



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CHILD CARE
CHILD ENROLLMENT

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

OPTIONAL	SCHOOL CHILD ATTENDS	TELEPHONE NUMBER ()
	NAME	
	ADDRESS (STREET, CITY, STATE, ZIP CODE)	

IDENTIFYING INFORMATION		HOME TELEPHONE NUMBER ()
MOTHER'S OR GUARDIAN NAME		
ADDRESS <input type="checkbox"/> 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 <input type="checkbox"/> 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)		TELEPHONE NUMBER ()
NAME		
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

O'Fallon Parks and Recreation
Non-Injectable Medication Administration Record
This information is confidential and for staff use only.

Parent or Guardian, Please complete the top portion of this form

Name of Participant: _____ Age: _____
Home Phone: _____ Work Phone: _____

This participant is free of infectious disease. Yes _____ No _____
This participant is up to date on all immunizations. Yes _____ No _____
This participant is able to participate in recreation activities (with the
limitations and restrictions listed on the Authorization form). Yes _____ No _____
Is participant taking medication we should know about? Yes _____ No _____
**Does the participant take any medication during the regular school
year? If yes, will the participant continue taking
the medication during the summer?** Yes _____ No _____
Yes _____ No _____

A trained staff member will aid in administering all medication

Name of Prescribed Medicine: _____ For treatment of: _____
Exact Dosage: _____ Time: _____
Date to Begin: _____ Date to End: _____ Pharmacy _____ RX# _____
Prescribing Physician: _____ Physician's Phone: _____

Please do not send more than a one-day supply of medication at a time.

Medication Forms *must be completed in full* and on file before your child can receive medication.

Please note: If the prescription for the specified medication should change during the summer a new form will need to be completed with the new prescription information.

Medication **MUST** be sent in a properly labeled container (most pharmacies will give you duplicate bottles). If the prescription changes, please send a *new* properly labeled container.

Children with **Inhalers** will need a completed Medication Form on file. The child will not be allowed to personally carry the Inhalers, although it will be readily accessible to be used as required. This is for the safety of all children.

Over-the-counter medications must be sent in the original containers and require a completed Medication Form on file.

The undersigned recognizes that the O'Fallon Day Camp staff member, who will be responsible for ensuring the above medication, is not a pharmacist, and accepts full responsibility for requesting that a staff member oversee such medication and further acknowledges that neither such person or the O'Fallon Parks and Recreation Department, City of O'Fallon, shall have any responsibility or liability arising out of my child taking medication in accordance with the instructions on the label, the undersigned also authorizes a staff member of the O'Fallon Parks and Recreation staff to aid in administering the medication listed above.

Signed _____ Date _____

O'Fallon Parks and Recreation
Drop Off and Pick Up Authorization
Parents and Guardians: Please include yourselves on this form!

Child's Name _____

In case of injury or illness and you can not be reach this list will be used to authorized care for your child. Please put them in the order that you wish us to contact them for such an emergency. Please initial the box if the following people are authorized to drop off and pick up my child from the Renaud Spirit Center Pre-School program. I understand my child will be allowed to be dropped off and picked up by these individuals ONLY. Proper photo identification will be required when signing the child in and out of camp.

Authorized Person #1 _____
Address _____
Phone _____ Relationship _____

Authorized Person #2 _____
Address _____
Phone _____ Relationship _____

Authorized Person #3 _____
Address _____
Phone _____ Relationship _____

Authorized Person #4 _____
Address _____
Phone _____ Relationship _____

Authorized Person #5 _____
Address _____
Phone _____ Relationship _____

Authorized Person #6 _____
Address _____
Phone _____ Relationship _____

Authorized Person #7 _____
Address _____
Phone _____ Relationship _____

Authorized Person #8 _____
Address _____
Phone _____ Relationship _____

Authorized Person #9 _____
Address _____
Phone _____ Relationship _____

Parent/Guardian Signature: _____ Date: _____

Renaud Spirit Center Pre-School Parent Authorization Form

Child's Name _____ Age _____ Birthday _____

Address _____

City _____ State _____ Zip Code _____

Parent/Guardian's Name _____

Phone (Home) _____ Phone (Work) _____

Additional Phone numbers in case of an emergency (cell, pager) _____

Identify activities that your child **Should not** participate in:

The following are special circumstances regarding my child, that we should be aware of (special medications, allergies, seizures, physical limitations, fears, etc.):

Will your child need any accommodations to participate in pre-school?

Yes _____ No _____ If yes, please explain _____

(For Parents or Guardian) The City of O'Fallon Parks and Recreation Department is committed to conducting the City's recreation programs and activities in a safe manner, and holds the safety of participants in high regards. The City of O'Fallon continually strives to reduce risks, and insists that all participants follow safety rules and instructions that are designed to protect the participants' safety. However, participants and parents or guardians of minors registering for the above listed programs must recognize that there is an inherent risk of injury when choosing to participate in recreational activities and programs. As an adult, you are solely responsible for determining if you, or your minor child or ward, are physically fit, with the prerequisite skills required for the activities contemplated by this agreement. It is always advisable -- especially if the participant is pregnant, disabled in any way, or has recently suffered illness, injury, or impairment -- to consult a physician before undertaking any activity. I give my permission for my child to take part in ALL ACTIVITIES OF THE RENAUD SPIRIT CENTER PRE-SCHOOL EXCEPT AS NOTED ABOVE. Recreational activities and programs are intended to challenge and engage the physical, mental, and emotional resources of each participant. Despite careful and proper preparation, instruction, medical advice, conditioning, and equipment, there is still a risk of serious injury and/or death when participating in any recreational activity or program. Understandably, not all hazards and dangers can be foreseen. Depending on the particular activity, participants must understand that certain risks, dangers, and injuries due to inclement weather, slipping, falling, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, premises defects, inadequate or defective equipment, inadequate supervision, instruction or officiating, and all other circumstances inherent to indoor and outdoor recreational activities or programs exist. In this regard, it must be recognized that it is impossible for the O'Fallon Parks and Environmental Services Department to guarantee absolute safety.

I also agree to grant full permission to the City of O'Fallon to use my name, photograph, videotape, or recordings for any publicity promotion purposes without obligation or liability to me or my family.

PARENT/GUARDIAN SIGNATURE _____ DATE _____



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 BUREAU OF CHILD CARE
 CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE
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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
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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