



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
 OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE
CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

| | | |
|---|----------------|----------------|
| 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 | 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 |
| 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 <input type="checkbox"/> | 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) | | |

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

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

| | |
|------|------------------|
| NAME | TELEPHONE NUMBER |
|------|------------------|

PREFERRED HOSPITAL

| | |
|------|------------------|
| NAME | TELEPHONE NUMBER |
|------|------------------|

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| ACKNOWLEDGEMENTS | | |
|-------------------------|--|--------------------------|
| A | I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW. | PARENT/GUARDIAN INITIALS |
| 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 |
| C | 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 |
| D | I <input type="checkbox"/> DO <input type="checkbox"/> 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**

- 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.

ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS

ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS

PARENT/GUARDIAN SIGNATURE

DATE

FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.

FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.