



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
 OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE
CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE

ADDRESS (STREET, CITY, STATE, ZIP CODE)

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER
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E-MAIL ADDRESS

EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER
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E-MAIL ADDRESS

EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

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

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

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

TO CONTACT THE FOLLOWING: _____ DAY CARE PROVIDER

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER
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PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER
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The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/ Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.

ACKNOWLEDGEMENTS		
A	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	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
C	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
D	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
E	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.	PARENT/GUARDIAN INITIALS
HEALTH REPORT FOR SCHOOL-AGE CHILD		
CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS		
<input type="checkbox"/> MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.		
<input type="checkbox"/> MY CHILD IS ABLE TO PARTICIPATE IN GROUP CARE BUT HAS SPECIAL HEALTH OR MEDICAL REQUIREMENTS AS LISTED BELOW.		
ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS		
ANY SPECIAL MEDICATIONS AND/ OR RESTRICTIONS		
PARENT/GUARDIAN SIGNATURE		DATE
FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.		
FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.		



Kids Day Out at Dayspring

I, _____, parent/guardian of _____, understand and agree that I am responsible to pay the monthly tuition fee for my child for the duration of the 2023-2024 school year, from September until May.

I understand that I must inform the Kids Day Out Director one month in advance if I wish to withdraw my child from class.

If I choose to withdraw from Kids Day Out, I understand that I am responsible for tuition payment for the remainder of the school year unless arrangements have been made and agreed upon with the Kids Day Out Director prior to my child's withdrawal.

Sign _____ Date _____



Kids Day Out at Dayspring

Please complete this form and return to Kids Day Out Director before the first day of school.

Child's Name _____ M ____ F ____ Age _____ Date of Birth _____

Address _____

Phone (H) _____ (C) _____ (W) _____

History of illness—Enter the year in which your child had any of the following:

Chicken Pox _____ Strep Throat _____ Epilepsy _____

German Measles (3-day) _____ Rheumatic Fever _____ Convulsions _____

Measles (Red) _____ Hepatitis _____ Diabetes _____

Scarlet Fever _____ Tuberculosis _____ Poliomyelitis _____

Is your child on any medication? Yes _____ No _____ If yes, please specify _____

List below all allergies, injuries, operations, serious illnesses, heart conditions, vision, hearing loss, and any other health information you feel would be helpful. _____

History of immunizations - Attach a physician's records or enter month, day, and year your child received the following:

	1st	2 nd	3rd	4th
	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Hepatitis B				
DTAP/DT				
POLIO				
HIB				
PCV (Pneumococcal)				
MMR				
Varicella (Chicken Pox)				

Missouri State Law, Section 210.003, RSMo, requires all children attending public, private, parochial day care centers, preschools or nursery schools to be adequately immunized, in the process of being immunized, or have a written exemption on file for the diseases listed above. Required immunizations for 19 months to kindergarten entry: 3+ Hepatitis B, 4+ DTaP/DT, 3+ Polio (IPV), 3+ Hib, 4 PCV, 1 MMR, and 1 Varicella.

Turn page over for Doctor Signature and Date!

This child has been examined. The health history has been reviewed. There are no apparent contraindications to participation in routine, group-care activities except as stated below:

Comments, Special needs, allergies, etc.

Doctor's Signature

Date



Kids Day Out at Dayspring

Kids Day Out at Dayspring is license exempt in the state of Missouri.

Licensed programs, such as childcare centers, are inspected by DESE for state health and safety requirements and require a current license to be on file.

License exempt programs, such as religious organizations are inspected for compliance with some health and safety requirements, but do not require a license. They must have a current inspection on file with DESE and retain "in compliance" Status.

By signing below, I acknowledge the license exempt status of the Kids Day Out at Dayspring program.

Signature

Date