ADAPTED BY COUNTRYSIDE FROM THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
COUNTRYSIDE MONTESSORI SCHOOL		

CHILD'S NAME	GENDER	BIRTHDATE

ADDRESS (STREET, CITY, STATE, ZIP)

IDENTIFYING INFORMATION

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

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

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

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

COMMENTS ON CHILD'S DEVELOPMENT
(NOTE CHILD'S PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, AND INDVIDUAL NEEDS)

RELATED CHILD

⚬ YES ⚬ NO	HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CACFP REQUIREMENT

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ⚬Full Time or ⚬Part Time		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM.	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM.	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
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	

PLEASE COMPLETE OTHER SIDE

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE COUNTRYSIDE MONTESSORI SCHOOL TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	PHONE

PREFERRED HOSPITAL

NAME	PHONE

IN THE EVENT OF A MEDICAL EMERGENCY, I ☐ DO ☐ DO NOT GIVE PERMISSION FOR COUNTRYSIDE MONTESSORI SCHOOL TO TRANSPORT MY CHILD TO THE PREFERRED HOSPITAL LISTED ABOVE (OR CLOSEST HOSPITAL IF A LIFE THREATENING EMERGENCY OCCURS).	PARENT/GUARDIAN INITIALS

ACKNOWLEDGEMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I AM AWARE THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I AM AWARE THAT THIS FACILITY DOES NOT TRANSPORT CHILDREN FOR FIELD TRIPS AND I AM RESPONSIBLE FOR TAKING MY CHILD TO THE FIELD TRIP AND SUPERVISING MY CHILD DURING THE FIELD TRIP.	PARENT/GUARDIAN INITIALS

PARENT'S/GUARDIAN'S SIGNATURE		DATE
FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE