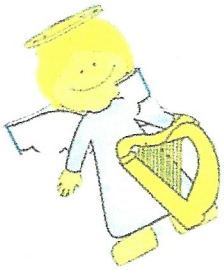


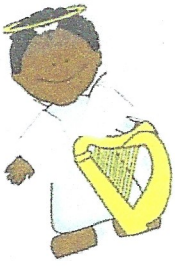
*Thank you for choosing Little Precious Angels Childcare! Our motto is "Little Precious Angels, they have wings...we give them knowledgeable flight." We are committed to developing each child to their fullest potential.*

*At Little Precious Angels Childcare, we understand how difficult it can be for parents to balance work, children and other commitments and responsibilities in their daily lives. For this reason, we strive to offer a childcare program that will enrich your child's development (socially, academically, physically, emotionally and more) while putting your mind at ease that your child is being well taken care of.*

*There is a large variety of toys, books, puzzles and more for children to learn, play and explore the world around them. This experience takes place in a clean and safe environment. The curriculum emphasizes learning as a fun and interactive place to grow. We want all of our children to be successful, this is why we encourage them to try. We applaud effort, not perfection in everything they do.*

*Please carefully read the parent handbook and fill out the enrollment packet. It is very important that you are informed of our policies and procedures. We look forward to being your childcare provider, working together and watching your child learn and grow.*

*Welcome to Little Precious Angels Childcare.*



# Little Precious Angels Childcare 2 LLC

**Private Pay**

*What you need to start*

- Enrollment Forms
- Shot Records/Vaccination Records
- Physical (must state child can attend Childcare)
- $35.00 non-refundable Registration fee (family fee)
- Deposit of one-week tuition for each child attending
- First week's tuition for each child attending
- Allergy Form with an action plan from child's physician

All payments are do before service can start.

If you have any questions, please contact the center director at 314-296-3561

**State Subsidy**

*What you need to start*

- Enrollment Forms
- Shot Records/Vaccination Records
- Physical (must state child can attend Childcare)
- $35.00 non-refundable Registration fee (family fee)
- Deposit of $50.00 for each child attending-Refundable with two weeks' notice of leaving, deposits will be refunded 30 days after the last day of service.
- Sliding fee for the month, must be paid before service for days approved by State
- Allergy Form with an action plan from child's physician

All payments are do before service can start.

Children on State subsidy are required to attend Little Precious Angels Childcare 2 LLC on all approved times given by the State of Missouri. (Example: if you are approved for 18 days per month, your child is required to be in attendance 18 days per month).

If you have any questions, please contact the center director at 314-296-3561

Amount Due:

Registration: **$35.00**

Deposit: $_____

Tuition: $_____

Total: $_____

Dear parents,

Little Precious Angels Childcare is not a drop off service, we require all children to be in attendance full time/ or subsidy approved days. Little Precious Angels is a weekly rated business and all payments are adjusted to the weekly rate requirements. You are responsible for paying the entire weekly rate, even when your child is not in attendance.

All payments must be paid in full before service.

Extra meals for children exceeding 10 hours must be paid, the next day. meals $3.88 per child.

Parents are responsible for paying all late fees (not covered by tuition).

Children are only allowed in our care for 10 hours, unless discussed with the director (must have a schedule)

All day shift children must be in attendance by 9am M-F, all day shift children must be picked up by 6pm or late fees will be charged.

All Evening shift children must be in after 9am but before 11am M-F, all evening shift children must be picked up by 9pm.

Subsidy and private pay parents are responsible for transportation fees of $15.00 per week (fee not covered by subsidy assistance), per school.

School age children are required to have a school calendar and parent schedule on file, so accommodations can be made when schools are closed, and the school age child will be in attendance for a full day. If we do not have a calendar or work schedule for school age full days, your child will not be excepted for the day.

Before and After care: All children for before care must be at the center for transportation by 8:25am, we will not serve breakfast for those arriving after 8:25am, the transportation vehicle leaves 8:28am and all children must be ready to go. We maintain this schedule, so all children arrive at school on time. After care children will be picked up at their designated time, if your child is not in school for transportation and Little Precious Angels was not notified, you will still be responsible for transportation fees and transportation suspended for the remainder of the week.

ALL SUBSIDY PAYMENTS, TRANSPORTATION FEES, and TUITION PAYMENTS ARE DUE BY THE FIRST BUSINESS DAY OF EACH MONTH FOR THE ENTIRE MONTH, *UNLESS DISCUSSED WITH THE DIRECTOR (Private pay only).*

Parent name (Print)_____

Parent Signature _____ Date _____

Director Signature _____ Date _____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

# CHILD CARE ENROLLMENT FORM

| 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 |
|---|---|
| ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐ | CELL PHONE NUMBER |
| E-MAIL ADDRESS | |
| EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE |
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |

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

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

**COMMENTS ON CHILD'S DEVELOPMENT**
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

**RELATED CHILD**

☐ YES ☐ NO — HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

**CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED**

| | 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. |
|---|---|---|---|---|
| MONDAY | ☐ | AM PM | AM PM | |
| TUESDAY | ☐ | AM PM | AM PM | |
| WEDNESDAY | ☐ | AM PM | AM PM | |
| THURSDAY | ☐ | AM PM | AM PM | |
| FRIDAY | ☐ | AM PM | AM PM | |
| SATURDAY | ☐ | AM PM | AM PM | |
| SUNDAY | ☐ | AM PM | AM PM | |

PLEASE ALSO COMPLETE PAGE 2

CACFP REQUIREMENT

**CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY**

☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE

**CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY**

| | | | |
|---|---|---|---|
| ☐ NEW YEARS'S DAY (JANUARY) | ☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY) | ☐ PRESIDENT'S DAY (FEBRUARY) | ☐ EASTER (MARCH/APRIL) |
| ☐ MEMORIAL DAY (MAY) | ☐ INDEPENDENCE DAY (JULY) | ☐ LABOR DAY (SEPTEMBER) | ☐ COLUMBUS DAY (OCTOBER) |
| ☐ VETERANS DAY (NOVEMBER) | ☐ ELECTION DAY (NOVEMBER) | ☐ THANKSGIVING (NOVEMBER) | ☐ CHRISTMAS DAY (DECEMBER) |

**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

DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

**PHYSICIAN OR CLINIC**

| NAME | TELEPHONE NUMBER |
|---|---|
| | |

**PREFERRED HOSPITAL**

| NAME | TELEPHONE NUMBER |
|---|---|
| | |

**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 HAVE BEEN INFORMED 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 ☐ DO<br>☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS.<br>I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED. | PARENT/GUARDIAN INITIALS |
| G | I ☐ DO<br>☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD. | PARENT/GUARDIAN INITIALS |
| H | I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE. | PARENT/GUARDIAN INITIALS |
| I | 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 |

| PARENT'S/GUARDIAN'S SIGNATURE | DATE |
|---|---|
| | |

CACFP REQUIREMENT

| | | |
|---|---|---|
| FIRST ANNUAL UPDATE | PARENT/GUARDIAN SIGNATURE | DATE |
| SECOND ANNUAL UPDATE | PARENT/GUARDIAN SIGNATURE | DATE |
| THIRD ANNUAL UPDATE | PARENT/GUARDIAN SIGNATURE | DATE |

# Child Pickup Authorization

**Additional persons who may pick up child/children on a less frequent basis:**

**Name:** _____

**Address:** _____

**Relationship:** _____

**Phone:** _____

**Name:** _____

**Address:** _____

**Relationship:** _____

**Phone:** _____

**Name:** _____

**Address:** _____

**Relationship:** _____

**Phone:** _____

**Name:** _____

**Address:** _____

**Relationship:** _____

**Phone:** _____

INFANT SAFE SLEEP POLICY

Little Precious Angels / LaDonna Smith DVN:002572514

2/8/1016

Purpose: The purpose of the Safe Sleep Policy is to maintain a safe sleep environment that reduces the risk of sudden infant death syndrome (SIDS) and sudden unexpected infant deaths (SUIDS) in children less than one year of age. Missouri law (210,223,1 RSMO) requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent safe sleep recommendations of the American Academy of Pediatrics (AAP). Missouri child care licensing rules require licensed child care facilities to provide parent (s) and/or guardian (s) who have infants in care a copy of the facility's Safe Sleep Policy.

SIDS is the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene and a review of the clinical history.

SUIDS is the sudden and unexpected death of an infant less than one year of age in which the manner and cause of death are not immediately obvious prior to investigation. Causes of sudden unexpected infant deaths include, but are not limited to, metabolic disorders, hypothermia or hyperthermia, neglect or homicide, poisoning and accidental suffocation.

Child care providers can maintain safer sleep environments for infants that help lower the chances of SIDS. Our goal is to take proactive steps to reduce the risk of SIDS in child care and to work with parents to keep infants safer while they sleep. To do so, this facility will practice the following safe sleep policy:

**SAFE SLEEP PRACTICE**

1. Infants will always be placed on their backs to sleep. When in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements, 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. Caregivers will put the infant to sleep as specified in the written instructions.

2. When Infants can easily turn from their stomachs to their backs and from their backs to their stomachs, they shall be initially placed on their backs, but shall be allowed to adopt whatever position they prefer for sleep. The AAP recommends that infants are placed on their back to sleep, but when infants can easily turn over from their back to their stomach, they may adopt whatever position they prefer for sleep. We will follow this recommendation by the AAP.

3. Sleeping infants shall have a supervised nap period. The caregiver shall check on the infant frequently during napping/sleeping and shall remain in close proximity to the infant in order to hear and see them if they have difficulty while napping or when they awaken. One caregiver is always present in the napping room at all times.

4. Steps will be taken to keep infants from overheating by regulating the room temperature, avoiding excess bedding and not over-dressing or over-wrapping the infant. Infants should be dressed appropriately for the environment, with no more than one (1) layer more than an adult would wear to be comfortable in that environment.

5. All caregivers will receive in-person or online training on infant safe sleep practice based on AAP safe sleep recommendations. This training must be completed within thirty (30) days of employment or volunteering and will be completed every three (3) years.

**SAFE SLEEP ENVIRONMENT**

1. Room temperature will be kept at no less than $68^0$ F and no more than $85^0$ F when measured two feet from the floor. Infants are supervised to ensure they are not chilled or overheated.

2. Infants' heads and face will not be covered during sleep/nap time. Infant cribs will not have blankets or bedding hanging on the sides of the crib. We may use sleep clothing (i.e. sleep sack, sleepers) that is designed to keep an infant warm without the possible hazard of covering the head or face during sleep/nap time.

3. No blankets, loose bedding, comforters, pillows, bumper pads or any object that can increase the risk of entrapment, suffocation or strangulation will be used in cribs, playpens or other sleeping equipment.

4. Toys and stuffed animals will be removed from the crib when the infant is sleeping/napping. When indicated on the INFANT & TODDLER FEEDING CARE PLAN or with written parent consent, pacifiers will be allowed in an infants' crib while they sleep/nap. The pacifier **cannot** have cords or attaching mechanisms.

5. Only an individually- assigned, safety-approved crib, portable crib or playpen with a firm mattress and tight - fitting sheet will be used for infant napping or sleeping.

6. Only one (1) infant may occupy a crib or playpen at one time.

7. Sitting devices such as car safety seats, strollers, swings, infant carriers, infant slings and other sitting devices will not be used for sleep/nap time. Infants who fall asleep anywhere other than a crib, portable crib or playpen must be placed in a crib or playpen for the remainder of their sleep/nap time.

8. No person shall smoke or otherwise use tobacco products in any area of the child care facility during the time when children cared for under the license are present.

9. Home monitors or commercial devices marketed to reduce the risk of SIDS shall not be used in place of supervision while children are sleeping/napping.

10. All parents/guardians of infants shall be informed and be given a copy of the facility's Safe Sleep Policy *upon enrollment.*

11. To promote healthy development, infants who are awake will be given supervised "tummy time" for exercise and play.

12. Soft music does play during nap time at a low volume so the children are able to be heard if they became distressed.

13. Lighting during nap/sleep is always on with at least a lamp so that children can be seen.

Missouri Department of Health and Senior Services
Section for Child Care Regulation and Child 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 form 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 |
|---|---|---|---|
| Breast Milk | | | |
| 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.

**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 | | | |

**Arrangements for Sleep – Licensing rules require that infants be placed on their back to sleep.**

| Time(s) Child Usually Naps | Length of Nap |
|---|---|
| | |

**Additional Instructions Related to Sleeping:**
**Note:** 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.

☐ 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 |
|---|---|
| | |

**Diapering Instructions**

List any lotions and/or ointments, etc. that you have provided and give permission for caregivers to use on your child. _____

For ☐Wet ☐Bowel Movement ☐Rash ☐Other

☐ 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 |
|---|---|
| | |

# MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

| 1. SPONSOR Name | 2. Site Name, if different from #1. | 3. Site Telephone Number |
|---|---|---|
| | | |

| 4. Name of Participant | 5. Date of Birth |
|---|---|
| | |

| 6. Name of Parent or Guardian | 7. Telephone Number |
|---|---|
| | |

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions.) CACFP, schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. CACFP, schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. CACFP, schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, nurse practitioner or parent or guardian may sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation-use extra pages as needed*)

12. Foods to be omitted and substitutions: (*please list specific foods to be omitted and required substitution; attach a sheet with additional information as needed*)

| A. Foods To Be Omitted | B. Foods to be Substituted |
|---|---|
| | |
| | |
| | |
| | |

13. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Adaptive Equipment:

| 15. Signature of Preparer* | 16. Printed Name | 17. Telephone Number | 18. Date |
|---|---|---|---|
| | | | |

| 19. Signature of Medical Authority* | 20. Printed Name | 21. Telephone Number | 22. Date |
|---|---|---|---|
| | | | |

* **Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.** The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

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 |

# Little Precious Angels Childcare

*Allergy Form

Child's Name:_____ Date of Birth_____

Please list any of your child's allergies and any medical conditions that your child may have.

Food:_____

_____

_____

Medications:_____

_____

_____

Any other substance that may cause an allergic reaction:_____

_____

_____

***Allergies <u>MUST</u> have a signed doctor's note.**

Personal Preference:_____

_____

_____

LPACC will do its best to accommodate Personal Preferences.

*If my child has an allergy, I authorize that my child's name may be posted in the classroom as a reminder to staff to help prevent allergic reactions.* This is very important to help keep your child as safe as possible and involved in a healthy environment.

Parent's Signature:_____ Date_____

LPACC Signature:_____ Title_____

Date_____

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

# MEDICATION AUTHORIZATION

SAVE
PRINT
RESET

## MEDICATION REQUIREMENT

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

(PROPER NAME OF MEDICATION)

| CHILD'S FULL NAME | DATE MEDICATION TAKEN FROM | UNTIL |
|---|---|---|
| | | |

| DOSAGE | TIME(S) OF DAY |
|---|---|
| | |

POSSIBLE SIDE EFFECTS

| SIGNATURE OF PARENT(S) OR GUARDIAN | DATE |
|---|---|
| | |

## RECORD OF ADMINISTRATION

| STAFF NAME | DATE | MEDICATION NAME | DOSAGE | TIME |
|---|---|---|---|---|
| | | | | |
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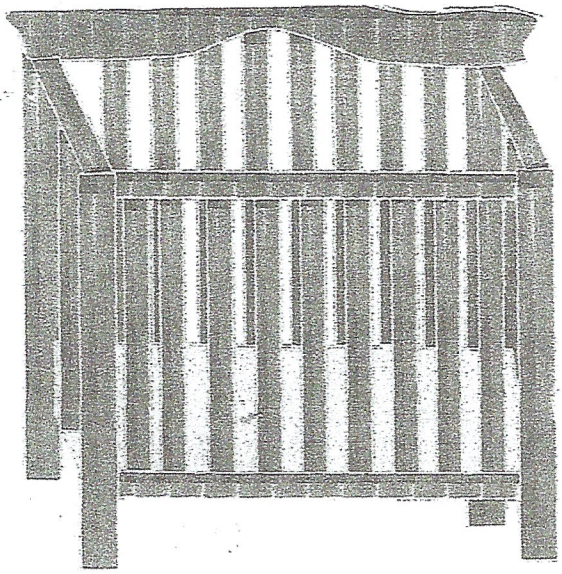
BCC-11



FORM TO BE RETAINED IN CHILD'S RECORD



I, _____

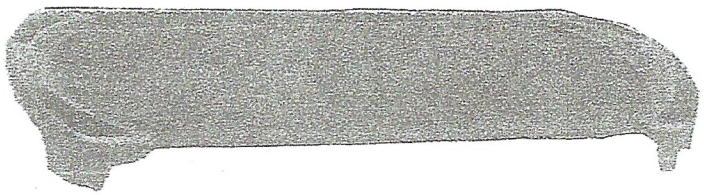
Am the parent of _____

and I give Little Precious Angels Childcare permission to transition my child from a crib to a cot.

The purpose of this transition is for my child to get used to sleeping on a cot on a regular basis while attending daycare.

_____

Parents Signature Date



**Little Precious Angels Childcare 2 LLC**

**Outside Waiver form**

I _____, the parent of _____ ("my child'), give permission for my child to be outside on the playground when their class goes outside.

I understand that injury can and may occur to my child, and hereby authorize Samantha Cross, Director, or another staff in charge, to seek and consent to emergency medical attention for my child as needed. I further agree to be liable for and pay all costs incurred in connection with such medical attention.

I hereby release Little Precious Angels Childcare 2LLC, its employees, agents and volunteers, from any and all liability, claims, demands, causes of action and possible causes of action whatsoever arising out of or related to any loss, damage or injury (including death) that may be sustained by my child while participating in outdoor activities.

The State of Missouri requires all children to be outside and to join in outside activities.

I understand and agree to all terms in this agreement.

_____ _____

Parent/Legal Guardian Signature Date

_____

Parent/Legal Guardian Print

_____ _____

Director Date

Dear Parent/Guardian

As the parent of a child/children at _____, I agree to the following:

I understand that my child(ren) whose name(s) are listed below may be photographed at _____during normal daycare hours, field trips, or activities. I understand that these photographs may be used in promoting child care services, either in print or on the Internet.

| Parent/Guardian Name | Relationship To Child |
|---|---|
| | |

Child 1Name

Child 2 Name

Child 3 Name

Address

| City | State | Zip |
|---|---|---|
| | | |

I give permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting our child care services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation.

| Parent/Guardian Signature | Date |
|---|---|
| | |

**Child and Adult Care Food Program**
**Parent Letter – Non-Pricing Child Care Centers**
**July 1, 2019 through June 30, 2020**

Dear Parent or Legal Guardian:

Our center is currently participating in the Child and Adult Care Food Program. This program reimburses the center for the partial cost of meals provided to children and allows the center to provide nutritious meals without increasing the center's fees to you. If your yearly income is equal to or below the amount listed for your family size on the chart below, your child is eligible for free or reduced-price meals. If the income is higher than the amount listed for your family size, you do not need to complete the income application.

| Family Size | Yearly Income | Family Size | Yearly Income |
|---|---|---|---|
| 1 | $23,107 | 5 | $55,815 |
| 2 | $31,284 | 6 | $63,992 |
| 3 | $39,461 | 7 | $72,169 |
| 4 | $47,638 | 8 | $80,346 |
| | | For each additional Family Member, add | +$8,177 |

To apply for free or reduced-price meal benefits for your children, you must complete the attached Income Eligibility Form (IEF). Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided; however you are not required to complete the IEF. Notify the center should the household income decrease and/or if the household size increases. A participant may be eligible for free or reduced-price meals. The application is valid until the last day of the month in which the form was approved/dated/signed one year earlier.

Sincerely,

Center Owner/Director

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 complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at:
http://www.ascr.usda.gov/complaint filing cust.html, 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:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

This statement implementation date is November 2015.

Child and Adult Care Food Program
Income Eligibility Guidance for Child Care Centers

## Parent/Guardian Instructions for Completing the Income Eligibility Form (IEF)

### PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

- List all children that you are applying to enroll in the child care.
- List each child's birth date.
- If you are applying for a foster child, the foster child is eligible for free meals regardless of household income, and you do not need to complete the IEF. Talk to the child care center director regarding documentation of a foster child's eligibility.
- If your child receives Temporary Assistance (formerly AFDC, now funded by TANF) payments or Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps), please indicate the appropriate case number in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete part 2.
- If you have a SNAP or Temporary Assistance case number for at least one of your children enrolled at the center, the eligibility extends to all of your children enrolled at the center. You do not need to complete Part 2.
- If you do not participate in SNAP or TANF, you must complete all sections of the form including Part 1, 2, 3, and 4.

### PART 2: HOUSEHOLD AND INCOME INFORMATION – Not completed if case number for SNAP or TANF is provided in Part 1.

- List all members of the household not included in Part 1. A household is a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses).
- Report the monthly income by source for each household member.
- The income reported on the application must include all income before taxes and before other deductions.
- Income Exclusions not to be reported or counted include:
  1. Payments received for the care of foster children.
  2. Student financial assistance provided for the costs of attendance at an educational institution, such as grants and scholarships.
  3. Loans, such as bank or student loans, since these funds are only temporarily available and must be repaid.

**PART 3: RACIAL ETHNIC INFORMATION - Completion is Voluntary**

**PART 4: SIGNATURE**

- The adult household member completing the application must sign and date the application.
- If the child(ren) is not a Temporary Assistance or SNAP recipient, the adult signing the application must provide the last four digits of his/her social security number.
- If you do not have a social security number, write "none" in the space provided.
- Failure to provide the last four digits of your social security number, if you have one, will make the income application invalid if the child(ren) is not a SNAP or Temporary Assistance recipient.
- The adult household member completing the IEF must attest to the fact that the information provided is correct, that it is being given in connection with the receipt of federal funds, that it is subject to verification, and that the deliberate misrepresentation of facts will subject the individual to prosecution under applicable state and federal statutes.

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) | 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) XXX-XX- | 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 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 |
|---|---|
| | |

CACFP-205

MO 580-1314 (2-11)

USDA is an equal opportunity provider, employer, and lender.