2017-2018 Enrollment Packet

Enrollment Guidelines

1. The Odessa R-VII Child Care Center will be open August 14, 2017 thru May 17, 2018.

2. District staff: The Childcare Center will be open August 9-11, 2017 for the teacher work days. If you will need care on these days, please let Wendy Reynolds (director) know for staffing.

3. Full Time enrollment is available for ages 6 weeks- school entry. No part time or drop in care is available.

4. To ensure a place for your child, please turn in completed enrollment form and enrollment fee of $25.00 to the director, Wendy Reynolds, by Friday, April 28th, 2017.

5. Tuition rates are as follows: Infant-2 year olds: $135.00 per week. Three-Five years: $110.00 per week

6. The Child Care Centers hours will be from 7:00 am to 4:30 pm Monday- Friday.

7. Each child will be allowed one week of non-attendance without fees. This time can only be taken in a one-week block. This non-attendance time may not be taken on a daily or partial week basis. This time may not be utilized to cover fees for any time that a child is in attendance (last week of teacher contract period or during the two week notice of a child exiting the program.)

8. The Child Care Center's first day in session will be August 14th. These are the dates for 2017-2018 school year when the Child Care Center will be closed with no payment required: September 4th (Labor Day), October 20th, November 22nd-24th(Thanksgiving), December 20th-January 1st (Winter Break), January 15th (MLK Day), February 16th (President's Day), March 16th(Spring Break) March 30th-April 3rd (Easter Break).

9. The enrollment fee, enrollment form, Medical Examination Report, immunization record, and media release form must be completed and on file prior to the first day of the child's attendance.

10. If you choose to exit the program a two-week notice is required. You will be responsible for paying the last two weeks of child care even if your child does not attend.

Odessa R-VII School District Child Care Center
2017-2018 Enrollment checklist

Please turn in the following checklist to Wendy Reynolds, Center Director, with your child's pre-enrollment paperwork.

_____ $25.00 Enrollment fee

_____ Completed Enrollment Form

_____ Medical Examination form

_____ Copy of Immunizations

_____ Media Release Form

_____ Handbook Acknowledgement Form

_____CACFP form(food program)

Odessa R-VII Child Care Center and S.O.A.R. Program
607 S. 3rd Street Odessa, MO 64076
816-633-5437

Media Release Permission Form

The Odessa R-VII Child Care Center plans to use photography throughout our center for school purposes such as documenting the learning process, special events, classroom routines, family involvement activities, family communication, newsletters, center bulletin boards, the district website, etc.

The center also plans to do classroom email updates that may contain pictures. This email update will be sent as a group email to the parents of children in each individual classroom. On occasion, there may be large group (multiple classroom) photos included.

☐ I understand that my student may be photographed for school purposes. These photos may be used in school publications, newsletters, group emails and other purposes stated above. Photographs may also be taken and used in the local newspaper. *If I do not wish for my child to be photographed, I will issue a written request to the school denying permission to take any photographs of my child.*

Student Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent Email Address for Updates: _____

Parent Email Address for Updates: _____

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	

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 ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ 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

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

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

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

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