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
	( )

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