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## MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

FACILITY/PROVIDER NAME  CHILD'S NAME  ADMISSION DATE  BIRTHDATE  BIRTHDATE  ADRESS (STREET, CITY, STATE, ZIP CODE)  IDENTIFYING INFORMATION  MOTHER S/GUARDIAN'S NAME  ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE   E-MAIL ADDRESS  EMPLOYER OR SCHOOL ATTEND  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  FATHER S/GUARDIAN'S NAME  ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE   E-MAIL ADDRESS  EMPLOYER OR SCHOOL ATTEND  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  FATHER S/GUARDIAN'S NAME  ADDRESS (STREET, CITY, STATE, ZIP CODE)  EMPLOYER OR SCHOOL ATTEND  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  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 NUMBERS (CELL, WORK, HOME)  AUTHORIZATION FOR EMERGENCY MEDICAL CARE  IUNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENT'S FOR MEDICAL CARE ON Y CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.  IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICA CARE, I AUTHORIZE  DAY CARE PROVIDER  TO CONTACT THE FOLLOWING:  PHYSICIAN OR CLINIC  TELEPHONE NUMBER  TELEPHONE NUMBER  TELEPHONE NUMBERS  TO CONTACT THE FOLLOWING:  PHYSICIAN OR CLINIC	The state of the s	CHILD CARE ENROLLMI	ENT FORM FO	OR LICENSE-EXEMI	PT FA	CILITIES	
ADDRESS (STREET, CITY, STATE, ZIP CODE)    DENTIFYING INFORMATION   HOME TELEPHONE NUMBER	FACILITY/PRO	VIDER NAME		ADMISSION DAT	E	DISCHARGE DATE	
DENTIFYING INFORMATION	CHILD'S NAME		GENDER		BIRTHDATE		
MOTHER'S/GUARDIAN'S NAME  ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐ CELL PHONE NUMBER  E-MAIL ADDRESS  EMPLOYER OR SCHOOL ATTEND  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  WORK TELEPHONE NUMBER  FATHER'S/GUARDIAN'S NAME  ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐ CELL PHONE NUMBER  E-MAIL ADDRESS  EMPLOYER OR SCHOOL ATTEND  EMPLOYER'SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)  WORK TELEPHONE NUMBER  (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.  NAME  RELATIONSHIP TO CHILD  TELEPHONE NUMBERS (CELL, WORK, HOME)  TO CONTACT THE FOLLOWING:  DAY CARE PROVIDER  PHYSICIAN OR CLINIC	ADDRESS (ST	REET, CITY, STATE, ZIP CODE)					
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DAY CARE PROVIDER  TO CONTACT THE FOLLOWING:  PHYSICIAN OR CLINIC							
TO CONTACT THE FOLLOWING:  PHYSICIAN OR CLINIC							
PHYSICIAN OR CLINIC							
	NAME					TELEPHONE NUMBER	
PREFERRED HOSPITAL							
NAME TELEPHONE NUMBER	NAME					TELEPHONE NUMBER	

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.

ACKNOWLEDGEMENTS							
Α	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS					
В	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					
С	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS					
D	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS					
E	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					
	HEALTH REPORT FOR SCHOOL-AGE CHILD CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS						
	CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECI REMENTS.	AL HEALTH OR MEDICAL					
MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW.							
ANY A	LLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS						
ANIV C	PECIAL MEDICATIONS AND/ OR RESTRICTIONS						
ANY 5	PECIAL MEDICATIONS AND/ OR RESTRICTIONS						
	NT/GUARDIAN SIGNATURE	DATE					
FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.  FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.							
FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.							

MO500-3312 (8-21) PAGE 2