MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES BUREAU OF CHILD CARE

**CHILD ENROLLMENT**

|  |  |  |  |
| --- | --- | --- | --- |
|  | CHILD’S NAME | SEX | BIRTH DATE |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | HOME TELEPHONE NUMBER( ) |
| OPTIONAL | **SCHOOL CHILD ATTENDS** |
| NAME | TELEPHONE NUMBER( ) |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) |
|  | **IDENTIFYING INFORMATION** |
| MOTHER’S OR GUARDIAN NAME | **HOME TELEPHONE NUMBER****(** ) |
| ADDRESS  CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.) | CELL PHONE NUMBER **(OPTIONAL)**( ) |
| EMPLOYED BY (OR SCHOOL ATTENDED) | HOURS OF EMPLOYMENTFROM TO |
| ADDRESS (STREET, CITY, STATE, ZIP CODE.. | BUSINESS TELEPHONE NUMBER( ) |
| FATHER’S OR GUARDIAN’S NAME | HOME TELEPHONE NUMBER( ) |
| ADDRESS  CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.) | CELL PHONE NUMBER (OPTIONAL)( ) |
| EMPLOYED BY (OR SCHOOL ATTENDED) | HOURS OF EMPLOYMENT FROM TO |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | BUSINESS TELEPHONE NUMBER( ) |
| **EMERGENCY CONTACT(S) (ONE REQUIRED)** |
| NAME | TELEPHONE NUMBER( ) |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | RELATIONSHIP |
| OPTIONAL | NAME | TELEPHONE NUMBER( ) |
| ADDRESS (STREET, CITY, STATE, ZIP CODE) | RELATIONSHIP |
|  | **PERSONS AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY (ONE REQUIRED)** |
| NAME | NAME |
| **COMMENTS ON CHILD’S DEVELOPMENT** |
| **(NOTE ALLERGIES, HABITS, SPECIAL LANGUAGE, ETC.)** |
|  |
|  |
| **TO BE COMPLETED BY CHILD CARE FACILITY (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)** |
| FACILITY NAME | ADMISSION DATE |
| ENROLLED FOR (DAYS OF THE WEEK) | FULL TIME/PART TIME |
| HOURS PER DAYFROM TO |
| DISCHARGE DATE |

MO 580-1932 (12-06) **PLEASE COMPLETE BACK** BCC-7

**CHILD’S 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 COUNTRYSIDE MONTESSORI SCHOOL to contact the following:

**PHYSICIAN OR CLINIC**

(Please list name and phone number of physician and/or clinic.)

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEPHONE ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED HOSPITAL**

(Please list name and phone number of physician and/or clinic.)

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEPHONE ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN THE EVENT OF A MEDICAL EMERGENCY, I GIVE PERMISSION FOR COUNTRYSIDE MONTESSORI SCHOOL TO TRANSPORT MY CHILD TO THE ABOVE HOSPITAL (OR CLOSEST HOSPITAL IF A LIFE THREATENING EMERGENCY OCCURS).

HEALTH INSURANCE COMPANY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH INSURANCE POLICY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH INSURANCE GROUP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENTS**

1. I HAVE RECEIVED A COPY OF THIS FACILITY’S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.
2. A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CHILD CARE CENTERS IS AVAILABLE AT THIS FACILITY FOR MY 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/LEGAL GUARDIAN SIGNATURE DATE**