Child's Name:_____ Date: _____

THIRD CHURCH PRESCHOOL

Preschool ENROLLMENT PACKAGE 2024-2025

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

CHILD'S NAME	SEX	AGE	BIRTHDATE	T-SHIRT SIZE
ADDRESS	CITY		STATE	ZIP CODE
SCHOOL ATTENDING (SCHOOL-AGERS ONLY):	GRADE			

PARENT/GUARDIAN CONTACT INFORMATION

MOTHER / GUARDIAN NAME			HOME PHONE ( )
ADDRESS (___ CHECK HERE IF SAME AS THE CHILD)	CITY	ZIP	CELL PHONE ( )
EMPLOYED BY / SCHOOL ATTENDING			E-MAIL ADDRESS
ADDRESS (INCLUDE CITY, STATE, ZIP CODE)			BUSINESS PHONE NUMBER ( )
WORK SCHEDULE (DAYS OF THE WEEK & HOURS)			

FATHER / GUARDIAN NAME			HOME PHONE ( )
ADDRESS(___ CHECK HERE IF SAME AS THE CHILD)	CITY	ZIP	CELL PHONE ( )
EMPLOYED BY / SCHOOL ATTENDING			BUSINESS PHONE NUMBER ( )
ADDRESS (INCLUDE CITY, STATE, ZIP CODE)			E-MAIL ADDRESS
WORK SCHEDULE (DAYS OF THE WEEK & HOURS)			

EMERGENCY CONTACTS (TWO REQUIRED – DO NOT LIST PARENTS AS EMERGENCY CONTACTS)

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.)

ELECTRONIC SIGN IN ID & PASSWORD

Choose a 4 Digit ID __ __ __ __ Choose a 4 Digit Password __ __ __ __ (Numbers can't be the same or repeating)

TO BE COMPLETED BY PROGRAM STAFF (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)

START DATE	DISCHARGE DATE	ENROLLED (DAYS OF THE WEEK & TIMES
RELATED CHILD? YES OR NO HOW IS CHILD RELATED TO PROVIDER?		

TRANSPORTATION & MEDIA AUTHORIZATION

I, the parent/guardian of the registrant, a minor, agree that the registrant and I will abide by the rules of Third Presbyterian Church Preschool (TPCP). Recognizing the possibility of physical injury associated with the activities and in consideration for TPCP accepting the registrant for its programs and activities, I hereby release, discharge, hold harmless, absolve and / or otherwise indemnify TPCP, 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.

Parent Signature _____ Date _____

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

Parent Signature _____ Date _____

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:
    a. 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.
    b. 1 to 5 minutes…….$10.00 per child
    c. 6 to 15 minutes……...$15.00 per child
    d. 16 to 30 minutes…….$30.00 per child
    e. Over 30 minutes…….$1.00 per minute

Excessive late arrivals may result in termination from the program.

Any fees for late pick-up are due 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 _____

RELEASE FORM

The following people are permitted to pick up my child, _____ from Third Presbyterian Church's Youth Program (Do not include parents 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)

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 ☐ LD ☐ AUTISM
☐ PTSD ☐ BD ☐ ED
☐ BIPOLAR ☐ ODD ☐ OTHER: _____
☐ 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.

I ____ DO _____ DO NOT Give permission for my child to participate in and be transported to/from field trips. I understand that I will be notified in advance 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 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.
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 ne accepted for care or remain in care.
E) I have been informed of the required health and safety inspections and the inspection forms are available for review.

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, 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 & 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

WEEKLY PROGRAM FEES		
	FULL TIME	**PART TIME**
Infants: 6 weeks – 23 months	$220	N/A
Preschool*	$175	N/A
School Age – Extended Care Program	$85	$55 (Before Care only) / $65 (After Care only)

*__ALL PRESCHOOL PARENTS:__ **Add a $10/week potty-training fee to tuition or sliding fee for any child not potty trained.**
***STATE PARENTS ONLY:** **Add a $10 co-pay per week to ALL tuition sliding payments.**

ANNUAL CURRICULUM FEE		
2 Yr olds - $25/yr	3 Yr olds - $35/yr	4 Yr olds/ 5yr. PreK - $45/yr

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/student.

— There is a non-refundable annual curriculum fee that is due at enrollment. (See above for pricing.) No curriculum will be issued to the child until the fee is paid in full. In addition, a $5/day late fee will be applied for curriculum fees not paid in full within 2 weeks after enrollment.

— There is a non-refundable annual laundry fee of $25 that is due at enrollment. This provides your child with the State required bedding for each week.

— A one-week non-refundable tuition deposit must be paid at enrollment. A minimum deposit of $25/student is due from any child receiving child care assistance from the State. 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 written-advance notice of withdrawal is not given to the Director the deposit is forfeited. Deposits will not be refunded.

— 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.

— A list of school supplies will be provided to you at enrollment. Within two weeks of enrollment, all supplies listed on the provided school supply list must be turned in to the classroom teacher. Additional supplies will be requested half way through the school year**. If all supplies are not turned in, then a $35 supply fee will be added to your account. Failure to pay the supply fee will result in standard late charges.**

— **Program fees (tuition, sliding 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 the first day 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.**

— 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** whether or not your child attends **any** portion of the week.

— In the event that a child contracts a major illness, suffers a major injury, contracts Corona Virus, is suspected to have Corona Virus or has been exposed to someone who has Corona Virus that will require an absence in excess of one week, a discounted rate or tuition waiver may be approved, but is not guaranteed. Arrangements must be made with the Program Director or Business Manager for a tuition waiver and or any discounted rates. A physician's signed statement with the physician's office or hospital stamp 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, discount 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.

— **Any child absent for 10 consecutive days or more without prior authorization will automatically be disenrolled** and their deposit, curriculum, registration and laundry fees will be forfeited**.**

— Any request for changes or adjustments concerning your tuition agreement must be made at least 1 week in advance and acknowledged in writing by the Program Director or Business Manager. 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.

— **More than two weeks of outstanding tuition/sliding fees will result in the discontinuation of services until the outstanding balance is paid in full.**

— Procare's Tuition Express is an automated payment processing system that allows you to make payments by swiping your credit/debit card at the sign-in kiosk. Your card information is kept secure with Tuition Express and not shared with the Center. An email address is required to use the service so that receipts verifying the transaction can be sent directly to you. There is a minimum 3% processing fee.

— The account balance and charges/payments can be reviewed at the kiosk. It is your responsibility to manage your finances to ensure the timeliness and fulfillment of all your financial obligations.

— It is imperative that you clock your child in and out of the electronic time system each day. You must sign a printout of your child's time in and out at the end of the month.

— 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.

— **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.**

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 _____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

RELIGIOUS ORGANIZATION CHILD CARE FACILITY NOTICE OF PARENTAL RESPONSIBILITY

LEGAL NAME OF FACILITY	DVN
Third Presbyterian Church Preschool	002172367
PHYSICAL ADDRESS (STREET, CITY, STATE, ZIP CODE)	
9990 Lewis and Clark Blvd, St. Louis, MO 63136	
FACILITY TELEPHONE NUMBER	FACILITY E-MAIL ADDRESS
314-868-9600	marie@tcpreschool.org

INSPECTIONS

Section 210.211 RSMo exempts this religious organization child care facility from state licensing and supervision by the Department of Elementary and Secondary Education(DESE). It is state inspected only for fire, health, and sanitation requirements as indicated below. Inspections are available on the Show Me Child Care Provider Search and can be accessed at https://dese.mo.gov/childhood/child-care/find-care

NAME OF AGENCY AND TYPE OF INSPECTION	ADDRESS	TELEPHONE NUMBER	INSPECTION	DATE
Office of Childhood - Child Care Compliance	220 S. Jefferson, St. Louis, MO 63103	314-877-0219	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	10/18/23
Fire Marshal's Office (Fire Safety Inspection)	P.O. Box 844, Jefferson City, MO 65102	314-504-7623	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	8/31/23
Local Health Office or DHSS (Sanitation Inspection)	111 Kingshighway, Suite E, Rolla, MI 65401	573-341-1655	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	8/16/2023

STANDARD STAFF/CHILD RATIOS ESTABLISHED BY THIS FACILITY

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
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
5 years of age and older	1 staff member for every	16

TOTAL NUMBER OF CHILDREN ENROLLED BY THIS FACILITY: 80

STAFF/CHILD RATIOS FOR LICENSED CENTERS

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 staff member for every	4
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

BACKGROUND CHECK REQUIREMENTS

Section 210.254 RSMo requires notification that background checks have been conducted under the provisions of section 210.1080 RSMo.
Section 210.1080 RSMo specifies criminal background checks for child care staff members. The requirements for religious organizations operating a child care facility are as follows:

- Facilities operated by a religious organization that receive federal funds for providing care for children must have qualifying background screening results for child care staff members as defined in 210.1080.1(1) RSMo.
- Facilities operated by a religious organization and that **do not** receive federal funds for providing care for children **are not** required to have qualifying background screening results for all child care staff members pursuant to 210.1080.9 RSMo.
- Child care staff members of facilities operated by a religious organization that receive federal funds for providing care for children, with disqualifying background screening results are prohibited from being on the premises during child care hours.
- Facilities operated by a religious organization that receive federal funds for providing care for children, must request criminal background checks for child care staff members every 5 years, as defined in 210.1080.1(1) RSMo.

BACKGROUND CHECKS HAVE BEEN CONDUCTED AS REQUIRED BY SECTION 210.1080 RSMO.
☒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

Section 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
PRINCIPAL OPERATING OFFICER/FACILITY DIRECTOR W. Marie Sims	DATE 10/18/23
INDIVIDUAL RESPONSIBLE FOR THE RELIGIOUS ORGANIZATION – PASTOR, MINISTER, PRIEST, ETC. Cedric Portis	DATE 10/18/23

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 **W. MARIE SIMS, PROGRAM DIRECTOR**			CHILD'S FIRST DATE ATTENDING

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD ATTENDS		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

WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION.

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

____ FULL DAY CARE
____ HALF DAY- MORNING
____ HALF DAY- AFTERNOON
____ BEFORE SCHOOL CARE
____ AFTER SCHOOL CARE
____ BEFORE & AFTER SCHOOL CARE
____ EVENING CARE
____ OVERNIGHT CARE

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

____ BREAKFAST
____ MORNING SNACK
____ LUNCH
____ AFTERNOON SNACK
____ SUPPER
____ 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 SIGNE CERTIFIES THAT THIS INFORMATION I 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
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

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
		/ /		
		/ /		
		/ /		
		/ /		

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.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

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 OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	WHITE
☐	☐	☐	☐	☐

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
	XXX-XX-	/ /
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): YEAR ☐	MONTH ☐	2 X A MONTH ☐	EVERY 2 WEEKS ☐	WEEKLY ☐	SNAP (Food Stamp) ☐	TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

MO 580-1314 (2-11) CACFP-205

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

SAVE
PRINT
RESET

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