



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

SAVE**PRINT****RESET**

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				
<input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/>	AM PM	AM PM	
	TUESDAY <input type="checkbox"/>	AM PM	AM PM	
	WEDNESDAY <input type="checkbox"/>	AM PM	AM PM	
	THURSDAY <input type="checkbox"/>	AM PM	AM PM	
	FRIDAY <input type="checkbox"/>	AM PM	AM PM	
	SATURDAY <input type="checkbox"/>	AM PM	AM PM	
	SUNDAY <input type="checkbox"/>	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	I <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	I <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	



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

SAVE

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IDENTIFYING INFORMATION

CHILD'S NAME

BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

- ☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.
- ☐ My child is able to participate in group care but has special health or medical requirements as listed below.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE

DATE



Missouri Department of Health and Senior Services
Section for Child Care Regulation
INDIVIDUAL PLAN FOR SPECIALIZED CARE

SAVE

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IDENTIFYING INFORMATION

CHILD'S NAME

BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

**SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT
HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY**

PHYSICIAN/SPECIALIST SIGNATURE

DATE

X