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

CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

FACILITY/PROVIDER NAME LittleLambsPreschool	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) **PLEASE LIST ALL INFORMATION FOR BOTH CONTACTS**

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)		

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

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

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 ☐ DO ☐ 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 ☐ DO ☐ 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

☐ MY CHILD IS IN GOOD HEALTH, IS ABLE TO PARTICIPATE IN GROUP CARE, HAS NO SPECIAL HEALTH OR MEDICAL REQUIREMENTS.

☐ 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.

PLEASE INCLUDE A COPY OF CHILDS IMMUNIZATION RECORDS

SAVE
PRINT
RESET

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

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

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY

PLEASE INCLUDE A COPY OF CHILDS IMMUNIZATION RECORDS

Little Lambs Preschool

CHILD RELEASE AUTHORIZATION

Please list any person(s) who might be picking up your child from preschool. Your child will not be allowed to go home with any person(s) who is not listed, unless a parent has made arrangements with the Director.

_____

Child(ren) Name

_____

Primary Pick up Person Relationship to Child

_____ _____ _____

Home # Cell # Work #

Authorized Pick Up:

1. _____

Name Relationship to Child

_____ _____ _____

Home # Cell # Work #

2. _____

Name Relationship to Child

_____ _____ _____

Home # Cell # Work #

3. _____

Name Relationship to Child

_____ _____ _____

Home # Cell # Work #

Notice to Parents Regarding Immunizations

In accordance with Section 210.003.7, RSMo., the parent or guardian of a child enrolled in or attending Little Lambs Preschool may request notice of whether there are any children enrolled in our facility with an immunization exemption on file. If you would like to request this information, please contact Ashley Collier and the information will be provided to you. Please note, the name or names of individual children are confidential and will not be released. Our response will be limited to whether or not there are children enrolled at our facility with an immunization exemption on file.

Child's Name _____ Date _____

Parents: Please sign where applicable and return to the preschool office. Thank you!

Handbook: I have read, understand and will follow the guidelines presented in the Little Lambs Preschool Parent Handbook. Please download a copy at littlelambskc.com.

Parent Signature: _____

Tuition/Late Fees: I understand that monthly tuition payments are due by the 1st school day of the specified month. A $10.00 late fee will be applied if payment is not received by the 10th school day of the month. If tuition is not paid by the 15th of the month, your child will not be able to return to school until paid in full.

Parent Signature: _____

Late Pick up Policy: If a child is picked up more than 5 minutes late, the teacher will bring that child to after school care and parent will be contacted. Any time your child needs to attend after school care, the drop in rate will be assessed. If a child is picked up late from after school care (5:00), you will be charged a $10 late pick up fee and $1/minute will be applied to your account. After three late pick ups your child may no longer attend aftercare programming at our discretion.

Parent Signature: _____

Lunch/Snack: I understand that Little Lambs Preschool cannot refrigerate or heat any food items for lunch or snack. A cold lunch must be provided every day that your child attends extended day classes. Please also include a bib (if applicable), eating utensils, etc... in your child's lunch box if they are needed. Also include a COLD PACK to keep their lunch cold. **We will not be able to serve homemade treats/snacks at school.**

Parent Signature: _____

Photo Consent: I give consent to let my child be photographed for use by Little Lambs Preschool on the Little Lambs website and/or on the Little Lambs Facebook page or on the classroom Band App.

Parent Signature: _____

Potty Training (if applicable): When you are ready to begin potty training, you agree to see your classroom teacher or the preschool director for potty training policies.

Parent Signature _____

Update March 2022