



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

IDENTIFYING INFORMATION

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

If you or a member of your immediate family ever served in the U.S. Armed Forces, [click here for more information about militaryrelated 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	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)		

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COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

RELATED CHILD

<input type="checkbox"/> YES <input type="checkbox"/> NO	HOW IS CHILD RELATED TO CHILD CARE PROVIDER
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CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CACFP REQUIREMENT

WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME CHECK WHAT DAYS THE CHILD WILL ATTEND		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
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
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PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER
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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
CACFP REQUIREMENT	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
USDA Nondiscrimination Statement			
<p>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.</p> <p>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, audiotope, 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.</p> <p>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:</p> <ol style="list-style-type: none"> 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 <p>This institution is an equal opportunity provider.</p>			