



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

**CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES**

FACILITY/PROVIDER NAME <b>KIRKWOOD UNITED METHODIST CHILDREN'S DAY OUT</b>	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)		

**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

**Kirkwood United Methodist Children's Day Out**

DAY CARE PROVIDER

TO CONTACT THE FOLLOWING:

**PHYSICIAN OR CLINIC**

NAME	TELEPHONE NUMBER
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**PREFERRED HOSPITAL**

NAME	TELEPHONE NUMBER
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**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 ADMITTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	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

**PERSON(S) AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY**

NAME	NAME
NAME	NAME
NAME	NAME
NAME	NAME

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PARENT/GUARDIAN SIGNATURE	DATE
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**FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE.**  
**FILING:** FILE FORM IN CHILD'S INDIVIDUAL RECORD.