Parents are asked to review and update emergency contact twice a year

All About Me

Precious Days Learning Academy
Child's Form

Name _____

Home Number _____ Birthday _____ Age _____

Address

_____

Parents Information
Mothers Name
_____

Day # _____ Cell #_____

Fathers Name _____

Day # _____Cell #_____

Emergency Contacts
Name _____
Relationship _____
Home # _____
Cell # _____

Name _____
Relationship _____
Home # _____
Cell # _____

The following individuals have access to my child's records

_____ _____

_____
Parent/Guardian Signature

Precious Days Learning Academy

Emergency Contact(s) with permission to pick up/drop off child

In addition to parents or medical personnel

Name _____

Address _____

Relationship _____

Home Phone _____ Cell Phone _____

Name _____

Address _____

Relationship _____

Home Phone _____ Cell Phone _____

Name _____

Address _____

Relationship _____

Home Phone _____ Cell Phone _____

Name _____

Address _____

Relationship _____

Home Phone _____ Cell Phone _____

Name _____

Address _____

Relationship _____

Home Phone _____ Cell Phone _____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME Precious Days Learning Academy	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit www.dese.mo.gov/veterans-services.

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY OTHER THAN PARENT (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)

NAME b	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)

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☐ No

CHILD'S RELATION TO CHILD CARE PROVIDER

ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

What is your race? (Select one or more.)

☐ American Indian or Alaskan native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

☐ Will child attend: ☐ Full time ☐ Part time

Check what days your child will attend.

	When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
☐ Monday	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
☐ Tuesday	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
☐ Wednesday	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
☐ Thursday	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
☐ Friday	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
☐ Saturday	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
☐ Sunday	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	

MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack ☐ None

HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ New Year's Day
☐ Martin Luther King, Jr.'s Birthday
☐ Lincoln's Birthday
☐ Washington's Birthday
☐ Easter
☐ Truman Day
☐ Memorial Day
☐ Juneteenth
☐ Independence Day
☐ Labor Day
☐ Columbus Day
☐ Veterans Day
☐ Thanksgiving Day
☐ Christmas Day

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event 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 the necessary arrangements, or in a critical emergency requiring medical care, I authorize

Precious Days Learning Academy
(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

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 ☐ do ☐ do not give permission for field trips/excursions. I understand 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
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 at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN 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 DEPARTMENTOF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CACFP ENROLLMENT FORM FOR CHILD CARE CENTERS

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

CHILD'S FULL NAME	DATE OF BIRTH

PARENT OR GUARDIAN NAME	STREET ADDRESS

CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
			( )

NAME OF CHILD CARE CENTER	PHONE NUMBER
Precious Days Learning Academy	( )

CENTER CONTACT PERSON'S NAME	CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE ⇊		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
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

WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION.

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

- ☐ FULL DAY CARE
- ☐ HALF DAY – MORNING
- ☐ HALF DAY – AFTERNOON
- ☐ BEFORE SCHOOL CARE
- ☐ AFTER SCHOOL CARE
- ☐ BEFORE AND AFTER SCHOOL CARE
- ☐ EVENING CARE
- ☐ OVERNIGHT CARE

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

- ☐ BREAKFAST
- ☐ MORNING SNACK
- ☐ LUNCH
- ☐ AFTERNOON SNACK
- ☐ SUPPER
- ☐ EVENING SNACK

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

- ☐ NEW YEARS DAY (JANUARY 1)
- ☐ MARTIN LUTHER KING'S BIRTHDAY (JANUARY)
- ☐ PRESIDENT'S DAY (FEBRUARY)
- ☐ MEMORIAL DAY (MAY)
- ☐ INDEPENDENCE DAY (JULY 4)
- ☐ LABOR DAY (SEPTEMBER)
- ☐ THANKSGIVING DAY (NOVEMBER)
- ☐ CHRISTMAS DAY (DECEMBER 25)

SIGNATURE OF PARENT OR GUARDIAN	DATE

ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIALED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM.

FIRST ANNUAL UPDATE	PARENT SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT SIGNATURE	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
	☐	/ /		
	☐	/ /		
	☐	/ /		
	☐	/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY)	DATE
	XXX-XX-	/ /
PRINTED NAME OF ADULT	**ADDRESS**	**PHONE NUMBER**
		( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ❑	MONTH ❑	2 X A MONTH ❑	EVERY 2 WEEKS ❑	WEEKLY ❑	SNAP (Food Stamp) ❑	TEMPORARY ASSISTANCE ❑

Eligibility Determination: ❑ Free ❑ Reduced ❑ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **email:** program.intake@usda.gov

This institution is an equal opportunity provider.

Precious Days Learning Academy

Authorization for Medical Treatment

_____ has my permission to obtain emergency medical treatment for my child (including administration of anesthesia if physician advises surgery) when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

My insurance provider is _____

Numbers or information pertaining to coverage are_____

_____

Preferred hospital/treatment center _____

I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in childcare.

Signature of Parent or Guardian _____

Date _____

Precious Days Learning Academy

Picture Permission

I give my permission for my child _____

to be photographed in the daily activities of this childcare facility for purposes of developmental recording. I understand that if these photographs are used in any promotional way, I will be asked to consent with another type of form

Signature of Parent or Guardian _____

Date _____

Precious Days Learning Academy

Parent Agreement Form

- A late fee will be charged for late pick-ups. There is a $3.00 fee for every 5 minutes _____
- I agree to pay in advance each week's tuition and co-payment unless otherwise approved by director _____
- My child is enrolled _____ days per week at a cost of $ _____ weekly _____
- I understand that if my child is absent for several consecutive days or a week, I am responsible for that payment week, to keep my child actively enrolled _____
- I understand that if my account becomes over 3 days past due, PDLA has the right, not to accept my children unless an agreement has been made and approved with the director _____
- A late charge of $15 will be applied to all tuitions not paid by 9:00 am on Tuesday morning, unless arrangements have been made with the director _____
- There is a $35 Return check fee _____
- Parents must provide PDLA with a two-week notice before leaving PDLA or the parents will be responsible for a two week tuition charge_____