August 26 - May 23, 2025

School Year 2024 Enrollment Form QUEST

(For Staff Use Only)
Non-refundable Registration Fee, $30.00
Paid: $ _____
Date: _____

Child: _____ **Age:** _____

Date of Birth: _____ Sex: _____

Payment Information *(Non-Refundable Registration Fee $30.00 Required)*

☐ Private Pay ☐ Catawba County Schools Employee, Role: _____
☐ Classified Employee ☐ Certified Employee

Siblings at QUEST: ☐ Yes ☐ No Names: _____
Separate registration forms required

Custody Arrangements ☐ Yes ☐ No
Documents MUST be on file with QUEST

Weekly Contract Information

☐ Before School Only -$35.00
☐ After School Only - $50.00
☐ Before and After School - $85.00
☐ Full Day Care -$26.00 / day

Daily Care Options

☐ Drop In Care
- ☐ Before -$11.00 / day
- ☐ After - $16.00 / day
- ☐ Full Day -$32.00 / day

QUEST Before /After Site:

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

QUEST Full Day Site:

☐ Catawba
☐ Mt. View
☐ Oxford
☐ Snow Creek
☐ St. Stephens
☐ Startown

Notes:

Contracted accounts are charged weekly regardless of attendance., except for Christmas and Spring break.

Parents are responsible for payment on CCS legal holidays. Accounts will be charged for the following legal holidays: Sept. 2, Nov. 11, 28, 29, Jan. 20, and April 18.

QUEST will be CLOSED Dec. 23-Jan. 1; accounts are not charged.

Parent / Guardian Information *(Email Required)*

1. **Name**: _____ Relationship: _____ Cell #: _____
Address: _____ City: _____ Zip Code: _____ Home #: _____
Email: _____ Employer: _____ Work #: _____

2. **Name** _____ Relationship: _____ Cell #: _____
Address: _____ City: _____ Zip Code: _____ Home #: _____
Email: _____ Employer: _____ Work #: _____

Authorized Pick Up and Emergency Contacts:

	Name:	Relationship	Phone:	Pick Up	Emerg.
1.				☐	☐
2.				☐	☐
3.				☐	☐

Permissions:

Can Photographs be publicized?
☐ Yes ☐ No

Access to Internet?
☐ Yes ☐ No

School Year 2024 Enrollment Form **QUEST**

Child: _____ **Age:** _____ **Date of Birth:** _____

Health Care Needs

Any child with health care needs such as allergies, asthma, or other chronic conditions must have a MEDICAL ACTION PLAN on file. The MEDICAL ACTION PLAN must be completed by the child's parent or health care professional.

Any Medical Condition listed below MUST have a Medical Action Plan.
(See Program Coordinator for appropriate forms)

Medical Action Plans attached: ☐ Yes ☐ No

Allergies/ Medical Conditions:

List any allergies, symptoms, and the type of response required

_____

_____

Medications

List any medications taken for health care needs

_____

_____

Fears or Behavior Characteristics

List any fears or behavior characteristics you feel we need to be aware of

_____

_____

Emergency Care Medical Information

Doctor: _____ Phone: _____

Hospital: _____ Phone: _____

Insurance Coverage

Health Insurance coverage is REQUIRED to attend QUEST. Catawba County Schools and QUEST will not be responsible for expenses related to any accident / incident.

Provider Name: _____

Emergency Medical Release ☐ Yes Parent Initials _____

If emergency medical care is deemed necessary and I cannot be reached, I hereby authorize QUEST staff to call 911. My child may also leave with the people noted as emergency contacts.

Field Trip / Playground Permission ☐ Yes Parent Initials _____

I give permission for my child to leave the school site to attend field trips / aquatic events and to play on school grounds outside the fenced area when properly supervised by QUEST staff

Parent Handbook ☐ Yes Parent Initials _____

I have received, read and acknowledged the QUEST Parent Handbook including: Discipline Policies, Fees, Payment Policies, Late Pick-Up Policies, NC Child Care Law & Rules, and the Parent Participation Plan. Additionally, I understand parents will be given a 2-week notice prior to changes to the discipline policy / procedures.

Notification of Smoking and Tobacco Restriction ☐ Yes Parent Initials _____

I understand all forms of smoking, tobacco use and/or products including vapes, e-cigarettes, etc. are prohibited on school grounds and QUEST sites.

Parent Signature: _____ Date: _____

For Office Use Only:

App Rec'd:
Date _____

ProCare Updated:
Date _____

Sent to Full Day Site:
Date _____

PC Signature:
_____

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

*** This is a required from. Please complete, sign, and return. This form allows your child to bring a water bottle, additional snack from home and/or a lunch box on full days. This also allows us to have special snack activities outside of our documented snack. Your child will always be given a snack and a milk while at QUEST. - - Thank you!*

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

CACFP Child & Adult Care Food Program

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:__________

This institution is an equal opportunity provider.

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

CACFP Child & Adult Care Food Program

Formulario para Inscripción de Infantes y Niños

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 Pensions	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

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

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.

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

_____ _____
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**

This institution is an equal opportunity provider.
Esta institución es un proveedor de igual oportunidades.

QUEST
Catawba County Schools
Safe Pick-Up / Delivery Procedures

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- ➢ **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

_____ have read and understand the QUEST Safe Pick-Up / Drop-Off Policy. I agree to follow the policy as stated above.

_____ / _____

Signature **Date**