Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **T-Shirt Size (circle one)**

**“Growing God’s Garden”**

**Third Presbyterian Church**

**Preschool & Youth Center**

**9990 Lewis & Clark Blvd**

**St. Louis, MO 63136**

**314-868-9600**

ENROLLMENT PACKAGE

2017-2018

YXS YS YM YL  
 AS AM AL AXL A2XL

**Mandatory Parent Orientation Meeting**  
 6/2/12 @ 10 a.m. or 6/3/12 @ 1 p.m.

THIRD PRESBYTERIAN CHURCH

VACATION BIBLE CAMP

JUNE 4TH – JULY 27TH

MC900436041[1]

|  |
| --- |
|  |

ENROLLMENT PACKET

Enrollment Checklist

(For Office Use Only)

* Completed & Signed Enrollment Application
* Signed Program Policies(Signed Transportation & Media Authorization/Late Pick Up)
* Release of Participation Form
* Authorization For Emergency Medical Care
* Child’s Health Statement
* Immunization Records
* Submitted Physical Exam
* Meal Substitution Form
* CACFP Enrollment Form
* Income Eligibility Form
* Submitted Deposit

Notes:

THIRD PRESBYTERIAN CHURCH

PRESCHOOL & YOUTH PROGRAM

**PARTICIPANT ENROLLMENT FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY PROGRAM STAFF (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)** | | | | |
| START DATE | ENROLLED (DAYS OF THE WEEK & TIMES) | | | FAMILY SUPPORT DIVISION   * YES * NO   CASE WORKER NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CASE WORKER NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| FILE COMPLETED BY | | | TITLE |
| DISCHARGE DATE | | STAFF SIGNATURE | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CHILD’S NAME | | SEX | | | AGE | BIRTHDATE | | | | T-SHIRT SIZE | |
| ADDRESS | | CITY | | | | STATE | | | | | ZIP CODE |
| **PARENT/GUARDIAN CONTACT INFORMATION** | | | | | | | | | | | |
| MOTHER / GUARDIAN NAME | | | | | | | HOME PHONE  ( ) | | | | |
| ADDRESS ( \_\_\_ CHECK HERE IF SAME AS THE CHILD) | | | | | | | CELL PHONE  ( ) | | | | |
| EMPLOYED BY / SCHOOL ATTENDING | | | | | | | E-MAIL ADDRESS | | | | |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE) | | | | | | | BUSINESS PHONE NUMBER  ( ) | | | | |
| FATHER / GUARDIAN NAME | | | | | | | HOME PHONE  ( ) | | | | |
| ADDRESS | CITY | | | ZIP | | | CELL PHONE  ( ) | | | | |
| EMPLOYED BY / SCHOOL ATTENDING | | | | | | | BUSINESS PHONE NUMBER  ( ) | | | | |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE) | | | | | | | E-MAIL ADDRESS | | | | |
| **EMERGENCY CONTACTS (TWO REQUIRED)** | | | | | | | | | | | |
| NAME | | | HOME PHONE | | | | | CELL PHONE | | | |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE) | | | | | | | RELATIONSHIP | | | | |
| Contact is authorized to pick child up? | | | YES | | | | | | NO | | |
| NAME | | | HOME PHONE | | | | | | CELL PHONE | | |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE) | | | | | | | RELATIONSHIP | | | | |
| Contact is authorized to pick child up? | | | YES | | | | | | NO | | |
| **COMMENT ON PARTICIPANT’S DEVELOPMENT** | | | | | | | | | | | |
| (NOTE ALLERGIES, HABITS, SPECIAL LANGUAGE, BEHAVIOR PATTERNS, ETC.) | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Mother’s Name** | **Employer’s or School’s Name** | **Employer’s or School’s Address** | **Employer’s or School’s Phone Number** |
|  |  |  |  |

**Mother’s Schedule**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **Start Time** |  |  |  |  |  |
| **End Time** |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Father’s Name** | **Employer’s or School’s Name** | **Employer’s or School’s Address** | **Employer’s or School’s Phone Number** |
|  |  |  |  |

**Father’s Schedule**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **Start Time** |  |  |  |  |  |
| **End Time** |  |  |  |  |  |

THIRD PRESBYTERIAN CHURCH

PRESCHOOL & YOUTH PROGRAM

**PROGRAM POLICIES**

**TRANSPORTATION & MEDIA AUTHORIZATION**

I, the parent/guardian of the registrant, a minor, agree that the registrant and I will abide by the rules of TPC. Recognizing the possibility of physical injury associated with the activities and in consideration for TPC accepting the registrant for its programs and activities, I hereby release, discharge, hold harmless, absolve and / or otherwise indemnify TPC, the employees and associated personnel, its affiliated organizations, vendors and sponsors, including the owners of fields and facilities utilized for the Programs, and all others who have participated in the planning, organizing and implementing of the activities, against any claim and from responsibility, loss, cost, damage and liability for or by reason of any illness, injury, death, misadventure, harm, loss or inconvenience suffered or sustained by or on behalf of the registrant as a result of the registrant’s participation in the program and/or being transported to or from the same, which transportation I hereby authorize.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

I, agree that TPC may use any photographs taken of my child for promotional activities. TPC may also use any works created by my child for promotional activities. This includes drawings, crafts, or written words.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT

Late Pick Up Policy:

1. Parents are notified of expected drop-off and pick-up times for their child at the time of enrollment.
2. Parents who fail to pick up the child at the agreed upon time create a hardship for employees and the Afterschool Program incurs additional costs for providing child care services.
3. If a parent fails to abide by the agreed upon pick-up and drop-off time, the parent will be assessed a late pick-up fee for each day a child remains at the center beyond the agreed upon time. This policy applies to all enrollees.
4. Late fees will be assessed on the following basis:
   1. At the discretion of the Program Administrator, parents will be given a maximum of 2 late days during the course of the year (from the child’s enrollment date) without a fee assessment to allow for unexpected emergencies. On these days, parents are expected to notify the center of their anticipated late arrival to retrieve their child.
   2. 1 to 5 minutes…………………………………………….$10.00 per child
   3. 6 to 15 minutes…………………………………………...$15.00 per child
   4. 16 to 30 minutes………………………………………….$30.00 per child
   5. Over 30 minutes………………………………………….$1.00 per minute

\*The Division of Family Service and/or the Moline Acres Police Department will be notified if any child is not picked up by 7:00 p.m. Excessive late arrivals may result in termination from the program.

**Any fees for late pick-up are due by CHECK or MONEY ORDER at the time the child is picked up or at the time the child returns to the center for services.**

I have read and agree to the terms and conditions of this policy.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PARTICIPANT’S LAST 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  **THIRD PRESBYTERIAN CHURCH PRESCHOOL & YOUTH CENTER**  to contact the following:  **PHYSICIAN OR CLINIC**  (Please list name and phone number of physician and / or clinic.) | | | | | | | | | | |
| NAME | | | | | TELEPHONE  ( ) | | | | | |
| ADDRESS | | | CITY | | | | STATE | | ZIP CODE | |
| **IN CASE OF EXTREME EMERGENCY, PARTICIPANT WILL BE TAKEN TO THE NEAREST HOSPITAL.** | | | | | | | | | | |
| **PREFERRED HOSPITAL**  (Please list name and phone number of hospital.) | | | | | | | | | | |
| NAME | | | | | | TELEPHONE  ( ) | | | | |
| ADDRESS | | | | CITY | | | | STATE | | ZIP CODE |
| **SPECIAL NEEDS** | | | | | | | | | | |
| Please check all that apply:   * ADD / ADHD * AUTISM * ED * OTHER: \_\_\_\_\_ * LD * BD * ODD * PTSD * BIPOLAR * MR / DD \_\_\_\_\_\_\_\_\_\_\_\_\_ | | Does the participant have an IEP? \_\_\_\_ Yes \_\_\_\_ No  Is the participant a foster child? \_\_\_\_ Yes \_\_\_\_ No  Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **TRANSPORTATION AUTHORIZATION** | | | | | | | | | | |
| I \_\_\_\_ DO \_\_\_\_\_ DO NOT Give permission for the facility to transport my child to and from the site. | | | | | | | | | | |
| **ACKNOWLEDGEMENTS** | | | | | | | | | | |
| 1. I have received a copy of this facility’s policies pertaining to the admission, care, and discharge of children. 2. I have been informed that a copy of the licensing rules for group child care homes and child care centers is available at this facility for review. 3. The provider and I have agreed on a plan for continuing communication regarding my child’s development, behavior and individual needs. 4. When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care. | | | | | | | | | | |
| **PARENT / GUARDIAN SIGNATURE** | | | | | | **DATE** | | | | |

|  |  |  |
| --- | --- | --- |
| **IDENTIFYING INFORMATION** | | |
| CHILD’S NAME | BIRTH DATE | |
| **HEALTH STATEMENT (CHECK ONE)** | | |
| * My child is in good health, is able to participate in group care, and 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. | | |
| **SPECIAL HEALTH OR MEDICAL REQUIREMENTS.** | | |
| PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS (SUCH AS ADD, ADHD OR AUTISM), SPECIAL NEEDS, ETC.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please indicate the best action for items listed above:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **PLEASE ATTACH A COPY OF YOUR CHILD’S CURRENT IMMUNIZATION RECORDS.**  In accordance with Section 210.003.7, RSMo., the parent or guardian of a child enrolled in Third Presbyterian Church Preschool & Youth Center may request notice of whether there are any children enrolled at our facility with an immunization exemption on file. If you would like to request this information, please contact the Director and the information will be provided to you. Please, note the name or names of individual children are confidential and will not be released. Our response will be limited to whether or not there are children enrolled at our facility with an immunization exemption on file. | | |
| Parent or Legal Guardian Signature | | Date |

THIRD PRESBYTERIAN CHURCH

PRESCHOOL & YOURH PROGRAM

**CHILD’S HEALTH STATEMENT**

THIRD PRESBYTERIAN CHURCH

PRESCHOOL & YOUTH PROGRAM

**MEDICAL FOOD SUBSTITUTION RECORD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Authorization by a recognized medical authority is required for food substitutions for food service in At-risk youth centers. A recognized medical authority includes a physician assistant, or nurse practitioner. The recognized medical authority must specify, in writing, the food to be omitted from the patient’s diet and the food or choice of foods that may be substituted. | | | | |
| PATIENT’S NAME | | | | |
| MEDICAL DIAGNOSIS / REASON | | | | |
| SPECIAL ASSISTANCE / EQUIPMENT REQUIRED | | | | |
| **FOOD SUBSTITUTION LIST** | | | | |
| **FLUID MILK** | **ALLOWED SUBSTITUTIONS** | | **TEXTURE (e.g. CUT UP, GROUND MINCE, PUREE, LIQUIDITY)** | |
|  |  | |  | |
|  |  | |  | |
|  |  | |  | |
| **MEAT & MEAT ALTERNATIVE**  **(e.g. EGGS, CHEESE, PEANUT BUTTER, BEANS, YOGURT)** | **ALLOWED SUBSTITUTIONS** | | **TEXTURE** | |
|  |  | |  | |
|  |  | |  | |
|  |  | |  | |
| **BREAD, CEREAL OR WHOLE GRAIN PRODUCTS** | **ALLOWED SUBSTITUTIONS** | | **TEXTURE** | |
|  |  | |  | |
|  |  | |  | |
| **FRUIT & VEGETABLE OR JUICE** | **ALLOWED SUBSTITUTIONS** | | **TEXTURE** | |
|  |  | |  | |
|  |  | |  | |
|  |  | |  | |
| **Additional dietary concerns and/or required equipment or assistance needed:** | | | | |
|  | | | | |
| **I (medical authority) certify that the above patient must be provided a special diet or requires special accommodations as indicated above.** | | | | |
| Signature | | Title | | Date |

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| WEEKLY PROGRAM FEES | | |
|  | **FULL TIME** | **PART TIME** |
| PRESCHOOL\* | $120 | N/A |
| SCHOOL AGE – EXTENDED CARE PROGRAM | $65 | $35 (Before Care only)  $45 (After Care only) |

\*Add a $10/week potty-training fee to tuition or sliding fee for any child not potty trained.

|  |
| --- |
| ANNUAL BOOK FEE |

\_\_\_2 Yr Olds = $25/year \_\_\_3/4 Yr Olds = $35/year \_\_\_Pre-K/5 Yr Olds = $45/year

Please initial by each statement below to indicate that you have read and agree to the policy as stated:

* There is a non-refundable annual registration fee of $50 per student. If your child receives state assistance, then the registration fee is $20.
* There is an annual book fee that is due at enrollment. (See the enrollment package for pricing.) No book will be issued to the child until the book fee is paid in full. In addition, a $5/day late fee will be applied for book fees not paid in full within 2 weeks after enrollment.
* A one-week tuition deposit must be paid at enrollment. This deposit can be applied to your child’s final week of attendance provided that you notify the Director, in writing, two weeks in advance of withdrawal from the program. If two-weeks advance notice of withdrawal is not given to the Director the deposit is forfeited.
* **Program fees (tuition, fees, etc.) are due on Thursday, prior to the week of service with a grace period extending until close of business on Friday. If program fees are not paid by close of business on Friday, a late fee of $10.00 will be imposed on Monday and $5.00 each additional day payment is not received will be assessed. Failure to pay the late fees will result in the continued accrual of the late fees until paid in full or may result in the discontinuation of services.**
* **Occasionally, notifications will be given indicating any outstanding balances. This is a courtesy and should not be relied upon. It is your responsibility to manage your finances to ensure the timeliness and fulfillment of all your financial obligations.**
* **More than two weeks of outstanding tuition/sliding fees will result in the discontinuation of services until the outstanding balance is paid in full.**
* There is a $10/week Potty Training Fee for any student not fully potty-trained. A student is considered fully potty-trained when they can communicate the need to use the restroom without prompting from an adult AND has fewer than 1 accident per week AND is consistent for at least 30 days.
* It is imperative that you accurately complete your child’s Sign In/Out sheet each day. Failing to do so may result in the State rejecting our invoice for your child (State Assistance Only) or the CACFP rejecting our invoice for our food program. In this case, the parent is responsible for the full tuition or any monies lost as a result of their negligence.
* State Assistance Only: If you desire for your child to begin receiving services prior to our receipt of the Child Care Provider Approval/Change Notice from the MO Department of Social Services, you will be charged the regular weekly tuition rate. Upon receipt of the Child Care Provider Approval/Change Notice a refund of the difference between the regular weekly tuition and the state approved sliding fee (provided that the approval authorization is dated back to the date services began) will be issued for the current month only.
* To maintain our high standard of quality, we budget for everyday costs related to our dedicated teachers and education resources. Therefore, to cover these costs, we charge a full-week of tuition/sliding fee if your child attends any portion of the week.
* If a child is ill and out of school for an entire week or more, a discounted rate may be approved, but is not guaranteed, by the Business Administrator. A doctor’s statement must be submitted before a discount, if any, will be considered.
* In the event that a child contracts a major illness or suffers a major injury that will require an absence in excess of two weeks, arrangements must be made with the Business Administrator for a tuition waiver. A physician’s statement must be submitted indicating that the child is prohibited from attending school. There is no waiver of tuition for illnesses/injuries under two weeks.
* **There is no tuition waiver or reimbursements given for family vacations, absences or holidays. Full tuition or sliding fees are due regardless of the child’s attendance and late fees will be applied for payments made past the due date.** A child who is absent for 14 consecutive days will be considered disenrolled and their deposit will be forfeited.
* Any changes or adjustments concerning your tuition agreement must be made at least 1 week in advance and acknowledged in writing by the Business Administrator or Director. No more than three (3) payment agreements will be granted per school year. If your account falls behind with no prior arrangements, we will not be able to continue serving your child and your account may be turned over to a collection agency.
* There are sibling discounts given for two or more siblings enrolled in the program; preschool and/or Before/After Care. Contact the Business Administrator to determine the applicable discount.
* A $15 laundry and usage fee will be assessed for not providing fresh clean bedding on Monday, after a child has soiled their laundry or the first day of the week that the child attends school. Laundry fees must be paid within 7 days of the issuance of the Laundry Fee Notification. Failure to pay within the 7 days will result in a $5/day late fee.
* Checks or money orders are the **ONLY** acceptable forms of payment. However, after two returned checks per year, only money orders will be accepted. A $25 returned check fee will be added to the amount due. The returned check and fee must be submitted within 7 days of notification or the child will not be allowed to return to the program.
* **All outstanding balances must be paid prior to a child attending a field trip.** Field trip fees will not be accepted on the day of the field trip. If your child is not permitted to attend the field trip, you will need to make other arrangements for your child’s care since there will be no staff available to care for your child at the Center.

I have received and read the program fee agreement and agree to conform to the policies established. I understand that failure to comply with the payment policy will result in the immediate termination of services provided by Third Presbyterian Church.

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | **Religious Organization Child Care Facility**  **Notice of Parental Responsibility** |

Facility Name\_\_\_\_\_\_\_Third Presbyterian Church reschool\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, City, State, Zip Code) \_\_\_\_9990 Lewis & Clark, St. Louis, MO 63136\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### INSPECTIONS

Section 210.211 RSMo exempts this religious organization child care facility from state licensing and supervision by the Department of Health and Senior Services (DHSS). It is state inspected only for fire, health and sanitation requirements as indicated below. Copies of the inspections are available.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME OF AGENCY  AND TYPE OF VISIT | ADDRESS | TELEPHONE NUMBER | INSPECTION | DATE |
| Section for Child Care Regulation  (Health and Safety Inspection) | 220 S. Jefferson, St. Louis, MO 63103 | 314-877-0219 | Pending □ Approved X Not approved □ | 10/31/16 |
| Fire Marshal’s Office  (Fire Safety Inspection) | P.O. Box 844, Jefferson City, MO 65102 |  | Pending □ Approved X Not approved □ | 08/3/16 |
| Local Health Office or DHSS  (Sanitation Inspection) | 220 S. Jefferson, St. Louis, MO 63103 | 314-877-2680 | Pending □ Approved X Not approved □ | 09/15/16 |

## STANDARD STAFF/CHILD RATIOS ESTABLISHED BY THIS FACILITY STAFF/CHILD RATIOS FOR LICENSED CENTERS

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| AGE RANGE | NUMBER OF STAFF | NUMBER OF CHILDREN |  | AGE RANGE | NUMBER OF STAFF | NUMBER OF CHILDREN |
| Under 2 years of age | 1 staff member for every | 0 |  | Under 2 years of age | 1 staff member for every | 4 |
| 2 to 4 years of age | 1 staff member for every | 8:1 for 2 yr olds  10:1 for 3/4 yr olds |  | 2 years of age | 1 staff member for every | 8 |
|  | 3 and 4 years of age | 1 staff member for every | 10 |
| 5 years of age and older | 1 staff member for every | 16 |  | 5 years of age and older | 1 staff member for every | 16 |

Total number of children enrolled by this facility \_76\_\_\_\_\_\_\_\_

**BACKGROUND CHECKS: CHILD ABUSE/NEGLECT AND CRIMINAL RECORD(S)**

Statute 210.254 RSMo requires the facility to conduct background checks for child abuse/neglect and criminal record reviews on each individual caregiver and all other personnel (who have contact with children in care**)** at the facility at the time of employment and every two years thereafter.

Background checks for child abuse and neglect through the Children’s Division (CD) and criminal record reviews through the Missouri State Highway Patrol have been conducted on each individual caregiver and all other personnel at the facility as required: X Yes  No

###### FACILITY DISCIPLINE AND EDUCATIONAL PHILOSOPHY/POLICIES

**The disciplinary philosophy and policies of this facility are:** To provide positive reinforcement and praise for good behavior and withholding the same for unacceptable behavior. We will use age-appropriate redirection, time-out and identification of acceptable behavior to rectify the situation. Unacceptable behavior is documented on a Behavior Modification Form and shared with the parent.

**The education philosophy and policies of this facility are:** To teach the whole child (spiritual, emotional, mental, physical) a developmentally appropriate and kindergarten-ready curriculum that will provide them with the skills and knowledge to excel academically, socially, emotionally and physically.

##### REQUIRED SIGNATURES

Statute 210.254 RSMo requires the facility to furnish two copies of this document to a parent(s) upon enrollment of a child. Parents acknowledge by signature that they have read and accepted the information contained in this document. One copy of this signed document is given to the parent(s); the other copy is retained in the child’s record at the facility.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT(S) DATE

Kristen Davis 10/31/16

PRINCIPAL OPERATING OFFICER/FACILITY DIRECTOR DATE

Cedric A. Portis, Sr. 10/31/16

INDIVIDUAL RESPONSIBLE FOR THE RELIGIOUS ORGANIZATION – PASTOR, MINISTER, PRIEST, ETC. DATE

***Statute 210.254 RSMo requires a new facility to file a copy of the Notice of Parental Responsibility with the Section for Child Care Regulation at least five days prior to beginning operation. Each facility must file the Notice of Parental Responsibility annually during the month of August.***

**RELEASE FORM**

The following people are permitted to pick up my child, from Third Presbyterian Church’s Youth Program (Do not include parents on form below):

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

Mother’s Name Contact Number(s)

Father’s Name Contact Number(s)

**RELEASE FORM**

The following people are permitted to pick up my child, from Third Presbyterian Church’s Youth Program (Do not include parents on form below):

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

|  |  |
| --- | --- |
| Name: | Relationship |
| Home #: | Cell #: |

Mother’s Name Contact Number(s)

Father’s Name Contact Number(s)

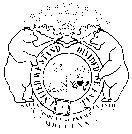
THIRD PRESBYTERIAN CHURCH

PRESCHOOL & YOUTH PROGRAM

CACFP ENROLLMENT FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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  ( ) | | | |
| NAME OF FACILITY  **THIRD PRESBYTERIAN CHURCH PRESCHOOL & YOUTH CENTER** | | | | | | | | | | | | PHONE NUMBER  ( 314 ) 868-9600 | | | | |
| CENTER CONTACT PERSON’S NAME  **KRISTEN DAVIS, BUSINESS MANAGER** | | | | | | | | | | | CHILD’S FIRST DATE ATTENDING | | | | | |
| IN THIS COLUMN, CHECK THE DAYS YOUR CHILD ATTENDS | |  | |  | | | | | WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION. | | | | | | | |
| CIRCLE AM OR PM | | CIRCLE AM OR PM | | | | |
| 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 \_\_\_\_ BEFORE SCHOOL CARE \_\_\_\_ EVENING CARE  \_\_\_\_ HALF DAY- MORNING \_\_\_\_ AFTER SCHOOL CARE \_\_\_\_ OVERNIGHT CARE  \_\_\_\_ HALF DAY- AFTERNOON \_\_\_\_ BEFORE & AFTER SCHOOL CARE | | | | | | | | | | | | | | | | |
| **CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER** | | | | | | | | | | | | | | | | |
| \_\_\_\_ BREAKFAST \_\_\_\_ LUNCH \_\_\_\_ SUPPER  \_\_\_\_ MORNING SNACK \_\_\_\_ AFTERNOON SNACK \_\_\_\_ 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 / GUARDIAN | | | | | | | | | | | | | | DATE | | |
| ANNUAL UPDATES: THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS CORRECT. IF CHANGES OCCUR, THE CHANGES ARE INITIALED OR A NEW FORM IS COMPLETED. | | | FIRST UPDATE | | | | | PARENT SIGNATURE | | | | | | | | DATE |
| SECOND UPDATE | | | | | PARENT SIGNATURE | | | | | | | | 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, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

 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 | |
|  | | | |  | |  | |  | | | |  | |
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| **PART 2 HOUSEHOLD AND INCOME INFORMATION** | | | | | | | | | | | | | |
| List all members of the household not 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. | | | | | | | | | | | | | |
| YEARLY MONTHLY 2 X A MONTH EVERY 2 WEEKS WEEKLY INCOME BASED ON (CHECK ONE) D D D D D | | | | | | | | | | | | | |
| HOUSEHOLD MEMBERS | | | GROSS WAGES | | | | WELFARE, CHILD SUPPORT, ALIMONY | | PENSIONS, RETIREMENT, SOCIAL SECURITY | | | | OTHER |
|  | | |  | | | |  | |  | | | |  |
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|  | | |  | | | |  | |  | | | |  |
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|  | | |  | | | |  | |  | | | |  |
| **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 ASIAN BLACK OR NATIVE HAWAIIAN OR OTHER  OR ALASKA NATIVE AFRICAN AMERICAN PACIFIC ISLANDER WHITE  D D D D D | | | | | | | | | | | | | |
| **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) | | | | | 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): TEMPORARY  YEAR MONTH 2 X A MONTH EVERY 2 WEEKS WEEKLY SNAP (Food Stamp) ASSISTANCE  D D D D D D D | | | | | | | | | | | |
| Eligibility Determination: D Free D Reduced D Paid | | | | | | | | | | | | | |
| SIGNATURE OF CENTER REPRESENTATIVE | | | | | | | | | | | DATE | | |