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| I:\Childcare\Photos\State_Seal_Color.png | MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICESSECTION 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 | 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 | 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) |
|  |
| **CACFP REQUIREMENT** | **RELATED CHILD** |
| YES NO | HOW IS CHILD RELATED TO CHILD CARE PROVIDER? |
| **CHILD’S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED** |
| CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND:FULL TIME OR 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 |

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| **CACFP REQUIREMENT** | **CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY** |
| BREAKFAST MORNING SNACK LUNCH AFTERNOON SNACK SUPPER EVENING SNACK NONE |
| **CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY** |
| NEW YEARS’S DAY (JANUARY) | MARTIN LUTHER KING JR.’S BIRTHDAY (JANUARY) | PRESIDENT’S DAY (FEBRUARY) | EASTER (MARCH/APRIL) |
| MEMORIAL DAY (MAY) | INDEPENDENCE DAY (JULY) | LABOR DAY (SEPTEMBER) | COLUMBUS DAY (OCTOBER) |
| VETERANS DAY (NOVEMBER) | ELECTION DAY (NOVEMBER) | THANKSGIVING (NOVEMBER) | CHRISTMAS DAY (DECEMBER) |
| **AUTHORIZATION FOR EMERGENCY MEDICAL CARE** |
| 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.IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZEDAY CARE PROVIDER OR HOME PROVIDERTO CONTACT THE FOLLOWING: |
| **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 CAREHOMES 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, ANDINDIVIDUAL 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 | I DODO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS.I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED. | PARENT/GUARDIAN INITIALS |
| G | I DODO 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 ENROLLEDIN 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 |

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