



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 SAME AS ABOVE <input type="checkbox"/>			
E-MAIL ADDRESS			
EMPLOYER OR SCHOOL		WORK/SCHOOL SCHEDULE	
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)		WORK TELEPHONE NUMBER	
FATHER'S/GUARDIAN'S NAME		TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>			
E-MAIL ADDRESS			
EMPLOYER OR SCHOOL		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 NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)			
NAME		RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)			
COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)			

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.

RELATED CHILD

YES NO

HOW IS CHILD RELATED TO CHILD CARE PROVIDER

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		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
CHECK WHAT DAYS THE CHILD WILL ATTEND				
MONDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
TUESDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
WEDNESDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
THURSDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
FRIDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
SATURDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
SUNDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	

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

<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 ARRANGEMENT, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

_____ (LIST CHILDCARE FACILITY NAME HERE)

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER
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PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER
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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 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
CACFP REQUIREMENT	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

USDA Nondiscrimination Statement

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- 1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- 2) Fax: (202) 690-7442; or
- 3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

SAVE

PRINT

RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE
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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.

[Large empty box for listing special health or medical requirements]

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE
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Fair Acres YMCA Kidz-In-Motion

Auto-Draft Agreement

I, _____ the parent/guardian of _____ authorize the financial institution listed on this form to honor pre-authorized debit entries initiated by the YMCA on my account as payment for child care services provided to the enrolled child for days attended the preceding week. When my financial institution honors the automatic funds transfer by debiting my account, such transactions constitute receipt for payment. Should any automatic funds not be honored by said financial institution when received by them, it is understood that I am personally responsible to make the payment via other means for the amount of said payment, and a late fee may apply. The YMCA reserves the right to make necessary rate adjustments at any given time, with proper advanced notification.

Credit/Debit Card

Card Type: (please circle) VISA MasterCard Discover American Express

Card Number: _____ Expiration Date: _____

CVV/CVC (security code on back) _____

Checking

Name of Financial Institution: _____

Account Number: _____ Routing Number: _____

(Please Attach a VOIDED check here)

Signature: _____ Date: _____

Printed Name of Signatory: _____