when developmentally appropriate**

Bright Path
The best start in life

Week 3

	Monday	Tuesday	Wednesday	Thursday	Friday
AM Snack	Whole Grain Cheerios, Seasonal Fresh Fruit and Milk	French Toast Stick and Applesauce	Yogurt Parfait with Vanilla Yogurt, Seasonal Fresh Fruit, and Granola	Whole Grain Waffle and Seasonal Fresh Fruit	Rice Cakes and Seasonal Fresh Fruit
	Water	Water	Water	Water	Water
Lunch	Bean Chili Pepper Sticks or Cucumbers Cornbread Seasonal Fresh Fruit	Grilled Chicken Nuggets Veggie Nuggets Rice Pilaf Broccoli Peaches	Rigatoni with Veggie Crumble Marinara Sauce Carrots Bananas	Diced Chicken and Cheese Wrap Toasted Cheese Cauliflower Seasonal Fresh Fruit	Whole Wheat Pizza Garden Salad Pineapple
	Milk	Milk	Milk	Milk	Milk
PM Snack	Sweet Potato Crackers Seasonal Fresh Fruit	Pita Wedges and Cucumbers with Hummus	Sun Butter and Apple Slices with Graham Crackers	Blueberry Muffin with Cream Cheese and Seasonal Fresh Fruit	Cherry Tomatoes and Red Pepper Sticks with Tzatziki Dip
	Water	Water	Water	Water	Water

- **V=Vegetarian option listed in green**
- **Infants will be offered the same as older children when developmentally appropriate**

Bright Path
The best start in life

Week 4

	Monday	Tuesday	Wednesday	Thursday	Friday
AM Snack	Rice Crispy Cereal with Seasonal Fresh Fruit and Milk	Whole Wheat Bagel and Cream Cheese	Whole Wheat Pancakes with Seasonal Fresh Fruit	Corn Muffin and Seasonal Fruit	Low Fat Cottage Cheese and Peaches
	Water	Water	Water	Water	Water
Lunch	Sun Butter and Banana Sandwich Carrots Applesauce	Chicken and Cheese Quesadillas with lettuce Bean and Cheese Quesadillas Pineapples	Turkey Burger Toasted Cheese Sweet Potato Fries Cucumber Slices Pears	Pasta with Chicken and Cheddar Cheese Buttered Pasta with Cheddar Cheese Broccoli Pears	Chicken Parm with Marinara Sauce and Mozzarella Cheese Pasta with Marinara Sauce and Mozzarella Cheese Peas Whole-Wheat Garlic Toast Seasonal Fresh Fruit
	Milk	Milk	Milk	Milk	Milk
PM Snack	Yogurt and Seasonal Fresh Fruit	Avocado Toast with Tomatoes	Cheese Cubes and Applesauce	Pita Wedges, Red Pepper Sticks and Guacamole	Bananas, Apple Slices and Sun Butter
	Water	Water	Water	Water	Water

- **V=Vegetarian option listed in green**
- **Infants will be offered the same as older children when developmentally appropriate**