Missouri Department of Health and Senior Services
Bureau of Child Care

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), behavior disorders, special needs, etc.

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE
X	

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP)		

IDENTIFYING INFORMTION

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

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY

(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP)		
NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP)		

COMMENTS ON CHILD'S DEVELOPMENT

(NOTE CHILD'S PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, AND INDVIDUAL 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.
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	

PLEASE ALSO COMPLETE PAGE 2.

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVE SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEAR'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 CENTER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	PHONE

PREFERRED HOSPITAL

NAME	PHONE

TRANSPORTATION TO AND FROM SCHOOL

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

NAME OF SCHOOL CHILD ATTENDS:

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.	
F	I UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSION AND THAT I WILL BE NOTIFIED, IN ADVANCE, WHEN THEY ARE PLANNED.	

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