

KINDERLAND CHILD DEVELOPMENT CENTER
1630 VICTOR AVENUE
REDDING, CA 96003

REGISTRATION PAYMENT AGREEMENT

September 202__-August 202__

I understand that a registration fee of \$50.00 is due for my child/ren
_____. I wish to pay this in

___ Full

___ 2 payments

Registration fees must be paid in full 1 month from first date of attendance.

Parent

KINDERLAND CONTRACT

The Kinderland Child Development Center parent handbook is available on-line. Written copies are available on request. Additional children enrolled in the future by this family will be covered under this contract as well. Kinderland reserves the right to change policies at any time. You will be notified of changes and copies of amended pages will be posted on the website. Again, written copies will be available on request.

I have read and understand the handbook. By signing this contract, I agree to abide by Kinderland's policies, rules and regulations.

CHILD(REN)'S NAME

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

PRINTED NAME

SOCIAL SECURITY #

DRIVER LICENSE #

DATE OF BIRTH

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

PRINTED NAME

SOCIAL SECURITY #

DRIVER LICENSE #

DATE OF BIRTH

Social Security and Driver's License numbers are required if paying by check. If we do not have these on file, you will need to pay by cash or credit card only. No checks will be accepted.

AUTHORIZED KINDERLAND REPRESENTATIVE

DATE

Kinderland
Child Development Center
1630 VICTOR AVE
REDDING, CA 96003

SCHEDULE OF SERVICES

Child(ren): _____
Print Name

Please complete and return to director. Indicate below which child care services you need.

Full day - Mon. Tues. Wed. Thurs. Fri.

A.M. Half day - Mon. Tues. Wed. Thurs. Fri.

P.M. Half day - Mon. Tues. Wed. Thurs. Fri.

Drop- Off - Schedule will vary, Call in Advance

SCHOOL -AGE CHILDREN – Kindergarten and Up

Before School

After School

Holidays & Summer Only

Parent Signature

Date

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
	HOME ADDRESS	NUMBER	STREET	CITY	STATE ZIP
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
	HOME ADDRESS	NUMBER	STREET	CITY	STATE ZIP
PERSON RESPONSIBLE FOR CHILD	LAST	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY
 (CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN
 AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD
 NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ DATE

_____ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
 ()

WORK PHONE
 ()

CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
IS / HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/ MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT* _____ MONTHS	BEGAN TALKING AT* _____ MONTHS	TOILET TRAINING STARTED AT* _____ MONTHS
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PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)		
BREAKFAST		
LUNCH		
DINNER		
WHAT ARE USUAL EATING HOURS?		
BREAKFAST		
LUNCH		
DINNER		
ANY FOOD DISLIKES?		
ANY EATING PROBLEMS?		

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*

PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:

PARENT/AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

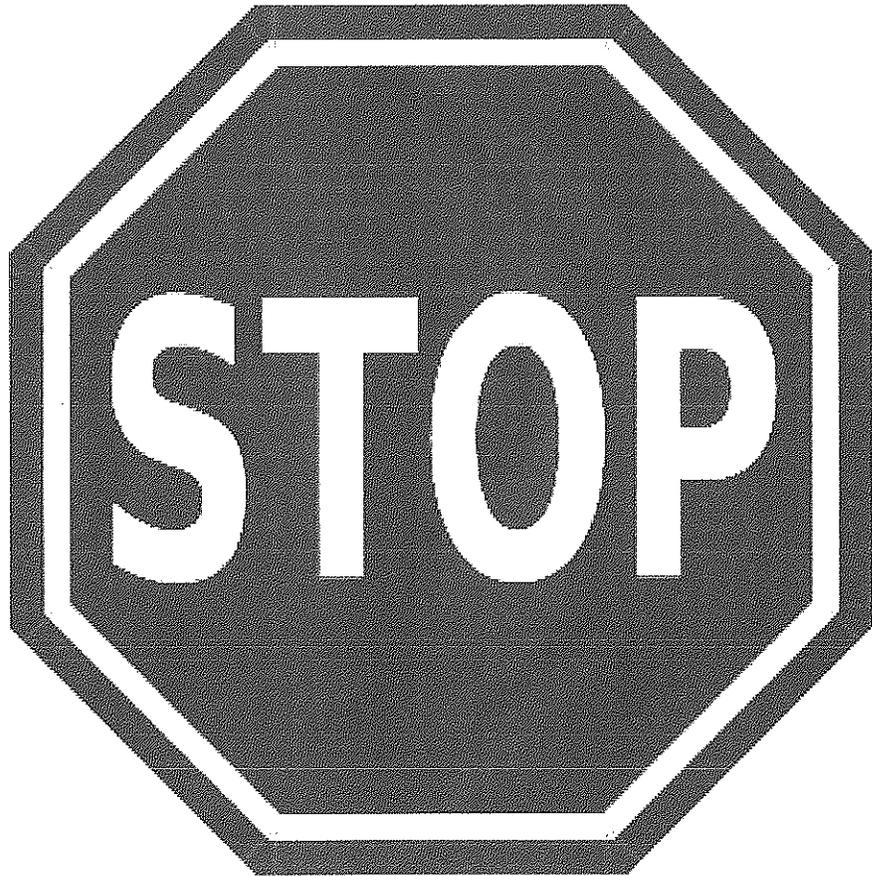
DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE

DATE



**Immunization Records are
required prior to start date.**

Thank You

PHYSICIAN'S REPORT—CHILD CARE CENTERS (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)
_____. This Child Care Center/School provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)
a.m./p.m. to _____ a.m./p.m. , _____ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: _____ Allergies/medicine: _____
Vision: _____ Insect stings: _____
Developmental: _____ Food: _____
Language/Speech: _____ Asthma: _____
Dental: _____
Other (Include behavioral concerns): _____

Comments/Explanations: _____

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DaP/ (DIPHTHERIA, TETANUS AND (ACELLULAR) PERTUSSIS OR TETANUS DT/Td AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
____ Communicable TB disease not present.

I have have not reviewed the above information with the parent/guardian.

Physician: _____ Date of Physical Exam: _____
Address: _____ Date This Form Completed: _____
Telephone: _____ Signature _____

Physician Physician's Assistant Nurse Practitioner

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: Community Care Licensing
 Licensing Office Address: 520 Cohasset Rd #6 Chico 95926
 Licensing Office Telephone #: (530) 859-5033

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

PERSONAL RIGHTS**Child Care Centers**

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME		
Community Care Licensing		
ADDRESS		
520 Cohasset Rd # 6		
CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
Chico, Ca	95926	530-895-5033

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)	(PRINT THE ADDRESS OF THE FACILITY)
(PRINT THE NAME OF THE CHILD)	
(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	
(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)	(DATE)

MEDIA PERMISSION

Child(ren): _____

I give permission for pictures/video of my child(ren) to be used or posted with the following:

Please Check All That Apply

- _____ Web Site – kinderlandusa.com
- _____ Facebook – kinderlandusa@facebook.com
- _____ Newspaper (rare)
- _____ Television (rare)
- _____ Classroom/Center
- _____ First Name(s) may be used

I understand that last names will not be used unless specific permission is granted.

Parent Signature

Date

MEAL BENEFIT FORM FOR CHILDREN
PROGRAM YEAR _____

Name of Child Care Center: _____
Please read the instructions. If you need help completing this form, call: _____
Complete, sign, and return form to: _____

1. CHILD INFORMATION

List names of all children enrolled for care.

Last Name	First Name	Middle Initial	Foster Child?*

*If all children listed are foster children, go to Section 4.

2. BENEFITS

If you are receiving CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), or Food Distribution Program on Indian Reservations (FDP|IR) benefits for your child, list the case number and do not complete Section 3. Go to Section 4.

Program	Case Number
CalFresh	
CalWORKs	
FDP IR	

3. ALL OTHER HOUSEHOLDS

Complete this section if you did not complete Section 2. List all household members including children enrolled for care. List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

Check here if this household receives no income. _____ Go to Section 4.

Applicants without income are requested to write a zero in the applicable field or mark no income. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

Names of all household members, including child(ren) listed above	Earnings from work before deductions	Child support, alimony	Payments from pensions, retirement, Social Security	Earnings from any other income
Example: Janet Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$0

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the CalFresh, CalWORKs, FDP|IR, or other eligible program case number is current, correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the meal benefit form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Printed Name: _____
Last Four Digits of SSN: _____ No SSN: _____
Signature of Parent or Guardian: _____
Date: _____

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKs), Program or FDP|IR case number for the participant or other (FDP|IR) identifier or when you indicate that the adult household member signing the application does not have a SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKS, or FDPIR office to determine current certification for CalFresh, CalWORKS, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions. If you choose to do so, please mark one or more of the following racial identities:

- American Indian or Alaskan Native _____
- Asian _____
- Black or African American _____
- Native Hawaiian or Other Pacific Islander _____
- White _____

Please mark one of the following ethnic identities:

- Hispanic or Latino _____
- Not Hispanic or Latino _____

FOR AGENCY USE ONLY

CATEGORICAL ELIGIBILITY

CalFresh/CalWORKS/FDPIR household categorically eligible? Yes _____ No _____
Foster child automatically eligible free? Yes _____ No _____

INCOME ELIGIBILITY

Annual Conversion (required if household reports various pay frequencies in Section 3):
weekly times (X) 52, every 2 weeks x 26, twice a month x 24, monthly x 12
Total Household Income and Frequency: \$ _____ per _____
Household Size _____

ELIGIBILITY CLASSIFICATION

Eligibility Classification: Free _____ Reduced-price _____ Base _____
Determining Official Name: _____
Determining Official Signature: _____ Date: _____

HOW TO COMPLETE THE MEAL BENEFIT FORM

1. CHILD INFORMATION:

- a. Print your child's name.
- b. Indicate yes to the right of child's name if a foster child.

2. BENEFITS: Complete this section, then skip to Section 4 and sign the form.

- a. List your current CalFresh, CalWORKS, or FDPIR case number(s) for your child(ren).
- b. Sign the form in Section 4. An adult household member must sign. You do not have to list an SSN.

3. ALL OTHER HOUSEHOLDS: Complete this section only if you do not have a case number.

- a. Complete this section and sign the form in Section 4. Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child you are applying for, and all other household members. If your household includes any foster children formally placed by a state child welfare agency or a court, you may choose to include the child(ren) in this list.
- b. Write the amount of income each person received last month before taxes or anything else was taken out and where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). If you have chosen to include any foster children in your care, only the personal use income is to be listed. Foster payments you receive from the placing agency for the care of the child do not need to be reported. Each income amount should be entered in the appropriate column on the form. If any amount last month was more or less than usual, write that person's usual monthly income.
- c. If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
- d. Sign the form and include the last four digits of your SSN in Section 4. If you do not have an SSN, place a checkmark next to No SSN.

4. LAST FOUR DIGITS OF SSN AND SIGNATURE:

- a. The form must have a signature of an adult household member.
- b. The adult household member who signs the statement must include the last four digits of his or her SSN. If they do not have an SSN, they will place a checkmark next to the No SSN line.

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE

American Indian or Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand, and Vietnam.

Black or African American—A person having origins in any of the black racial groups of Africa. Terms such as **Haitian** or **Negro** can be used in addition to **Black or African American**.

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY

Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term **Spanish origin** can be used in addition to **Hispanic or Latino**.

Not Hispanic or Latino