



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		ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME		GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)			
<b>IDENTIFYING INFORMATION</b>			
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	
<b>EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED</b>			
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)			
<b>COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, &amp; INDIVIDUAL NEEDS)</b>			

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 MDA 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@desse.mo.gov](mailto:civilrights@desse.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	

## 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

### 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 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
<b>CACFP REQUIREMENT</b>	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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**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.							
<b>PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER</b>							
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			
		/ /					
		/ /					
		/ /					
		/ /					
<b>PART 2: HOUSEHOLD AND INCOME INFORMATION</b>							
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) <input type="checkbox"/> YEARLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> 2 X A MONTH <input type="checkbox"/> EVERY 2 WEEKS <input type="checkbox"/> WEEKLY							
HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER			
<b>PART 3: RACIAL ETHNIC INFORMATION</b> (You are not required to answer this section)							
Are you of Hispanic or Latino origin? <input type="checkbox"/> YES <input type="checkbox"/> 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			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>PART 4: SIGNATURE</b>							
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.							
<b>FOR CENTER USE ONLY</b>							
TOTAL HOUSEHOLD SIZE	INCOME	INCOME BASED ON (CHECK ONE):			SNAP (Food Stamp)	TEMPORARY ASSISTANCE	
		YEAR	MONTH	2 X A MONTH	EVERY 2 WEEKS	WEEKLY	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eligibility Determination: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Paid							
SIGNATURE OF CENTER REPRESENTATIVE						DATE	



# **Authorization For Emergency Care and Transportation**

**Child's Name** \_\_\_\_\_

If, at any time, due to such circumstances as an injury or sudden illness or other unforeseen emergency, medical treatment is necessary, I authorize Tendercare Learning Center #4 to take whatever emergency measures they deem necessary for the protection of my child while in their care.

I understand that a natural or deliberate disaster or emergency may result in the need for my child to be transported to another location for safety.

I understand that this may involve contacting a doctor, interpreting and carrying out his or her instructions, and transporting my child to a hospital or doctor's office; including the possible use of an ambulance located at

\_\_\_\_\_  
\_\_\_\_\_

Or the doctor contacted will be

\_\_\_\_\_

I understand that this may be done prior to contacting me, and that any expense incurred for such treatment, including ambulance fees, is my responsibility.

X

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date

X

Tendercare Learning Center #4

\_\_\_\_\_  
Date

## Tendercare Policies

**Please be sure you have read and understand the below policies. Please initial beside each policy and sign at the bottom**

\_\_\_ Tuition is due on Friday before childcare is provided. A \$25 late fee will apply for accounts not paid before Tuesday. If your account falls one week behind, you will have to withdraw your child until tuition is current. This includes state co-pays. If a collections or small claims court is needed to collect these funds, you will be responsible for any additional expenses that occur.

\_\_\_ Tuition credit is not given for absences due to illness or holidays or behavioral instances. However, after one year of enrollment each family will receive five vacation days.

\_\_\_ All children must be escorted inside the building by an adult. We will only release children to adults on the authorized release form. Parents must sign their child in and out each day.

\_\_\_ In order to keep all of our children healthy, it is our policy that your child be fever, diarrhea and vomit free for at least 24 hours before returning to the center if sent home.

\_\_\_ Each parent will need to supply a complete change of clothing, diapers if applicable, wipes and a blanket to be kept at school.

\_\_\_ Toys, cell phones and gaming systems should not be brought to the center. We provide a large variety of age-appropriate, educational toys and manipulatives.

\_\_\_ All files must always be kept current to be in compliance with state laws. Please inform us of any changes in medications, phone, address or contact information. Immunizations, medical forms and DFS contract must be kept up-to-date

\_\_\_ All medications brought into the center must be given to the director. A medical form must be completed and signed by the guardian in order for us to administer the medication to the child. The medication must be in the original bottle with your child's name on it along with instructions.

\_\_\_ Should a serious medical condition occur, we will make an immediate attempt to contact you or your emergency contact. If we are unable to reach either, we will call for emergency assistance 911. Parents will assume responsibility for any resulting expenses.

\_\_\_ Our center is open from 6 AM to 6 PM Monday through Friday. Late charges will apply at the rate of one dollar(\$1) per minute per child after 6 PM. These fees are due upon pick up. Family services will be contacted for any child left after 7 PM.

\_\_\_ Our drop off time is 9:30 AM. If your child will be arriving later than this time, for a doctors appointment etc. please call and notify the center. If you do not call by 930, your child will not be admitted. Students will not be admitted after 12 PM.

\_\_\_ If a child is unable to adjust or is having discipline issues after a reasonable manner of time, the director reserves the right to request a withdrawal of the child.

Parent or Guardians Signature with date:- \_\_\_\_\_

## Tendercare Fee Agreement

My child, \_\_\_\_\_ will be attending Tendercare Learning Center on the following days:

Registration fee: \$ 100.00

(Circle Days Attending) Monday Tuesday Wednesday Thursday Friday

\_\_\_\_ PLAN 1 – Daily

My establishment daily amount will be \$ \_\_\_\_\_ with a three-day minimum. This is ONLY available for infants and toddlers in space is available. Days of attendance must be the same every week or we must have a schedule a week in advance. **A Minium of three days will be charged to your account regardless of attendance.** Tuition is due the Friday before the week of care. A late fee of \$ 25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM. Part-time enrollment can be cancelled if space is needed for full-time childcare.

\_\_\_\_ Plan 2- Weekly

My established amount will be: \$ \_\_\_\_\_. Tuition is due Friday before the week of care. A late fee of \$25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM.

\_\_\_\_ Plan 3- State Assistance

State contract amount: \_\_\_\_\_ Sliding Fee/day \$ \_\_\_\_\_ Co-pay/Wk. \$ \_\_\_\_\_

Total parent responsibility: \$ \_\_\_\_\_ per week

Contract start date: \_\_\_\_\_ End date: \_\_\_\_\_ Approved hours: \_\_\_\_\_ Approved Days: \_\_\_\_\_

- I understand that Plan 2 & Plan 3 are weekly rates and apply regardless of my child's attendance. No refunds allowed for missing days. Tuition is due the Friday before care. A late fee of \$ 25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM.
- There are no refunds for missing days or Holidays. Each family will receive 5 vacation days after one year of enrollment.
- I understand that childcare services will be suspended until past due amounts are paid. All accounts must be current to continue receiving services.
- I understand the fee is \$ 40.00 for an NSF (non-sufficient funds) check and must be paid in full with tuition before continuing services.
- Late child pickup fees are due upon pick up of \$1.00 per minute, per child after 6:00 PM.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION  
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE  
CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

SAVE  
PRINT  
RESET

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

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY



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

& MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
CHILD AND ADULT CARE FOOD PROGRAM

**INFANT AND TODDLER FEEDING AND CARE PLAN**

**FOR CHILD CARE FACILITY USE**

The formula provided by this child care facility is:

CHECK A BOX

☐ YES ☐ NO

This child care facility is participating in the Child and Adult Care Food Program (CACFP). In order to claim meals and reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

**INSTRUCTIONS (FOR PARENTS)**

Please complete for child who is less than 24 months of age. Update information as needed.

Use a new form or initial/date changes on this form.

CHILD'S NAME

DATE OF BIRTH

DATE ENROLLED

**FEEDING INFORMATION**

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply: ☐ Parent ☐ Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

☐ Yes Explain: \_\_\_\_\_

☐ No

Does your child use a pacifier? ☐ Yes ☐ No

Note: Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

**INFANT FEEDING PREFERENCE (under 12 months)**

Mark your preference (check all that apply).

☐ I will provide breast milk for my infant.

☐ I will nurse my infant at the center at these times: \_\_\_\_\_

The facility's formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

If breast milk is unavailable for a feeding, the facility should:

☐ I request that the formula provided by the child care facility be served to my infant.

☐ I will provide infant formula for my infant. Name of formula: \_\_\_\_\_

☐ I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. OR

☐ I will provide solid foods for my infant.

In accordance with Federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights and policies, 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, etc.) 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/casr/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 mail to U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, by fax (202) 690-7442, or email at [program.intake@usda.gov](mailto:program.intake@usda.gov). This Institution is an equal opportunity employer.

**TODDLER FEEDING PREFERENCE (12 through 23 months)**

Check all that apply: ☐ Spoon ☐ Cup ☐ Feeds Self ☐ Feeding Table or Chair

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Milk			
Table Food			

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 800-735-2965; email [offices@doe.ms.gov](mailto:offices@doe.ms.gov)



**ARRANGEMENTS FOR SLEEP – Licensing rules require that infants be placed on their back to sleep.**

TIME(S) CHILD USUALLY NAPS

LENGTH OF NAP

**Additional Instructions Related to Sleeping:**

Note: When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) must put the infant to sleep in accordance with such written instructions.

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

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

**DIAPERING INSTRUCTIONS**

LIST ANY LOTIONS AND/OR OINTMENTS, ETC. THAT YOU HAVE PROVIDED AND GIVE PERMISSION FOR CAREGIVERS TO USE ON YOUR CHILD

FOR ☐ 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; CLEARLY LABELED WITH MY CHILD'S NAME

SPECIAL INSTRUCTIONS FOR CARE (E.G., RESTRICTIONS, ALLERGIES, ETC.):

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

Dear Parent / Guardian:

In the event of an emergency situation, **<Tendercare Learning Center #4>**, has outlined the below response plan. Please know that **< Tendercare Learning Center #4>**, will make every attempt to notify you so it is vital that you keep your emergency contact information up-to-date. Keep this letter with you so that you will know how to contact us in the event of an emergency.

#### Evacuation / Relocation

If the emergency is confined to the immediate area at the **< Tendercare Learning Center #4>**, e.g. fire, and the children cannot stay on the premises, the children will be taken to **< Youth In Need>** (across the street)

Address: **<1815 Boone's Lick Road>**

City, State Zip: **<St. Charles Mo, 63301>**

1. Telephone Number: **<636-946-5600>**. The children and staff will remain at this location while you or your emergency contact is notified of the situation.

If the emergency is more wide spread and encompasses a larger area such as the neighborhood due to an environmental threat, e.g. flood, and the children cannot remain in the immediate area, they will be transported to **<Tendercare Learning Center #11>(St. Charles, Mo)**

Address: **<4778 central School Road1**

City, State Zip: **<St. Charles, Mo, 63304>**

Telephone Number: **<636-928-9907>**

The children and staff will remain at this location while you or your emergency contact is notified of the situation.

#### Notification

1. Every effort will be made to contact you as soon as the children and staff are safe. If we cannot reach you, we will contact your alternate emergency contact. Children will only be released to you or your alternate emergency contact during times of emergency.

Information about the event can be obtained through radio stations, **< WII 314-644-6397>**

Radio Z 314-432-9170

2.

#### Emergency Supplies

1. We encourage you to bring individual emergency packs for each child to keep at our facility that includes a change of clothes, a few family photos and a comfort item like a small teddy bear to help comfort your child during a crisis. These individual packs will be stored in our safe room and only accessed during an emergency.

Please rest assure that **< Tendercare Learning Center #4>** staff will remain with and care for the children at all times during an emergency to ensure the children's safety. As always, please don't hesitate to contact me if you have any questions or concerns.

Sincerely,

**<Director/Owner>**

**(THIS LETTER IS MEANT TO ALSO BE GIVEN TO PARENTS UPON ENROLLMENT)**

# Safe Sleep For Your Baby



- Always place your baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.
- Use a firm sleep surface, such as a mattress in a safety-approved\* crib, covered by a fitted sheet, to reduce the risk of SIDS and other sleep-related causes of infant death.
- Room sharing—keeping baby's sleep area in the same room where you sleep—reduces the risk of SIDS and other sleep-related causes of infant death.
- Keep soft objects, toys, crib bumpers, and loose bedding out of your baby's sleep area to reduce the risk of SIDS and other sleep-related causes of infant death.
- To reduce the risk of SIDS, women should:
  - Get regular health care during pregnancy, and
  - Not smoke, drink alcohol, or use illegal drugs during pregnancy or after the baby is born.
- To reduce the risk of SIDS, do not smoke during pregnancy, and do not smoke or allow smoking around your baby.
- Breastfeed your baby to reduce the risk of SIDS.
- Give your baby a dry pacifier that is not attached to a string for naps and at night to reduce the risk of SIDS.
- Do not let your baby get too hot during sleep.
- Follow health care provider guidance on your baby's vaccines and regular health checkups.
- Avoid products that claim to reduce the risk of SIDS and other sleep-related causes of infant death.
- Do not use home heart or breathing monitors to reduce the risk of SIDS.
- Give your baby plenty of Tummy Time when he or she is awake and when someone is watching.



## Remember Tummy Time!

Place babies on their stomachs when they are awake and when someone is watching. Tummy Time helps your baby's head, neck, and shoulder muscles get stronger and helps to prevent flat spots on the head.

\* For more information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or <http://www.cpsc.gov>.

For more information about SIDS and the Safe to Sleep® campaign:

Mail: 31 Center Drive, 31/2A32, Bethesda, MD 20892-2425

Phone: 1-800-505-CRIB (2742)

Fax: 1-866-760-5947

Website: <http://safetosleep.nichd.nih.gov>

NICH Publications 12-5759



Eunice Kennedy Shriver National Institute  
of Child Health and Human Development

## INFANT SAFE SLEEP POLICY

Facility Name: Tendercare Learning Center # \_\_\_\_\_

Facility DVN: \_\_\_\_\_

Date Adopted: February 6, 2023

**Purpose:** The purpose of the Safe Sleep Policy is to maintain a safe sleep environment that reduces the risk of sudden infant death syndrome (SIDS) and sudden unexpected infant deaths (SUIDS) in children less than one year of age. Missouri law (S 210.223.1, RSMo,) requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent safe sleep recommendations of the American Academy of Pediatrics (AAP). Missouri child care licensing rules require licensed child care facilities to provide parent(s) and/or guardians(s) who have infants in care be provided a copy of the facility's safe sleep policy.

Sudden infant death syndrome is the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and a review of the clinical history.

Sudden unexpected infant death is the sudden and unexpected death of an infant less than one year of age in which the manner and cause of death are not immediately obvious prior to investigation. Causes of sudden unexpected infant death include, but are not limited to, metabolic disorders, hypothermia or hyperthermia neglect or homicide, poisoning, and accidental suffocation.

Child care providers can maintain safer sleep environments for infants that help lower the chances of SIDS. Our goal is to take proactive steps to reduce the risk of SIDS in child care and to work with parents to keep infants safer while they sleep. To do so, this facility will practice the following safe sleep policy:

### Safe Sleep Practices

1. Infants, less than one (1) year age, will always be placed on their backs to sleep. When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements. Caregivers will put the infant to sleep as specified in the written instructions.
2. When infants can easily turn from their stomachs to their backs and from their backs to their stomachs, they shall be initially placed on their backs, but shall be allowed to adopt whatever positions they prefer for sleep. The American Academy of Pediatrics recommends that infants are placed on their back to sleep, but when infants can easily turn over from their back to their stomach, they may adopt whatever position they prefer for sleep. We will follow this recommendation by the American Academy of Pediatrics.
3. Sleeping infants shall have a supervised nap/sleep period. The caregiver shall be positioned where he or she can hear and see the infant. The caregiver shall physically check on the infant frequently during napping or sleeping and shall remain in close proximity to the infant in order to hear and see them if they have difficulty during napping/sleeping or when they awaken.
4. Equipment such as a sound machine, that may interfere with the caregiver's ability to see or hear a child who may be distressed, is prohibited.
5. Steps will be taken to keep infants from overheating by regulating the room temperature, avoiding excess bedding, and not over-dressing or over-wrapping the infant. Infants should be dressed appropriately for the environment, with no more than one (1) layer more than an adult would wear to be comfortable in that

# MY FIRST DAY

Welcome to Tendercare Learning Center.

Below is a list of things that your  
child/children will need for their first day.

1. Completed Enrollment Packet
2. Updated shot record
3. Labeled Crib Sheet and Blanket
4. Extra Change of Clothes
5. Diapers and Wipes (if needed)
6. Weekly Tuition Payment

