MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU OF 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 CODE)		

IDENTIFYING INFORMATION

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

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

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

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

COMMENTS ON CHILD'S DEVELOPMENT
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL 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.
MONDAY	☐	AM PM	AM PM	
TUESDAY	☐	AM PM	AM PM	
WEDNESDAY	☐	AM PM	AM PM	
THURSDAY	☐	AM PM	AM PM	
FRIDAY	☐	AM PM	AM PM	
SATURDAY	☐	AM PM	AM PM	
SUNDAY	☐	AM PM	AM PM	

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

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

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEARS'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 PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

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.	PARENT/GUARDIAN INITIALS
F	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
H	I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE.	PARENT/GUARDIAN INITIALS
I	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

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

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 _____

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:_____

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_____

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

Emergency Preparation

Dear Parent/Guardian:

In the event of an emergency situation the Renaud Spirit Center Preschool has outlined the below response plan. Please know that the Renaud Spirit Center Preschool will make every attempt to notify you so it is vital that you keep your emergency contact information up-to-date. Keep this letter with you so that you will know how to contact us in the event of an emergency.

Evacuation/Relocation

- If the emergency is confirmed to the immediate area at the Renaud Spirit Center Preschool e.g. fire, and the children cannot stay on the premises, the children will be taken to O'Fallon City Hall, located at 100 North Main Street. The children and staff will remain at this location while you or your emergency contact is notified of the situation.
- If the emergency is more wide spread and encompasses a larger area such as the neighborhood due to an environmental threat, e.g. flood, and the children cannot remain in the immediate area, they will be transported to O'Fallon City Hall located at 100 N. Main Street O'Fallon, MO 63366. The children and staff will remain at this location while you or your emergency contact is notified of the situation.
- Please sign the attached authorization for emergency care and transportation and return at time of enrollment.

Emergency Care

- In the event that a child, or all children are in need of a physical exam or emergency care, the child or children will be transported to Progress West HealthCare Center located at 2 Progress Point Parkway O'Fallon, MO 63368 where they will be examined by a physician and you will be notified.

Notification

- Every effort will be made to contact you as soon as the children and staff are safe. If we cannot reach you, we will contact your alternate emergency contact. Children will only be released to you or your alternate emergency contact during times of an emergency.
- Information about the event can be obtained through our web site at www.renaudspiritcenter.com

Emergency Supplies

- We encourage you to bring individual emergency packs for each child to keep at our facility that includes a change of clothes, blanket, a few family photos and a comfort item like a teddy bear to help comfort your child during a crisis. These individual packs will be stored in our safe room and only accessed during an emergency.

Please rest assured that the Renaud Spirit Center Preschool staff will remain with and care for the children at all times during an emergency to ensure the children's safety. As always, please don't hesitate to contact us if you have any questions or concerns.

Authorization for Emergency Care and Transportation

Name of child: _____

If, at any time, due to such circumstances as an injury or sudden illness or other unforeseen emergency, medical treatment is necessary, I authorize the Renaud Spirit Center Preschool to take whatever emergency measures they deem necessary for the protection of my child while in their care.

I understand that a natural or deliberate disaster or emergency may result in the need for my child to be transported to another location for safety.

I understand that this may involve contacting a doctor, interpreting and carrying out his or her instructions, and transporting my child to a hospital or doctor's office, including the possible use of an ambulance.

If possible, the hospital I prefer my child be transported to is_____
located at_____

or the doctor contacted will be (include doctor's name and address) _____
_____
_____
_____

I understand that this may be done prior to contacting me, and that any expensive incurred for such treatment, including ambulance fees, is my responsibility.

_____

Parent/Guardian Signature Date

_____

Renaud Spirit Center Preschool Date

Renaud Spirit Center Pre-School Tuition Agreement

Student's Last Name _____ Student's First Name _____ Home Phone _____

Address _____ City _____ State and Zip _____

Renaud Spirit Center Pre-School Session

Session	Start Date	Price	Initials

Office Use Only

Staff Initials	Date

Method of Payment

Method of Payment (Circle One):

Visa MasterCard Checking Savings

Checking or Savings Routing Number / Last 4 Digits of Visa or Master Card: _____

Checking or Savings Account Number / CC Exp Date: _____

Name on Card: _____

1. The City of O'Fallon will charge the credit card listed for each session's tuition.
2. Tuition will be debited on the 15th of each month in order to pre-pay for the following month.
3. Failure to complete this form will result in your child's place to be forfeited.
4. Please be aware that there will be no refunds.
5. By completing this form one will reserve their child's spot for all sessions listed above.
6. Please be aware that each occurrence of insufficient funds during the monthly withdrawal process will result in a $15 charge. RSC Pre-School participants will have until the 1st of the next month to pay in the balance. If the balance is not paid off by the first, then participation in the program will be suspended.

Applicant's Signature _____ Date _____

The credit card # portion will be destroyed after the account is set up

Visa or Master Card Number _____ CC Exp Date _____