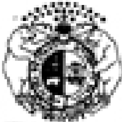


A

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 ( )	

SCHOOL CHILD ATTENDS (OPTIONAL)

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
NAME (OPTIONAL)	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	

Kids World North
9833 Halls Ferry Rd. St. Louis Mo. 63136

Parent Agreement

- A late fee will be charged for late pick-ups . There is a charge of $3.00 every 5 min ________
- I agree to pay in advance each weeks tuition and or co-payment unless it otherwise is approved by the Director _________
- My child is enrolled ____days per week at a cost of (Private Pay) = $______ (State Pay) sliding fee + co-pay = $______
- I understand that if my child is absent for several consecutive days or a week, I am still responsible for payment for that week, to keep My child actively enrolled________
- I understand that if my account becomes over 3 days past due, KWN has the right, not accept My child unless an agreement has been made and approved with the Director_______
- A late charge of $15 will be applied to all tuitions not paid by 6:00 p.m. Tuesday, unless other arrangements have been made with the Director_____
- There is a $35 for returned checks________
- Parents must provide KWN with a two week notice before leaving KWN or the parents will be responsible for a two week tuition charge.

Parents Signature_________________________________

Date_____________

Parental/Guardian Consent Photo Release Contract

We are sending you this parental consent form to both inform you and to request permission to photograph and/or video record your child during the time they are in care at **Kids World**. ***NO*** personally identifiable information will be published on the **Kids World** web site as well as any other forms of expressions. **The law requires that we ask for your permission to use information about your child.**

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the management of **Kids World** and such rescission will take effect upon receipt by approved management staff.

Check one of the following choices:

☐

I/We GRANT permission for my child(ren) to be photographed and/or recorded while in the care of **Kids World.**

Child's Name: (please print) ________________________________

Print name of Parent/Guardian: (print)

____

Signature of Parent/Guardian: (sign)

____

Relation to Student: ____

Date: ________________

All About Me

Kids World North LLC

Child's Information

Name: ____

Home#: ________________ Birthday: ______________ Age: ________

Address: ____________________________ Zip ________________

Parents Information:

Mother's Name: ____________________ Day# _________Cell#_______

Father's Name: _____________________ Day# _________Cell#_______

Please Release my child to the following people:

Name: ____________________________________

Relationship: _______________________________

Home # ___________________________________

Cell # ____________________________________

Name: ____________________________________

Relationship: _______________________________

Home # ___________________________________

Cell # ____________________________________

Name: ____________________________________

Relationship: _______________________________

Home # ___________________________________

Cell # ____________________________________

A

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
	( )
ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL	

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

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

TRANSPORTATION TO AND FROM SCHOOL

I ☐ (DO) ☐ (DO NOT) GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD TO AND FROM SCHOOL.

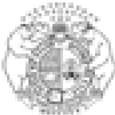
FIELD TRIPS

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	DATE



MISSOURI DEPARTMENTOF HEALTH AND SENIOR SERVICES (MDHSS)
COMMUNITY FOOD AND NUTRITION ASSISTANCE – CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CACFP ENROLLMENT FORM FOR CHILD CARE CENTERS

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

CHILD'S FULL NAME	DATE OF BIRTH

PARENT OR GUARDIAN NAME	STREET ADDRESS

CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
			( )

NAME OF CHILD CARE CENTER	PHONE NUMBER
	( )

CENTER CONTACT PERSON'S NAME	CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE ⇊		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.
MON		AM PM	AM PM	
TUES		AM PM	AM PM	
WED		AM PM	AM PM	
THURS		AM PM	AM PM	
FRI		AM PM	AM PM	
SAT		AM PM	AM PM	
SUN		AM PM	AM PM	

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

- ❑ FULL DAY CARE
- ❑ HALF DAY – MORNING
- ❑ HALF DAY – AFTERNOON
- ❑ BEFORE SCHOOL CARE
- ❑ AFTER SCHOOL CARE
- ❑ BEFORE AND AFTER SCHOOL CARE
- ❑ EVENING CARE
- ❑ OVERNIGHT CARE

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

- ❑ BREAKFAST
- ❑ MORNING SNACK
- ❑ LUNCH
- ❑ AFTERNOON SNACK
- ❑ SUPPER
- ❑ EVENING SNACK

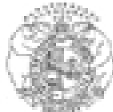
CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

- ❑ NEW YEARS DAY (JANUARY 1)
- ❑ MARTIN LUTHER KING'S BIRTHDAY (JANUARY)
- ❑ PRESIDENT'S DAY (FEBRUARY)
- ❑ MEMORIAL DAY (MAY)
- ❑ INDEPENDENCE DAY (JULY 4)
- ❑ LABOR DAY (SEPTEMBER)
- ❑ THANKSGIVING DAY (NOVEMBER)
- ❑ CHRISTMAS DAY (DECEMBER 25)

SIGNATURE OF PARENT OR GUARDIAN	DATE

ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIALED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM.

FIRST ANNUAL UPDATE	PARENT SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT SIGNATURE	DATE



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 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 ☐

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

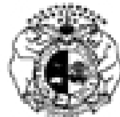
Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing 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): YEAR ☐ MONTH ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐ SNAP (Food Stamp) ☐ TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INFANT FEEDING PREFERENCE – CENTERS

Kids World North LLC will feed your infant breast milk provided by you and / or we will provide iron fortified infant formula.

The formula we provide is : **Good Start**

Please mark your preference (choose all that apply)

- ☐ I will bring expressed breast milk for my infant.
- ☐ I will come to the center to breastfeed my infant.
- ☐ I want the center to provide formula for my infant.
- ☐ I will bring formula for my infant.
  Please list kind of formula you will bring: ______________________________

This center is participating in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursements, the center must provide infant cereal and other foods when your baby is developmentally ready for them.

Please mark your preference

- ☐ I want the center to provide solid food for my infant based on CACFP guidelines.
- ☐ I will bring solid food for my infant when he / she is ready for it.

Name of infant ______________________________________ Date of Birth____________________

Signature of Parent / Guardian ____

Date ____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

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

PARENT'S SPECIALIZED INSTRUCTIONS FOR INFANTS AND TODDLERS

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

INSTRUCTIONS TO PARENTS:

- Please complete for child who is less than 24 months of age.
- Update diet information as needed until child is on complete table food. Use a new form or initial/date changes on this form.

FEEDING METHOD

(Check all that apply.)

☐ SPOON ☐ CUP ☐ BOTTLE ☐ WARM BOTTLE ☐ HOLDS OWN BOTTLE ☐ FEEDS SELF ☐ FEEDING TABLE OR CHAIR

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
FORMULA			
WHOLE MILK			
INFANT FOOD			
JUNIOR FOOD			
TABLE FOOD			

ARRANGEMENTS FOR SLEEP

(The American Academy of Pediatrics and other nationally recognized authorities for infant health advise that infants should be placed on their backs to sleep to reduce the risk of Sudden Infant Death Syndrome.)

TIME CHILD USUALLY NAPS	USUAL LENGTH OF NAP

SPECIAL NEEDS/INSTRUCTIONS RELATED TO SLEEPING

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

______________________________ ______________
(PARENT'S SIGNATURE) (DATE)

DIAPERING INSTRUCTIONS

I give permission for caregivers to use ____________________________ on my child for:
(Lotions and/or ointments, etc. that I have provided)

☐ 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:

SPECIAL INSTRUCTIONS FOR CARE (Restrictions, allergies, etc.)

PARENT/LEGAL GUARDIAN SIGNATURE	DATE
▶	

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

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

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

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.)

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

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
SECTION FOR CHILD CARE REGULATION

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

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

B

Evidence of Blood Lead Testing

Child's Name: ____

Child's Date of Birth: ______________________

Receipt of Test

Received a Venous / Capillary blood lead test on ________________(date).
(Circle one)

Test was administered by: ____________________________________
(Signature of Medical Provider)

Medical Provider Address (City, State, Zip Code)

____

____

____

Refusal of Test

I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the age of six years. I do object to my child being blood tested in order to determine if he/she is lead poisoned.

Reason for Refusal ______________________________________

Signed ______________________________Date:______________
(Parent/Guardian)

Relation to Child: ____

Parent/Guardian Address (City, State, Zip Code)

____

____

____

Provide patient with two copies: One for record
One for child-care provider

One copy should be retained in patient's chart.