

Dear Parent(s),

Thank you for your interest in Emmanuel Family & Child Development Center. We are eager to offer your child(ren) quality childcare services.

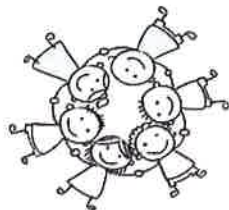
The following items are required to enroll your child:

- ☐ \$30 Registration Fee (This fee is per family and is due on or before the start date.)
- ☐ Enrollment Form
- ☐ Immunization Record
- ☐ Health Report for School-Age child
- ☐ Permission for Child to Leave Facility
- ☐ Income Eligibility Form (Please complete one per family.)
- ☐ Photography and Videotaping Release
- ☐ Childcare Payment Agreement
- ☐ Authorization for Pick-up
- ☐ Parent Consent to Evaluation
- ☐ Parent & Child's Social Security Cards
- ☐ Child's Medical Insurance Card
- ☐ Parent/Guardian Photo ID
- ☐ Foster Child Placement Papers
- ☐ Current Picture of your child

After your child has been accepted for enrollment you will receive a Parent Handbook. Please refer to the Parent Handbook for the policies and procedures of the Center.

If you are receiving state assistance from the stat for childcare services you will need to notify your case worker immediately with EFCDC DVN#, which is 001478584. The number to childcare authorization services is 1-855-373-4636. If you are paying for childcare services privately, please see the office about the fee schedule.

Once again, thank you for your interest in our Center. We hope to welcome you and your family to our Center soon!





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 YEAR'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	☐ 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	☐ 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
PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

SAVE

PRINT

RESET

IDENTIFYING INFORMATION

CHILD'S NAME

BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

- ☐ 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.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE

DATE



2416 Swope Parkway - Kansas City, MO 64130
816-921-3164 FAX 816-861-1270

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2016 through June 30, 2017

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	Yearly Income	Family Size	Yearly Income
1	\$21,978	5	\$52,614
2	\$29,637	6	\$60,273
3	\$37,296	7	\$67,951
4	\$44,955	8	\$75,647

For each additional Family Member, add +\$7,696

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,

Emmanuel Family & Child Development Center

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.



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)	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	



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Photography & Videotaping Release

From time to time Emmanuel Family & Child Development Center or its subsidiaries, or the news media may videotape or photograph your child and/or their class.

By signing my name on this document, I acknowledge and agree:

- That Emmanuel Family & Child Development Center or its subsidiaries have my permission to allow the recording of my child's likeness or photograph for future use.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to my child's participation in activities which may result in such photography or videotaping.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to the use of such photography or videotaping.
- That I and/or my child will receive no financial or in-kind compensation for the use of my child's likeness or image by Emmanuel Family & Child Development Center or its subsidiaries as well as the media.
- This authorization in no way guarantees that my child's likeness or image will be used.

If I do not wish for my child's likeness or image to be used according to such above-stated conditions, I acknowledge and agree that I will provide the Director with written notification of such intent, prior to my child's enrollment within Emmanuel Family & Child Development Center, or at a later date if need should arise.

I hereby authorize my child to participate in activities which may be videotaped or photographed, and acknowledge my understanding and agreement to the terms and conditions stated with this document.

Child's Name

Parent or Guardian Signature & Date



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Childcare Agreement For:

Child's Name and Date of Birth

Child's Name and Date of Birth

Child's Name and Date of Birth

I understand the hours of the program for which I have registered my child and agree to adhere to them promptly. I also understand that I must escort my child into the building and leave him/her in the care of a staff member. The staff will release the child only to the parents or to the persons designated that is 18 years or old.

I further agree to read the Center's guidelines when received and to adhere to those guidelines as stated. I acknowledge that I understand and have received a copy of the Center's current prices and payment policies, including but not limited to the following policies:

- A. All registration fees, activity fees, co-pays, and tuition are non-refundable in whole or in part. I have been informed that the payment is due promptly on Mondays and is late after Friday, at which time late fees may be assessed. EFCDC has the right to terminate the contract due to repeated late payments, returned checks, or in the event that the child(ren)'s behavior endangers the other children or the Provider.
- B. If I receive state childcare assistant, I know I am responsible for making sure that my case remains open during the duration of my child's attendance at the Center or I will be charged full tuition for my children. If my childcare case does close and my children have attended the center after it closes I am responsible for paying full tuition for my children.
- C. Because my child's spot is reserved, I am responsible for payment of tuition/copay even if my child is absent due to sickness, vacation, or any other reason. I understand that a collection agency will be used to collect any monies not paid on this account in the event that I withdrawal my child(ren) from the Center leaving a remaining balance.
- D. I may take up to 2 weeks (as a block of 5 consecutive days each) vacation credit (non-cumulative from year to year) without obligation for tuition if my child has been enrolled for 12 consecutive months on a continuing basis, and provided that I give the Center two weeks' notice of vacation.
- E. Late fees are charged for late payments and pickups.

The Director and staff are available for individual conferenced concerning your child's adjustment to and progress in the school program. If any special problems arise in the school affecting your child, such occurrences will be promptly brought to your attention. In the event of withdrawal from the program, 2 weeks withdrawal notice is required; your regular tuition/co-pay charges continue during this 2 week notice period. A new registration fee will be due upon re-enrollment.

The agreed upon fee for childcare is \$ _____ per week, Overtime services may be provided at the discretion of EFCDC and at the rate of \$ _____ per hour.

Parent or Guardian Signature

Date

Parent Social Security Number

EFCDC Representative

Date



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Authorization for Pick-Up

Child's Name _____

Parent's Name _____

Home #: _____

Work #: _____

Cell #: _____

Person(s) listed below are authorized by the parent/guardian to take their child(ren) from the facility.

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

EF CDC Office Staff will check each person for identification. We will not allow any child to be removed from the Center without proper authorization.



FAMILY & CHILD DEVELOPMENT CENTER

2416 Swope Parkway - Kansas City, MO 64130

816-921-3164 FAX 816-861-1270

Parent Consent to Evaluation:

The first five years are very important for your child because this time sets the stage for success in school and later on in life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please sign below indicating that you agree to have your child participate in the screening/monitoring programs used at Emmanuel Family & Child Development Center.

- The Ages & Stages Questionnaires (ASQ-3)
- The Department of Education and Second Education Core Competencies (DESE)
- The Devereux Early Childhood Assessment Development Screenings (DECA)

Parent or Guardian Signature & Date

Child's Name

Child's Date of Birth

Child's Primary Care Physician



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
PERMISSION FOR CHILD TO LEAVE FACILITY

SAVE

PRINT

RESET

NAME OF CHILD	
ACTIVITY	
LOCATION	
METHOD OF TRANSPORTATION (WALK, BUS, CAR, ETC.)	
TRANSPORTED BY (PERSON RESPONSIBLE FOR SUPERVISION)	
TIME OF LEAVING	TIME OF EXPECTED RETURN
DATE OF ACTIVITY	PERMISSION GRANTED EFFECTIVE
	FROM: TO:
SIGNATURE (PARENT(S), GUARDIAN OR DESIGNEE)	DATE

MO 580-2036 (6-14)

BCC-18



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
PERMISSION FOR CHILD TO LEAVE FACILITY

NAME OF CHILD	
ACTIVITY	
LOCATION	
METHOD OF TRANSPORTATION (WALK, BUS, CAR, ETC.)	
TRANSPORTED BY (PERSON RESPONSIBLE FOR SUPERVISION)	
TIME OF LEAVING	TIME OF EXPECTED RETURN
DATE OF ACTIVITY	PERMISSION GRANTED EFFECTIVE
	FROM: TO:
SIGNATURE (PARENT(S), GUARDIAN OR DESIGNEE)	DATE

MO 580-2036 (6-14)

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