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

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME PHONE
ADDRESS (STREET, CITY, STATE, ZIP) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE
	E-MAIL
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP)	WORK PHONE

FATHER'S/GUARDIAN'S NAME	HOME PHONE
ADDRESS (STREET, CITY, STATE, ZIP) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE
	E-MAIL
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP)	WORK PHONE

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY

(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP)		

NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP)		

COMMENTS ON CHILD'S DEVELOPMENT

(NOTE CHILD'S PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, AND INDVIDUAL 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.
MON		AM PM	AM PM	
TUES		AM PM	AM PM	
WED		AM PM	AM PM	
THURS		AM PM	AM PM	
FRI		AM PM	AM PM	
SAT		AM PM	AM PM	
SUN		AM PM	AM PM	

PLEASE ALSO COMPLETE PAGE 2.

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVE SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEAR'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 AUTHORIZE

_____

DAY CARE CENTER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	PHONE

PREFERRED HOSPITAL

NAME	PHONE

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 UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSION AND THAT I WILL BE NOTIFIED, IN ADVANCE, WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD	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

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

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

PARENT'S SPECIALIZED INSTRUCTIONS FOR INFANTS AND TODDLERS

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

INSTRUCTIONS TO PARENTS:
- Please complete for child who is less than 24 months of age.
- Update diet information as needed until child is on complete table food. Use a new form or initial/date changes on this form.

FEEDING METHOD

(Check all that apply.)
☐ SPOON ☐ CUP ☐ BOTTLE ☐ WARM BOTTLE ☐ HOLDS OWN BOTTLE ☐ FEEDS SELF ☐ FEEDING TABLE OR CHAIR

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
FORMULA			
WHOLE MILK			
INFANT FOOD			
JUNIOR FOOD			
TABLE FOOD			

ARRANGEMENTS FOR SLEEP

(The American Academy of Pediatrics and other nationally recognized authorities for infant health advise that infants should be placed on their backs to sleep to reduce the risk of Sudden Infant Death Syndrome.)

TIME CHILD USUALLY NAPS	USUAL LENGTH OF NAP

SPECIAL NEEDS/INSTRUCTIONS RELATED TO SLEEPING

My child is 12 months old or older, and I give permission for my child to sleep on a cot.

_____ _____
(PARENT'S SIGNATURE) (DATE)

DIAPERING INSTRUCTIONS

I give permission for caregivers to use _____ on my child for:
(Lotions and/or ointments, etc. that I have provided)

☐ WET ☐ BOWEL MOVEMENT ☐ RASH ☐ OTHER

☐ I do not want caregivers to use any lotions, powders, ointments or similar items on my child.

I will furnish the following baby supplies for my child:

SPECIAL INSTRUCTIONS FOR CARE (Restrictions, allergies, etc.)

PARENT/LEGAL GUARDIAN SIGNATURE	DATE
▶	

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

MEDICATION AUTHORIZATION

MEDICATION REQUIREMENT

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

(PROPER NAME OF MEDICATION)

CHILD'S FULL NAME	**DATE MEDICATION TAKEN FROM**	**UNTIL**

DOSAGE	TIME(S) OF DAY

POSSIBLE SIDE EFFECTS

SIGNATURE OF PARENT(S) OR GUARDIAN	DATE

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

Missouri Department of Health and Senior Services
Section for Child Care Regulation

INDIVIDUAL PLAN FOR SPECIALIZED CARE

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	