



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	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE <input type="checkbox"/>	
E-MAIL ADDRESS	

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

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

ADDRESS (STREET, CITY, STATE, ZIP CODE)
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**COMMENTS ON CHILD'S DEVELOPMENT  
 (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)**

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<b>CACFP REQUIREMENT</b>	<b>RELATED CHILD</b>	
	<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**

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

CACFP REQUIREMENT	<b>CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY</b>			
	<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			
CACFP REQUIREMENT	<b>CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY</b>			
	<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**

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 AUTHORIZE \_\_\_\_\_  
(LIST CHILDCARE FACILITY NAME HERE)

**TO CONTACT THE FOLLOWING:**

<b>PHYSICIAN OR CLINIC</b>	
NAME	TELEPHONE NUMBER

<b>PREFERRED HOSPITAL</b>	
NAME	TELEPHONE NUMBER

**ACKNOWLEDGMENTS**

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 HOME 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
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CACFP REQUIREMENT	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE