Kid's Creation Learning Center

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 **KID'S CREATION LEARNING CENTER** | 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 ☐ | CELL PHONE NUMBER |
| E-MAIL ADDRESS | |
| EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE |
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |

| FATHER'S/GUARDIAN'S NAME | HOME TELEPHONE NUMBER |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐ | CELL PHONE NUMBER |
| E-MAIL ADDRESS | |
| EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE |
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |

## 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)

CACFP REQUIREMENT

## RELATED CHILD

☐ YES ☐ NO — HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

## CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

| | CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐ FULL TIME OR ☐ 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 | ☐ | AM PM | AM PM | |
| TUESDAY | ☐ | AM PM | AM PM | |
| WEDNESDAY | ☐ | AM PM | AM PM | |
| THURSDAY | ☐ | AM PM | AM PM | |
| FRIDAY | ☐ | AM PM | AM PM | |
| SATURDAY | ☐ | AM PM | AM PM | |
| SUNDAY | ☐ | AM PM | AM PM | |

**CACFP REQUIREMENT**

**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**

| | | | |
|---|---|---|---|
| ☐ NEW YEARS'S DAY (JANUARY) | ☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY) | ☐ PRESIDENT'S DAY (FEBRUARY) | ☐ EASTER (MARCH/APRIL) |
| ☐ MEMORIAL DAY (MAY) | ☐ INDEPENDENCE DAY (JULY) | ☐ LABOR DAY (SEPTEMBER) | ☐ COLUMBUS DAY (OCTOBER) |
| ☐ VETERANS DAY (NOVEMBER) | ☐ ELECTION DAY (NOVEMBER) | ☐ THANKSGIVING (NOVEMBER) | ☐ 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

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 ☐ DO<br>☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS.<br>I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED. | PARENT/GUARDIAN INITIALS |
| G | I ☐ DO<br>☐ 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 |

We do not provide infant formula or baby food for children under 12 months

Missouri Department of Health and Senior Services
Section for Child Care Regulation and Child and Adult Care Food Program
**INFANT AND TODDLER FEEDING AND CARE PLAN**

**THIS SECTION TO BE COMPLETED BY CHILD CARE FACILITY:**
The formula provided by this child care facility is: _____.

**(Check a box)** ☐**Yes** ☐**No** This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

**Instructions to Parents –** Please complete for child who is less than 24 months of age. *Update information as needed. Use a new form or initial/date changes on this form.*

| CHILD'S NAME | DATE OF BIRTH | DATE ENROLLED |
|---|---|---|
| | | |

**Feeding Information**

| Type of Food | Feeding Time | Kinds of Food | Amount of Food |
|---|---|---|---|
| Breast Milk | | | |
| Formula | | | |
| Infant Food | | | |
| Table Food | | | |

Who is preparing (mixing) the formula? Check all that apply: ☐Parent ☐Caregiver

Does your child have any problems with feedings, such as choking or spitting up?
☐Yes Explain:_____
☐No

Does your child use a pacifier? ☐Yes ☐No
**Note:** Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

**Infant Feeding Preference (under 12 months)**

Mark your preference (check all that apply).

☐ I will provide breast milk for my infant.

☐ I will nurse my infant at the center at these times: _____

The facility's formula may be used to supplement feedings if necessary: ☐Yes ☐No

If breast milk is unavailable for a feeding, the facility should: _____

☐ I request that the formula provided by the child care facility be served to my infant.

☐ I will provide infant formula for my infant. Name of formula: _____

☐ I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**

☐ I will provide solid foods for my infant.

| Toddler Feeding Preference (12 through 23 months) | | | |
|---|---|---|---|
| Check all that apply: ☐Spoon ☐Cup ☐ Feeds Self ☐ Feeding Table or Chair | | | |
| **Type of Food** | **Feeding Time** | **Kinds of Food** | **Amount of Food** |
| Breast Milk | | | |
| Milk | | | |
| Table Food | | | |

**Arrangements for Sleep – Licensing rules require that infants be placed on their back to sleep.**

| Time(s) Child Usually Naps | Length of Nap |
|---|---|

**Additional Instructions Related to Sleeping:**
**Note:** When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) must put the infant to sleep in accordance with such written instructions.

☐ My child is 12 months or older, and I give my permission for my child to sleep on a cot.

| Signature of Parent/Legal Guardian | Date |
|---|---|

**Diapering Instructions**

List any lotions and/or ointments, etc. that you have provided and give permission for caregivers to use on your child. _____
For ☐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; clearly labeled with my child's name:

Special Instructions for Care (e.g., restrictions, allergies, etc.):

| Signature of Parent/Legal Guardian | Date |
|---|---|

Kid's Creation Learning Center

# INFANT SAFE SLEEP POLICY

To provide infants in our facility with a safe environment in which to grow and learn, we are implementing policies and procedures to create a safe sleep environment.

Following the recommendations of the American Academy of Pediatrics (AAP) for safe Sleep environments to reduce the risk of sudden infant death syndrome (SIDS), our written policy is as follows:

- All infants under 12 months of age will always be placed on their backs in safety-approved cribs, with a firm, tight-fitting mattress. An exception note from the infant's physician is provided, indicating a medical reason for an alternate sleep position and detailing the position.
- Positioning devices will not be used or tolerated. The only exception is if a note from the infant's physician provided a medical reason to do so.
- Soft material such as pillows, quilts, comforters, sheepskin, stuffed toys, and loose bedding will not be placed in the infant's sleep environment. Sleep clothing (i.e. sleep sack, sleepers) that is designed to keep an infant warm without the possible hazard of covering the head or face during sleep/nap time.
- There will be no smoking in the childcare facility during the hours children are in care.
- Each infant will **have** their own crib. Infants will not share a crib with other infants.
- Each parent or guardian of the infant in care will receive a copy of the safe sleep policy upon enrollment.
- When infants can easily turn from their backs to their stomachs and from their backs to their stomachs they shall be put down to sleep on their back but allowed to adopt whatever position they prefer for sleep.
- Sleeping infants shall always have a supervised nap period. The staff shall check on the infant frequently during napping or sleeping and shall remain in proximity to the infant to always hear and see them. There will be adequate lighting, and there will not be any equipment that interferes with the caregiver's ability to see or hear the child, who may become distressed.
- Parents must approve pacifiers in the infant crib, and **ABSOLUTELY NO PACIFIER CAN HAVE CORDS OR ATTACHING MECHANISMS.**
- Supervised "tummy times" will be observed while the infant is awake.
- Childcare staff and ALL new employees will be trained in safe sleep and SIDS risk reduction every 3 years.

Signature of Child Care Provider Date

Signature of Parent Date

This safe sleep policy is adapted from the Infant Morality Risk Reduction Work Team of the National SIDS Infant Death Program Support Center (NSIDPSC) & American Academy of Pediatrics *"Reducing the Risk of SIDS in Child Care.*
"Revised May 15, 2016

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

# SCHOOL-AGE CHILD HEALTH REPORT

Kid's Creation Learning Center

## IDENTIFYING INFORMATION

| CHILD'S NAME | BIRTHDATE |
|---|---|
| | |

## HEALTH STATEMENT (CHECK ONE)

☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.

☐ My child is able to participate in group care but has special health or medical requirements as listed below.

## SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

| PARENT OR LEGAL GUARDIAN SIGNATURE | DATE |
|---|---|
| | |





TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY.

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

# SCHOOL-AGE CHILD HEALTH REPORT

## IDENTIFYING INFORMATION

| CHILD'S NAME | BIRTHDATE |
|---|---|
| | |

## HEALTH STATEMENT (CHECK ONE)

☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.

☐ My child is able to participate in group care but has special health or medical requirements as listed below.

## SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

| PARENT OR LEGAL GUARDIAN SIGNATURE | DATE |
|---|---|
| | |





TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY.