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

# CHILD ENROLLMENT

| CHILD'S NAME | SEX | BIRTH DATE |
|---|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | HOME TELEPHONE NUMBER ( ) | |

OPTIONAL

## SCHOOL CHILD ATTENDS

| NAME | TELEPHONE NUMBER ( ) |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | |

## IDENTIFYING INFORMATION

| | |
|---|---|
| MOTHER'S OR GUARDIAN NAME | HOME TELEPHONE NUMBER ( ) |
| ADDRESS ☐ CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.) | CELL PHONE NUMBER (OPTIONAL) ( ) |
| EMPLOYED BY (OR SCHOOL ATTENDED) | HOURS OF EMPLOYMENT FROM TO |
| ADDRESS (STREET, CITY, STATE, ZIP CODE.. | BUSINESS TELEPHONE NUMBER ( ) |
| FATHER'S OR GUARDIAN'S NAME | HOME TELEPHONE NUMBER ( ) |
| ADDRESS ☐ CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.) | CELL PHONE NUMBER (OPTIONAL) ( ) |
| EMPLOYED BY (OR SCHOOL ATTENDED) | HOURS OF EMPLOYMENT FROM TO |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | BUSINESS TELEPHONE NUMBER ( ) |

## EMERGENCY CONTACT(S) (ONE REQUIRED)

| NAME | TELEPHONE NUMBER ( ) |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | RELATIONSHIP |

OPTIONAL

| NAME | TELEPHONE NUMBER ( ) |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | RELATIONSHIP |

## PERSONS AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY (ONE REQUIRED)

| NAME | NAME |
|---|---|
| | |

## COMMENTS ON CHILD'S DEVELOPMENT

**(NOTE ALLERGIES, HABITS, SPECIAL LANGUAGE, ETC.)**

## TO BE COMPLETED BY CHILD CARE FACILITY (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)

| FACILITY NAME | ADMISSION DATE |
|---|---|
| ENROLLED FOR (DAYS OF THE WEEK) | FULL TIME/PART TIME |
| HOURS PER DAY FROM TO | |
| DISCHARGE DATE | |

CHILD'S NAME

## AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of accident or illness to 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

______________________________________________

PROVIDER/LICENSEE

to contact the following:

**PHYSICIAN OR CLINIC**
(Please list name and phone number of physician and/or clinic.)

| NAME | TELEPHONE<br>( ) |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL | |

**PREFERRED HOSPITAL**
(Please list name and phone number of hospital.)

| NAME | TELEPHONE<br>( ) |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL | |

## ALLERGIES, MEDICATIONS, MEDICAL CONDITIONS AND/OR ANY OTHER INFO WE MAY NEED:

## FIELD TRIPS

I UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSIONS AND THAT I WILL BE NOTIFIED WHEN THEY ARE PLANNED.

## ACKNOWLEDGEMENTS

| | |
|---|---|
| A) | I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN. |
| 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 CHILD CARE CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW. |
| C) | THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR AND INDIVIDUAL NEEDS. |
| D) | WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE. |

| PARENT/LEGAL GUARDIAN SIGNATURE<br> | DATE |
|---|---|