

Child's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Growing in Academic Excellence & Godly Character



THE FIRST CHURCH  
PRESCHOOL

**INFANT & TODDLER  
ENROLLMENT PACKAGE  
2022-2023**

# 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:

- |                                     |                              |                                       |
|-------------------------------------|------------------------------|---------------------------------------|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> LD  | <input type="checkbox"/> AUTISM       |
| <input type="checkbox"/> PTSD       | <input type="checkbox"/> BD  | <input type="checkbox"/> ED           |
| <input type="checkbox"/> BIPOLAR    | <input type="checkbox"/> ODD | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> 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 thereafter 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 be 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.

<b>PARENT / GUARDIAN SIGNATURE</b> ▶	<b>DATE</b>
---	-------------



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**

<b>FLUID MILK</b>	<b>ALLOWED SUBSTITUTIONS</b>	<b>TEXTURE (e.g. CUT UP, GROUND MINCE, PUREE, LIQUIDITY)</b>
<b>MEAT &amp; MEAT ALTERNATIVE (e.g. EGGS, CHEESE, PEANUT BUTTER, BEANS, YOGURT)</b>	<b>ALLOWED SUBSTITUTIONS</b>	<b>TEXTURE</b>
<b>BREAD, CEREAL OR WHOLE GRAIN PRODUCTS</b>	<b>ALLOWED SUBSTITUTIONS</b>	<b>TEXTURE</b>
<b>FRUIT &amp; VEGETABLE OR JUICE</b>	<b>ALLOWED SUBSTITUTIONS</b>	<b>TEXTURE</b>

**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	\$210	N/A
Preschool*	\$165	N/A
School Age – Extended Care Program	\$75	\$45 (Before Care only) / \$55 (After Care only)

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

ANNUAL CURRICULUM FEE		
2 Yr olds - \$25/yr	3 Yr olds - \$35/yr	4 Yr olds/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 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, 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 requests for 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.
- **More than two weeks of outstanding tuition/sliding fees will result in the discontinuation of services until the outstanding balance is paid in full.**
- Procure'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 \_\_\_\_\_



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 <b>THIRD PRESBYTERIAN CHURCH PRESCHOOL &amp; YOUTH CENTER</b>			PHONE NUMBER ( 314 ) 868-9600	
CENTER CONTACT PERSON'S NAME <b>KRISTEN DAVIS, BUSINESS MANAGER</b>			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**

<input type="checkbox"/> NEW YEARS DAY (JANUARY 1)	<input type="checkbox"/> INDEPENDENCE DAY (JULY 4)
<input type="checkbox"/> MARTIN LUTHER KING'S BIRTHDAY (JANUARY)	<input type="checkbox"/> LABOR DAY (SEPTEMBER)
<input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY)	<input type="checkbox"/> THANKSGIVING DAY (NOVEMBER)
<input type="checkbox"/> MEMORIAL DAY (MAY)	<input type="checkbox"/> 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)	BIRTH DATE	FOSTER CHILD	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

**PART 2 HOUSEHOLD AND INCOME INFORMATION**

List all members of the household 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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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	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 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 a social security number is not mandatory, but if a social security number is 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):	SNAP (Food Stamp)	TEMPORARY ASSISTANCE
		YEAR <input type="checkbox"/> MONTH <input type="checkbox"/> 2 X A MONTH <input type="checkbox"/> EVERY 2 WEEKS <input type="checkbox"/> WEEKLY <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eligibility Determination:  Free  Reduced  Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
------------------------------------	------



**Third Church Infant Center  
Individual Care Plan**

Date: \_\_\_\_\_

Child's Name	Child's Birth Date:
Parent's Name:	
Family Member of:	

**ARRIVAL**

What time will you arrive at the school?

What will help you and your child say good-bye to each other in the morning?

**DIAPERING**

When does our child usually need a diaper change?

Are there any special instructions for diaper changes?

**SLEEPING**

How will we know that your child is tired and needs to sleep?

When does your child usually sleep? For how long does he or she sleep?

What helps your child to fall asleep?

We put babies to sleep on their backs. Is your baby used to sleeping on his or her back?

YES or NO

How does your child wake up? Does he or she wake up quickly or slowly? Does your child like to be taken out of the crib immediately or to lie alone in the crib for a few minutes before being held?

**AWAKE TIME**

How does your baby like to be held? What position does your baby prefer when awake?

What does your child like to do when he or she is awake?

## **DEPARTURE**

What time will you be picking up your child?

## **EATING**

Will you be bringing breast milk or formula to preschool?

How many ounces does your child drink at one time?

Does your baby drink water during the day? YES or NO If so when and how much?

Is your baby eating solid foods? YES or NO If so, which ones?

Does your baby eat any finger foods? If so, which ones?

What foods does your child dislike?

Is your child sensitive or allergic to any foods? If so, please list them.

Are there any foods that you **don't** want your child to eat?



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION AND CHILDE AND ADULT CARE FOOD PROGRAM  
**INFANT AND TODDLER FEEDING AND CARE PLAN**

**THIS SECTION TO BE COMPLETED BY CHILD CARE FACILITY:**  
The formula provided by this child care facility is: \_\_\_\_\_  
(Check a box)  Yes  No This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

**Instructions to Parents** - Please complete for child who is less than 24 months of age. *Update information as needed. Use a new for or initial/date changes on this form.*

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED
--------------	---------------	---------------

FEEDING INFORMATION			
TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply:  Parent  Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

Yes Explain: \_\_\_\_\_  
 No

Does your child use a pacifier?  Yes  No

Note: Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

**INFANT FEEDING PREFERENCE (under 12 months)**

Mark your preference (check all that apply).

- I will provide breast milk for my infant.
- I will nurse my infant at the center at these times: \_\_\_\_\_

The facility's formula may be used to supplement feedings if necessary:  Yes  No

If breast milk is unavailable for a feeding, the facility should: \_\_\_\_\_

- I request that the formula provided by the child care facility be served to my infant
- I will provide infant formula for my infant. Name of formula: \_\_\_\_\_
- I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**
- I will provide solid foods for my infant.

In accordance with Federal civil rights law and U.S. Department of agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complain of discrimination, complete the [USDA Program Discrimination Complaint Form](https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint). (AD-3027) found online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail to U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, by fax (202) 690-7442, or email at [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity employer.

**TODDLER FEEDING PREFERENCE (12 through 23 months)**

Check all that apply:  Spoon  Cup  Feeds Self  Feeding Table or Chair

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breast Milk			
Milk			
Table Food			



<b>ARRANGEMENTS FOR SLEEP – Licensing rules require that infants be placed on their back to sleep.</b>	
TIME(S) CHILD USUALLY NAPS	LENGTH OF NAP
<p><b>Additional Instructions Related to Sleeping:</b>  <b>Note:</b> When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) must put the infant to sleep in accordance with such written instructions.</p>	
<input type="checkbox"/> My child is 12 months or older, and I give my permission for my child to sleep on a cot.	
SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE
<b>DIAPERING INSTRUCTIONS</b>	
LIST ANY LOTIONS AND/OR OINTMENTS, ETC. THAT YOU HAVE PROVIDED AND GIVE PERMISSION FOR CAREGIVERS TO USE ON YOUR CHILD	
FOR <input type="checkbox"/> WET <input type="checkbox"/> BOWEL MOVEMENT <input type="checkbox"/> RASH <input type="checkbox"/> OTHER	
<input type="checkbox"/> I do not want caregivers to use any lotions, powders, ointments or similar items on my child.	
I WILL FURNISH THE FOLLOWING BABY SUPPLIES FOR MY CHILD; CLEARLY LABELED WITH MY CHILD'S NAME	
SPECIAL INSTRUCTIONS FOR CARE (E.G., RESTRICTIONS, ALLERGIES, ETC.):	
SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE