



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 <input type="checkbox"/>	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 <input type="checkbox"/>	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)

RELATED CHILD

YES NO HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CACFP REQUIREMENT	CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME OR <input type="checkbox"/> 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			
	<input type="checkbox"/> BREAKFAST <input type="checkbox"/> MORNING SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> AFTERNOON SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK <input type="checkbox"/> NONE			
	CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY			
	<input type="checkbox"/> NEW YEAR'S DAY (JANUARY)	<input type="checkbox"/> MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	<input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY)	<input type="checkbox"/> EASTER (MARCH/APRIL)
<input type="checkbox"/> MEMORIAL DAY (MAY)	<input type="checkbox"/> INDEPENDENCE DAY (JULY)	<input type="checkbox"/> LABOR DAY (SEPTEMBER)	<input type="checkbox"/> COLUMBUS DAY (OCTOBER)	
<input type="checkbox"/> VETERANS DAY (NOVEMBER)	<input type="checkbox"/> ELECTION DAY (NOVEMBER)	<input type="checkbox"/> THANKSGIVING (NOVEMBER)	<input type="checkbox"/> CHRISTMAS DAY (DECEMBER)	
AUTHORIZATION FOR EMERGENCY MEDICAL CARE				
<p>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.</p> <p>IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE</p> <p style="text-align: center;">_____ DAY CARE PROVIDER OR HOME PROVIDER</p> <p>TO CONTACT THE FOLLOWING:</p>				
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	<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	
G	<input type="checkbox"/> DO <input type="checkbox"/> 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	



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

JOPLIN FAMILY YMCA
**FINANCIAL AGREEMENT &
AUTHORIZATION FOR
AUTOPAYMENT**

Child's Name _____ Date of Birth _____

Responsible Party's Information

Name _____
First MI Last
 Address _____
Street Apt # City State Zip
 Home Phone # _____ Cell Phone # _____ Work # _____
 Social Security # _____ Relationship to child _____ Email _____
 Preferred method of contact: Phone _____ Email _____

- Automatic bank and credit card drafts for the enrolled child's tuition are processed at 9am on Monday mornings, regardless of bank holidays, unless the Joplin Family YMCA billing office is closed.
- Weekly tuition is billed at a flat weekly rate. No other discounts will be provided based on closures or absences for holidays, illness, weather or any other unforeseeable events. I understand I will be charged the same rate every week whether the enrolled child attends the program or not.
 - I understand I am only allowed ONE excused week of absences per calendar year.
 - A written notice must be submitted to Childcare Billing Office a week prior or no later than the Friday prior to any additions/changes to the enrolled child's record/account. Add/Change Forms are available at the site or online for me to use as written notice for cancellation out of the program and for additions/changes. If I do not provide advance written notice, I will be charged the regular weekly rate.
- If the child is enrolled into the activity days or drop program, my payments are due in advance and must be received before the child attends the program. Proof of payment will be required at drop off. If payment is not made before the enrolled child attends, I will incur a \$10 late fee. If I do not make my payment in full by close of business Friday, my balance will be automatically deducted from my bank account or charged to my credit card the following Monday.
- A ONE TIME and PERMANENT switch from the weekly program to the daily drop program (and vice versa) is allowed. Written notice of the switch must be submitted by a week or Friday prior to the planned week of change.
- I am fully responsible for updating changes to my credit/debit card number, expiration and security code or my bank checking/savings information a week or the Friday prior to my next bank draft date.
- If my payment for my tuition or balance is returned or declined, I will be notified immediately and will be assessed a \$25 return-payment fee, and my payment will be due immediately.
- If I do not make my payment in full by close of business Friday, the enrolled child will not be allowed to attend the program until payment is made.
- If I receive assistance through a third party agency, I am fully responsible for the remaining balance the third party does not pay.
- If the enrolled child is not allowed to attend the program due to non-payment and I do not make payment, I will be referred to a third-party collection agency.

BANK DRAFT (Attach a voided check to this form)

Name on Bank Account _____
 Name of Bank _____
 Routing # _____
 Account # _____
 Checking Savings

CREDIT CARD DRAFT

Name on Card _____
 Card Type _____
 Card # _____
 Expiration Date _____
 Security Code _____

I have given authority to the above bank or credit card company to honor all preauthorized ACH drafts on my account for childcare payment and/or outstanding balance due for the current program my child is enrolled.

I understand that by signing this form I assume all financial responsibility for this child and agree to abide by all policies in the parent handbook (included with the enrollment packet).

Parent/Guardian Signature: _____ Date: _____