



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE
CHILD CARE ENROLLMENT FORM

| | | |
|------------------------|----------------|----------------|
| FACILITY/PROVIDER NAME | ADMISSION DATE | DISCHARGE DATE |
| CHILD'S NAME | GENDER | BIRTHDATE |

ADDRESS (STREET, CITY, STATE, ZIP CODE)

IDENTIFYING INFORMATION

| | |
|--|-----------------------|
| MOTHER'S/GUARDIAN'S NAME | HOME TELEPHONE NUMBER |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/> | CELL PHONE NUMBER |
| E-MAIL ADDRESS | |
| EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE |
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |
| FATHER'S/GUARDIAN'S NAME | HOME TELEPHONE NUMBER |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/> | CELL PHONE NUMBER |
| E-MAIL ADDRESS | |
| EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE |
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY
(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

| | | |
|---|-----------------------|---|
| NAME | RELATIONSHIP TO CHILD | TELEPHONE NUMBERS (CELL, WORK, HOME) |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | | |
| NAME | RELATIONSHIP TO CHILD | TELEPHONE NUMBERS (CELL, WORK, HOME) |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | | |

COMMENTS ON CHILD'S DEVELOPMENT
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

RELATED CHILD

YES NO HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

| | | | | |
|--------------------------|---|---|--|--|
| CACFP REQUIREMENT | CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME OR <input type="checkbox"/> PART TIME | WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM | WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM | WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES. |
| | MONDAY | AM PM | AM PM | |
| | TUESDAY | AM PM | AM PM | |
| | WEDNESDAY | AM PM | AM PM | |
| | THURSDAY | AM PM | AM PM | |
| | FRIDAY | AM PM | AM PM | |
| | SATURDAY | AM PM | AM PM | |
| | SUNDAY | AM PM | AM PM | |

| | | | | |
|---|--|--|---|---|
| CACFP REQUIREMENT | CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY | | | |
| | <input type="checkbox"/> BREAKFAST <input type="checkbox"/> MORNING SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> AFTERNOON SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK <input type="checkbox"/> NONE | | | |
| | CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY | | | |
| | <input type="checkbox"/> NEW YEAR'S DAY (JANUARY) | <input type="checkbox"/> MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY) | <input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY) | <input type="checkbox"/> EASTER (MARCH/APRIL) |
| <input type="checkbox"/> MEMORIAL DAY (MAY) | <input type="checkbox"/> INDEPENDENCE DAY (JULY) | <input type="checkbox"/> LABOR DAY (SEPTEMBER) | <input type="checkbox"/> COLUMBUS DAY (OCTOBER) | |
| <input type="checkbox"/> VETERANS DAY (NOVEMBER) | <input type="checkbox"/> ELECTION DAY (NOVEMBER) | <input type="checkbox"/> THANKSGIVING (NOVEMBER) | <input type="checkbox"/> CHRISTMAS DAY (DECEMBER) | |
| AUTHORIZATION FOR EMERGENCY MEDICAL CARE | | | | |
| <p>I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.</p> <p>IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE</p> <p style="text-align: center;">_____ DAY CARE PROVIDER OR HOME PROVIDER</p> <p>TO CONTACT THE FOLLOWING:</p> | | | | |
| PHYSICIAN OR CLINIC | | | | |
| NAME | | | TELEPHONE NUMBER | |
| PREFERRED HOSPITAL | | | | |
| NAME | | | TELEPHONE NUMBER | |
| ACKNOWLEDGEMENTS | | | | |
| A | I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN. | | PARENT/GUARDIAN INITIALS | |
| B | I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW. | | PARENT/GUARDIAN INITIALS | |
| C | THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS. | | PARENT/GUARDIAN INITIALS | |
| D | WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE. | | PARENT/GUARDIAN INITIALS | |
| E | I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS. | | PARENT/GUARDIAN INITIALS | |
| F | <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED. | | PARENT/GUARDIAN INITIALS | |
| G | <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD. | | PARENT/GUARDIAN INITIALS | |
| H | I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE. | | PARENT/GUARDIAN INITIALS | |
| I | I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED. | | PARENT/GUARDIAN INITIALS | |
| PARENT'S/GUARDIAN'S SIGNATURE | | | DATE | |
| CACFP REQUIREMENT | FIRST ANNUAL UPDATE | PARENT/GUARDIAN SIGNATURE | DATE | |
| | SECOND ANNUAL UPDATE | PARENT/GUARDIAN SIGNATURE | DATE | |
| | THIRD ANNUAL UPDATE | PARENT/GUARDIAN SIGNATURE | DATE | |