


CHILD NUTRITION SERVICE, INC.

	MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION FOR CHILD CARE REGULATION / BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE CHILD CARE ENROLLMENT FORM
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FACILITY/PROVIDER NAME <i>Rashawn Carter-Kamay</i>	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE

ADDRESS (STREET, CITY, STATE, ZIP CODE)

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER

E-MAIL ADDRESS

EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER
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E-MAIL ADDRESS

EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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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)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

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

RELATED CHILD

YES NO HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CACFP REQUIREMENT	CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME OR <input type="checkbox"/> PART TIME	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	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
	MONDAY	<input type="checkbox"/>	AM PM	AM PM
	TUESDAY	<input type="checkbox"/>	AM PM	AM PM
	WEDNESDAY	<input type="checkbox"/>	AM PM	AM PM
	THURSDAY	<input type="checkbox"/>	AM PM	AM PM
	FRIDAY	<input type="checkbox"/>	AM PM	AM PM
	SATURDAY	<input type="checkbox"/>	AM PM	AM PM
	SUNDAY	<input type="checkbox"/>	AM PM	AM PM
				Child's Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic
				Child's Race

CACFP REQUIREMENT	CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY			
	<input checked="" type="checkbox"/> BREAKFAST <input type="checkbox"/> MORNING SNACK <input checked="" type="checkbox"/> LUNCH <input checked="" type="checkbox"/> AFTERNOON SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK <input type="checkbox"/> NONE			
	CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY			
	<input checked="" type="checkbox"/> NEW YEAR'S DAY (JANUARY)	<input checked="" type="checkbox"/> MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	<input checked="" type="checkbox"/> PRESIDENT'S DAY (FEBRUARY)	<input checked="" type="checkbox"/> EASTER (MARCH/APRIL)
	<input checked="" type="checkbox"/> MEMORIAL DAY (MAY)	<input checked="" type="checkbox"/> INDEPENDENCE DAY (JULY)	<input checked="" type="checkbox"/> LABOR DAY (SEPTEMBER)	<input type="checkbox"/> COLUMBUS DAY (OCTOBER)
<input type="checkbox"/> VETERANS DAY (NOVEMBER)	<input type="checkbox"/> ELECTION DAY (NOVEMBER)	<input checked="" type="checkbox"/> THANKSGIVING (NOVEMBER)	<input checked="" 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 ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE				
<i>Rashawn Carter-Kamay</i>				
DAY CARE PROVIDER OR HOME PROVIDER				
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 HOMES 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	