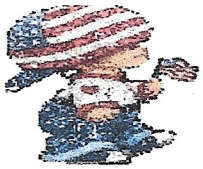
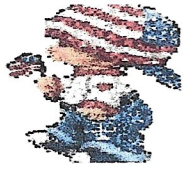


AMERIKIDS



TO BE COMPLETED BY CHILD CARE FACILITY		
Student ID	Enrollment Date	Drop Date

CHILD'S NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	

IDENTIFYING INFORMATION	
MOTHER'S NAME	HOME NUMBER ( ) Cell Number ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
EMPLOYED BY	HOURS OF EMPLOYMENT From To
ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )
FATHER'S NAME	HOME NUMBER ( ) Cell Number ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
EMPLOYED BY	HOURS OF EMPLOYMENT From To
ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )

EMERGENCY CONTACT(S) / PERSON(S) AUTHORIZED TO TAKE CHILD FROM AMERIKIDS	
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	

PLEASE COMPLETE BACK

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

PHYSICIAN AND PREFERRED HOSPITAL TO BE USED IN AN EMERGENCY

I understand that in case of an accident or injury to my child, I will be notified immediately. If my child requires emergency medical care, the physician and preferred hospital to be used are as follows.

DOCTOR/CLINIC NAME	TELEPHONE ( )
PREFERRED HOSPITAL NAME	TELEPHONE ( )

FIELD TRIPS AND TRANSPORATION

[ ] I do [ ] I do NOT

Give consent for my child to take part in field trips or excursions within a one (1) mile radius of the facility.
It is my understanding that I will be notified when such trips are planned.

SCHEDULE	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival					
Departure					

AGREEMENTS

A. I have been informed of the required health and safety inspections and that they are available for review.
B. When my child is ill, I understand and agree that my child may not be accepted for care.
C. I have was given and have read the AmeriKids Parent Handbook.
D. I understand that AmeriKids honors out-of-school suspensions.
E. I understand the pictures of my child/ren may be used at AmeriKids and on the AmeriKids.net website.
F. 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/LEGAL GUARDIAN SIGNATURE

HEALTH REPORT

CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS

ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS

ANY SPECIAL MEDICATIONS AND/OR RESTRICTIONS

This certifiies that my child is to my knowledge in good health and free of disabilities that would endanger him/her or other children at AmeriKids.

PARENT/LEGAL GUARDIAN SIGNATURE	DATE

Religious Organization Child Care Facility
Notice of Parental Responsibility

Facility Name AMERIKIDS CHRISTIAN CENTER

Address (Street, City, State, Zip Code) 1017 North Main Street, O'Fallon, MO 63366

INSPECTIONS

Section 210.211 RSMo exempts this religious organization child care facility from state licensing and supervision by the Department of Health and Senior Services (DHSS). It is state inspected only for fire, health and sanitation requirements as indicated below. Copies of the inspections are available.

NAME OF AGENCY AND TYPE OF VISIT	ADDRESS	TELEPHONE NUMBER	INSPECTION			DATE
Section for Child Care Regulation (Health and Safety Inspection)	220 S. Jefferson, 2nd Floor St. Louis, MO 63103	314-877-0228	Pending	Approved XX	Not Approved	10-7-22
Fire Marshal's Office (Fire Safety Inspection)	P.O. Box 844 Jefferson City, MO 65102	573-248-2095	Pending	Approved XX	Not Approved	8-8-23
Local Health Office or DHSS (Sanitation Inspection)	220 S. Jefferson, 2nd Floor St. Louis, MO 63103	314-877-0228	Pending	Approved XX	Not Approved	7-6-23

STANDARD STAFF/CHILD RATIOS ESTABLISHED BY THIS FACILITY

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 Staff member for every	6
2 to 4 years of age	1 staff member for every	20
5 years of age and older	1 staff member for every	30

STAFF/CHILD RATIOS FOR LICENSED CENTERS

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 staff member for every	4
2 years of age	1 staff member for every	8
3 and 4 years of age	1 staff member for every	10
5 years of age and older	1 staff member for every	16

Total number of children enrolled by this facility 85

BACKGROUND CHECKS: CHILD ABUSE/NEGLECT AND CRIMINAL RECORD(S)

Statute 210.254 RSMo requires the facility to conduct background abuse/neglect and criminal record reviews on each individual caregiver and all other personnel (who have contact with children in care) at the facility at the time of employment and every two years thereafter.

Background checks for child abuse and neglect through the Children's Division (CD) and criminal record reviews through the Missouri State Highway Patrol have been conducted on each individual caregiver and all other personnel at the facility as required: XX Yes No

FACILITY DISCIPLINE AND EDUCATIONAL PHILOSOPHY/POLICIES

The disciplinary philosophy and policies of this facility are:

1) Redirect when possible; 2) When discipline is necessary, our staff will speak quietly to the child; 3) Students must observe all school rules; 4) Students must have respect for the truth; 5) If behaviors warrant, a student may be removed from class for extended periods of time to maintain a positive learning environment for others; and 6) In cases of serious behavior problems, we will discuss options with the parent(s). Every effort will be made to resolve such issues.

The education philosophy and policies of this facility are:

Provide a Christian based learning curriculum that is flexible and comprehensive while ensuring the best education possible for each student. The program will serve to guide each student in understanding, appreciating and relating to the Word of God as revealed in the Bible.

REQUIRED SIGNATURES

Statute 210.254 RSMo requires the facility to furnish two copies of this document to a parent(s) upon enrollment of a child. Parents acknowledge by signature that they have read and accepted the information contained in this document. One copy of this signed document is given to the parent(s); the other copy is retained in the child's record at the facility.

PARENT(S) _____ DATE _____

PRINCIPAL OPERATING OFFICER/FACILITY DIRECTOR _____ DATE 30 June 2023

INDIVIDUAL RESPONSIBLE FOR THE RELIGIOUS ORGANIZATION-PASTOR, MINISTER, PRIEST, ETC. _____ DATE 30 June 2023

Statute 210.254 RSMo requires a new facility to file a copy of the Notice of Parental Responsibility with the Section for Child Care Regulation at least five days prior to beginning operation. Each facility must file the Notice of Parental Responsibility annually during the month of August.

BCC-104

- **NOTICE OF PARENTAL RESPONSIBILITY – BACKGROUND SCREENING TRACKING SHEET**

Name of Caregiver(s)/Other Personnel	Child/Abuse Neglect Screen Submitted	Child/Abuse Neglect Screening Received	Criminal Background Screening Submitted	Criminal Background Screening Received
CHERI PRICE	3-22-23	3-22-23	3-22-23	3-22-23
MICHAEL PRICE	3-22-23	3-22-23	3-22-23	3-22-23
STEFANIE FOELLER	3-22-23	3-22-23	3-22-23	3-22-23
TORIA SHOWEN	3-22-23	3-22-23	3-22-23	3-22-23
SUSAN SCHIERMEIER	3-22-23	3-22-23	3-22-23	3-22-23
SIERRA BARTON	3-22-23	3-22-23	3-22-23	3-22-23
ALICIA MARCINIAK	6-20-23	6-20-23	6-20-23	6-20-23
ALLYSON MARTIN	7-6-23	7-6-23	7-6-23	7-6-23
ANITA PIERCE	8-11-23	8-11-23	8-11-23	8-11-23
JESSICA NELSON	11-9-22	11-8-22	11-8-22	11-8-22

AMERIKIDS

Christian Center

1017 N. Main Street
O'Fallon, MO 63366
636-379-9543

26 February 2014

AmeriKids Parents

We will be implementing a new procedure immediately regarding children with possible allergic reactions to foods. If your child had a reaction to a particular food or drink, we would need documentation from their pediatrician describing what exactly your child cannot ingest.

On those days when our menu shows food or foods that your child should not have, the family will be responsible for providing an entrée or complete meal or appropriate drink for their child. Our present policy requires the family to provide Vitamin D or Soy milk when their pediatrician recommends that for their patient since we provide only 2% milk for our meals.

Please contact the office if you have any questions regarding this change of policy.

God Bless You,

Mr. Mike and Ms. Cheri

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CHILD CARE

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
▶	

MO 580-1918 (4-06)

BCC-12

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.

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)**

PLEASE ATTACH CURRENT IMMUNIZATION RECORDS.

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)	NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN NAME
	TELEPHONE NUMBER

TO BE FILED IN CHILD'S RECORDS