



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION/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)

**IDENTIFYING INFORMATION**

MOTHER'S/GUARDIAN'S NAME	TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE

E-MAIL ADDRESS

EMPLOYER OR SCHOOL	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	TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE

E-MAIL ADDRESS

EMPLOYER OR SCHOOL	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 NUMBER(S)
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ADDRESS (STREET, CITY, STATE, ZIP CODE)

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
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ADDRESS (STREET, CITY, STATE, ZIP CODE)

**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**

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. 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
MONDAY	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
TUESDAY	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
WEDNESDAY	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
THURSDAY	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
FRIDAY	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
SATURDAY	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
SUNDAY	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	

CACFP REQUIREMENT

<b>CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY</b>				
CACFP REQUIREMENT	<input type="checkbox"/> BREAKFAST <input type="checkbox"/> MORNING SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> AFTERNOON SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK <input type="checkbox"/> NONE			
	<b>CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY</b>			
	<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)	
<b>AUTHORIZATION FOR EMERGENCY MEDICAL CARE</b>				
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				
<b>NORA STEWART EARLY LEARNING CENTER</b>				
<small>(LIST CHILDCARE FACILITY NAME HERE)</small>				
<b>TO CONTACT THE FOLLOWING:</b>				
<b>PHYSICIAN OR CLINIC</b>				
NAME			TELEPHONE NUMBER	
<b>PREFERRED HOSPITAL</b>				
NAME			TELEPHONE NUMBER	
<b>ACKNOWLEDGMENTS</b>				
<b>A</b>	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.		PARENT/GUARDIAN INITIALS	
<b>B</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	
<b>C</b>	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.		PARENT/GUARDIAN INITIALS	
<b>D</b>	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	
<b>E</b>	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	
<b>F</b>	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	
<b>G</b>	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.		PARENT/GUARDIAN INITIALS	
<b>H</b>	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	
<b>I</b>	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	



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION

**CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)**

SAVE  
PRINT  
RESET

**IDENTIFYING INFORMATION**

CHILD'S NAME	BIRTHDATE
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**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.)

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SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE
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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



Missouri Department of Health and Senior Services

Child Care Regulation

OFFENDING COMMAND: show

STACK:

INDIVIDUAL PLAN FOR SPECIALIZED CARE

IDENTIFYING INFORMATION

CHILD'S NAME

BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE



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.

**PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER**

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
		/ /		
		/ /		
		/ /		
		/ /		

**PART 2: HOUSEHOLD AND INCOME INFORMATION**

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)  YEARLY  MONTHLY  2 X A MONTH  EVERY 2 WEEKS  WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

**PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)**

Are you of Hispanic or Latino origin?  YES  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"/>

**PART 4: SIGNATURE**

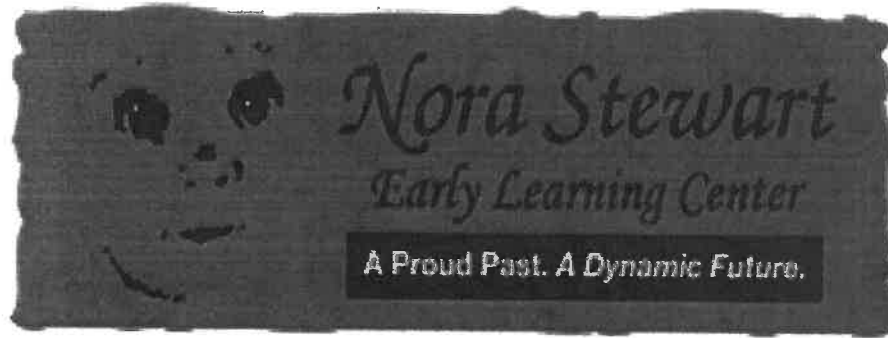
I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) XXX-XX-	DATE / /
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.

**FOR CENTER USE ONLY**

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE):					TEMPORARY ASSISTANCE
		YEAR	MONTH	2 X A MONTH	EVERY 2 WEEKS	WEEKLY	SNAP (Food Stamp)
		<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							DATE
SIGNATURE OF CENTER REPRESENTATIVE						DATE	



### **Non-Prescription Topical Application Permission**

I give permission for the following non-prescription topical treatments to be applied my child \_\_\_\_\_ on an as needed basis in accordance with the directions listed on the packaging. I understand that only products I have provided will be applied to my child.

**Sunscreen (Please indicate brand):** \_\_\_\_\_

**Diapering Cream (Please indicate brand):** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Nora Stewart Early Learning Center Admission/Tuition Agreement

Responsible Parent Guardian Name: \_\_\_\_\_

Child(ren) Name(s): \_\_\_\_\_  
is/are scheduled to attend Nora Stewart Early Learning Center on \_\_\_\_\_ and my tuition will be \_\_\_\_\_  
(Date) (Cost)

Please read the following information in each box and sign your initials indicating you understand and agree to the terms of your financial responsibility.

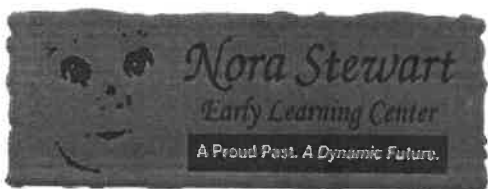
- \_\_\_\_\_ I agree **Tuition Fee:** I will be responsible for paying a deposit and first week tuition fees before my child's first day.
- \_\_\_\_\_ I agree **Tuition Due Dates:** Tuition is posted on Mondays; you will be charged a \$10 late fee on Tuesday. If payment is not received by Wednesday at noon your child will not be able to return that Thursday until payment is received.
- \_\_\_\_\_ I agree **Parent Handbook:** I agree to read and abide by rules and policies set forth in the parent handbook.
- \_\_\_\_\_ I agree **Late Pick Up Fee:** I understand that if I do not pick up my child(ren) by 5:45 pm then a \$10 late fee will be charged at 5:46 pm. After 5:46 pm a \$1 a minute will be charged. That fee will need to be paid before you drop off your child(ren) the next business day.
- \_\_\_\_\_ I agree **Tuition Paid Regardless of Absences, Holidays, Vacations or Suspension:** Tuition is based on your contracted enrollment days. Tuition is due regardless of illness, holidays, vacations or suspensions. You are enrolling your child(ren) at a fee of \$\_\_\_\_\_ weekly, bi-weekly, semi-monthly or monthly.
- \_\_\_\_\_ I agree **Field Trips:** Occasionally classes will take a field trip; fees may be associated with the field trip and is due before the trip takes place.
- \_\_\_\_\_ I agree **Returned Checks:** There will be a \$15 returned check fee assigned for each returned check from the bank. After two returned checks, you may no longer write a check and must pay with a cashier's check or money order.
- \_\_\_\_\_ I agree **Cash Payments:** Cash payments are **NOT** accepted by NSEL for the protection of the staff.
- \_\_\_\_\_ I agree **Sign In/Out Binders:** Binders are located in front of each classroom by the door. Please complete and sign the time in and time out every day.
- \_\_\_\_\_ I agree **Withdrawal Notice:** You must give the Director written notice of withdrawal two weeks prior to terminating child care services, all tuition and/or other charges is payable prior to withdrawal.
- \_\_\_\_\_ I agree **Morning Cut Off Time:** All children are to be in the facility by 9:30 am. If not, please provide a medical excuse after 9:30 am or your child(ren) will not be able to attend for that day.
- \_\_\_\_\_ I agree **Collection Fees/Charges:** Should it be necessary for Nora Stewart Early Learning Center to hire a collection agency for non-payment of fees, the responsible party will be billed an **additional 35% to cover collection costs**, plus reasonable attorney fees if necessary.

I, the undersigned parent/guardian understand and will adhere to the policies and procedures listed within the Nora Stewart Early Learning Center Admission/Tuition Agreement as well as the Nora Stewart Early Learning Center Parent Handbook, and I accept all my financial responsibilities in this contract.

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

Date: \_\_\_\_\_

(Updated 11/8/16)



## Emergency Contact Information Form

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

**Parent/Guardian #1 Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

**Parent/Guardian #2 Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

### Emergency Contacts:

1. Name: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Relationship to child: \_\_\_\_\_

2. Name: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Relationship to child: \_\_\_\_\_

3. Name: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Relationship to child: \_\_\_\_\_





# PICK UP AUTHORIZATION FORM

Name

Relationship

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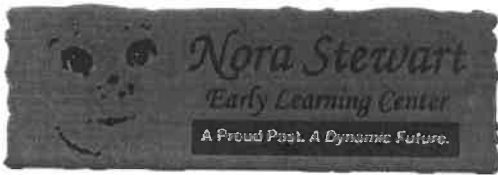
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Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Nora Stewart Early Learning Center Video/Photo Release Form

I give Nora Stewart Early Learning Center, a 501 ©3 not-for-profit organization, my consent and permission to photograph and/or videotape me and/or my child for the following promotional and/or educational purposes (please PUT A LINE THROUGH each that you disapprove of):

**Annual School Pictures**  
**Classroom Displays**  
**Classroom Play, Activities, etc.**  
**Education Purposes (ex. Training Teachers)**  
**Kindergarten Transition**  
**Newspaper**  
**Records**

**Posters**  
**Progress Monitoring**  
**Promotional Publications**  
**Television**  
**Website**  
**Parent/Guardian Portfolios &**

I understand I will not receive financial compensation for my participation, or my child's participation.

In giving consent, I release Nora Stewart Early Learning Center and their agents from any liability for any violation of any person or property rights, which I might have in connection with such material. I waive any rights to approve accompanying written or narrative material. I represent that I am either the parent or legal guardian of the child noted below.

Child's Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
(Print Name)

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

Date: \_\_\_\_\_