Exclusive Kidz Zone

Kipp Wonder Academy

STUDENT ENROLLMENT CHECKLIST!!!

P	lease	return	the	following	items:

	_Completed Application
	_School Age Health Form (5yrs & above)
Market Address of Committee of the Commi	_Child Medical Exam Form (4yr)
	_Shot Records
	_Signed Tuition Agreement
Please kee	ProCare Auto Pay Contract

ProCare Letter

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

BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM SAVE								RESET
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Exclusive Kidz Zone Parent Contract and Policy

Parent Responsibilities:

- Parent/Guardian is responsible for paying Zone fees as stated on fee contract.
- If a child misses a day the full weekly fee is still due.
- Parent/Guardian must see that their child attends day care Monday Friday.
- Anyone other than parent/guardian dropping off or picking up children must be
 18 years or older and is listed on the drop off or pick up form.
- Additional fees will be charged for children left at the Zone past 7pm.
- Parent/Guardian understand that child(ren) will be required to stay home. Or be picked up from the zone if he/she has a fever, contagious illness; or diarrhea. Child cannot come back for at least 24 hours if they had a fever or diarrhea. If child has a contagious illness, they need a doctor's statement in order to return.
- If the person picking up the child is unfamiliar to the staff, the parent/guardian must call the Zone before the child is picked up. Parent/guardian should inform the person that they will need to show identification when they pick up the child and sign a release.
- Parents must fill out, sign, and date the necessary forms when enrolling their child.
- Parent must inform the zone, address change, phone number changes, and emergency contact changes.
- Parent agrees to notify the zone at least five days before child is withdrawn.
- Parent gives permission for child to take part in promotional campaigns that my involve picture taking or videotaping.
- When Kipp Wisdom Academy is closed, Exclusive Kidz Zone is closed.

Zone Responsibilities:

- 1. The day care center provides childcare services five days a week with the exception of listed **holidays** listed in the Parent Handbook.
- 2. The Zone is open from 6:00am to 8:00am & 4:00pm to 7:00pm (Mon Thurs) & 1:30pm to 7:00pm (Friday Only).
- 3. The Zone will provide:
 - a. Developmentally appropriate activities and experience based on State License Regulations and our curriculum.
 - b. Emergency accident care while child is in the care of the day care staff
 - c. A healthy atmosphere
 - d. Breakfast, Afternoon Snack & Dinner
- 4. To provide a copy of Licensing Rules for Child Day Care Centers in MO, to provide staff trained in childcare.
- 5. To screen staff for child abuse and neglect and criminal record, accessible to parents upon request.
- 6. Continue to communicate with family regarding child's development by way of phone calls, conferences, email, daily reports, progress reports...etc.

I AGREE TO ENTER INTO THIS CONTRACT WITH DIAVE' DAYE CARE CENTER.
MY FAILURE TO ABIDE BY THE TERMS OF THIS AGREEMENT WILL RESULT IN
THE TERMINATION OF THE CHILD CARE SERVICES I RECEIVE.

I HAVE READ AND FULLY UNDERSTAND ALL THE TERMS OF THIS CONTRACT.

(PARENT/LEGAL GUARDIAN SIGNATURE)	(DATE)
1 1 (hra	
(Teneshe H. Dady	
(DAY CARE RESPRESENTATIVE SIGNATURE)	(DATE)

Exclusive Kidz Zone HEALTH CARE POLICIES

The State of Missouri requires (9CSR 30-62.192) your child MUST have a health exam yearly and immunizations must be kept up to date.

If your child shows signs of general discomfort or seems unwell, the temperature will be taken.

There will be **NO EXCLUSION** for children who exhibit the following symptoms. They will be sent home without exception.

- Fever over one hundred degrees (100 F) by mouth or ninety degrees (99) under the arm.
- 2. Diarrhea more than one (1) abnormally loose stool
- 3. Sever coughing high pitched croupy sound, whooping sounds
- 4. Yellowish skin or eyes
- 5. Pinkeye tears, redness of eyelid lining, swelling, drainage, pus
- 6. An infected skin patch(es) crusty, bright yellow, dry or gummy areas of the skin
- 7. Vomiting more than once
- 8. Headache or stiff neck
- 9. Severe itching of body or scalp
- 10. Any type communicable disease

The child must be picked up immediately once notified.

The ill child will be kept isolated from the other children until the parent(s) arrives. Be assured that our staff will be attentive to him/her.

When a child goes home with a communicable disease such as: pink eye, lice, rashes, colds with discolored mucus, yellow discoloration in eyes or skin, impetigo, and ringworm, he/she must have a doctor's statement to return.

Parent's Signature	Date
Child's Name	

Exclusive Kidz Zone AUTHORIZATION SLIP

In order to ensure the safety and well-being of your child we are asking you to initial all items in which you give your permission. I understand that there will be times when the day care may have to take immediate action for the safety of my child(ren): I therefore grant permission to Exclusive Kidz Love to seek immediate medical attention from the nearest healthcare professional or emergent care facility. I therefore grant permission to said medical professionals to administer any necessary shots (anti-toxin, etc.) or other life stabilizing procedures or surgeries to be administered. I understand that part of the program of the day care is carried out through field trips, neighborhood walks, and any other field trips outside the daycare facility will require additional fieldtrip form. It is very important that the form below is filled out so that we may release your child (ren) to the correct person. All the people listed below will need picture identification on file. Your child will only be released to persons with proper identification and a picture ID on file. The person taking your child home must be at least 18 years of age. If the person is not known by the day care staff they will need to provide identification. It is important to notify the day care of any changes in your authorization. Only the following people are authorized to pick up my child from the center. I will call the zone the day of change if someone different than the individuals listed below will be picking up my child(ren). **Phone Number** Authorized to take my child home Relationship 1. _____ Parent/Legal Guardian's Signature:

Date: _____

EXCLUSIVE KIDZ ZONE

Brightwheel Program Acknowledgement

To our parents,

We have implemented a new program to keep our communication on track. We like to keep you informed in an accurate and timely manner. To do so our staff has been trained on an app called brightwheel to ensure that all teachers are communicating directly with their student's parents on issues, incidents, progress, behavior and all your child's needs.

Parent Statement:		
l acknowledge and accept Brightwheel as my	form of communication co	ncerning my child
My email address is		•
Parent or Guardian Signature:		
Thank you,		
Ms. Tamiko Blount		
Director		

****Partnership with Diave' Daye Child Development Center*****

Child and Adult Care Food Program Parent Letter – Non-Pricing Child Care Centers July 1, 2019 through June 30, 2020

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 Size	Yearly Income	Family Size	Yearly Income
1	\$23,107	5	\$55,815
2	\$31,284	6	\$63,992
3	\$39,461	7	\$72,169
4	\$47,638	8	\$80,346
	For each	additional Family Member, add	+\$8,177

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,

Center Owner/Director

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:



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

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 is officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and rederal laws. SIGNATURE OF ADULT FAMILY MEMBER SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) 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 in least four digits of a social security number of the adult household member signing the application or indicate that the household member signing the allowers of the last four digits of a social security number. Provision of the last four digits of a social security number. Provision of 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 identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be contributed in the application of the provided of the application of the application of the provided o										
Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (Formetry APDC, now funded by TATN), complete Parts 1.3, and 4 only. Complete P. 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 PART 2: HOUSEHOLD AND INCOME INFORMATION			and the second s		ren), please	fill out this for	m and retur	n it to the c	hild care o	enter.
formerly Food Stamp) or Temporary Assistance sos an unable for all of the children for the Part 1, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance ose number for all of the children is the Internation Assistance ose number for all of the children is the Internation Assistance ose number for all of the children is the Internation Assistance ose number for all of the children is the Internation Assistance ose number for all of the children is the Internation Assistance ose number for all of the Children is the Internation Assistance ose number for the Nousehold not including the children listed in Part 1. Indicate source and amount of current monthly gross income in the Internation of the Nousehold before deductions, such as taxes and social security. Where there are wage earners and self-employed in income of the Nousehold before deductions, such as taxes and social security. Where there are wage earners and self-employed in income of the Nousehold before deductions, such as taxes and social security. Where there are wage earners and self-employed in income of the wage earner cannot be offset by the business isoses of the self-employed duti. It islat month's income may be self-employed on the proposed self-employed duti. It islat month's income may be self-employed on the proposed self-employed duti. It islat month's income may be self-employed on the proposed self-employed duti. It islat month's income may be self-employed duti. It islat month's income may be self-employed duti. It islat month's income may be self-employed duti. It is all months income of the self-employed duti. It islat month's income may be self-employed duti. It islat month's income information. **NOOME BASED ON (CHECK ONE)** **HOUSEHOLD MEMBERS** **GROSS WAGES** **WEERLY** **PART 3: RACIAL ETHNIC INFORMATION (You are not required to senswer this section)* **										
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HOUSEHOLD MEMBERS GROSS WAGES WELFARE, CHILD SUPPORT, ALIMONY RETREMENT, 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) NOR ALSKA NATIVE PART 4: SIGNATURE I hereby certify that all information provided is correct. Lunderstand that this information is being given in connection with the receipt of federal funds, that is 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) XXX-XX- 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 in last four digits of a social security number. Provision of the last four digits of a social security number. Provision of the last four digits of a social security number is not made that the signer has none, the application cannot be approved. The social security number returned in the social security number and investigations, and may include contacting and increasing and investigations, and may include contacting and entermine income, contacting a SNAP or Temporary Assistance benefits, contracting the stream of the application. These verification efforts may be characteristication for receipt of SNAP or Temporary Assistance benefits, contacting the stream on the application. These verification efforts may be contracted in the stream of the scale security number may be contracted in the stream of the scale security number may be contracted in the stream of the scale security number in complete the advantage of the scale security of the sc	the income of the wage reflect your circumstand over the prior 12 month	eamer cannot be off ces, you may provide s. Foster children m	fset by the busing e a projection of ay be eligible req	ess losses f your curre gardless of	of the self-e ent annual in household	mployed adul ncome. Irregi income. Conf	t. If last mo ular self-em act the cen	onth's incomployed inco ter for more	ne does no ome may b informatio	ot accurately be averaged on.
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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION FOR CHILD CARE REGULATION

SAVE PRINT

RESET

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

CHILD'S NAME	BIRTHDATE
HEALTH STATEMENT (CHECK ONE)	
(ONEOR ONE)	
П	
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 spec	cial health or medical requirements as listed helow
SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL I	REQUIREMENTS
PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDI SPECIAL NEEDS, ETC.	NG CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS,
	*
PARENT OR LEGAL GUARDIAN SIGNATURE	
TAILERY OR LEGAL GOARDIAN SIGNATURE	DATE
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4O 580-2851 (6-14) TO BE FILED IN CI	HILD'S RECORD AT CHILD CARE FACILITY.



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

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

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IDENTIFYING INFORMATION			
CHILD'S NAME	BIRTHDATE		
CURRENT STATE OF HEALTH			
Based on my assessment of this child's medical history, current stathis child can participate in a child care program. This child has no	ate of health and my physical examination of the child on/, special care needs unless specified below.		
(Date of medical examination	on must be within the last 12 months.)		
PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE			
Complete this section only if child requires special care at a diabetes, asthma, behavior problems, hearing or visual impairments	child care facility, e.g. special diets, allergies, ear infections, convulsions, ent, etc. (Attach additional pages as needed.)		
-			
SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVIS	SION 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		

Exclusive Kidz Zone Tuition Agreement

☐ Verified for payment to Exclusive Kidz Zone for childcare services through the Family Support Division of the State of Missouri.
Beginning: Ending:
The tuition for your child will be \$ per week plus the payment from the Family Support Division of the State of Missouri.
Parent is to assure that child will be in the care of Exclusive Kidz Zone 90% of the time. Failure to comply with the 90% or perfect attendance monthly may result in one or more of the following:
 90 day probation Assessment of the fees Removal from the program
Initials required.
Fee Schedule:
 Before / Aftercare = \$65.00 weekly Before & Aftercare =\$80.00 Weekly Before or Aftercare & Friday - \$75.00 Weekly
Tuition verified payment for this child is \$
Tuition registration \$
Amount due before child's first day \$ (registration & first week's tuition)
I have read and understand that all fees are due prior to my child's enrollment. My child's tuition Is to be paid a week or 2 weeks ahead based on the payment arrangement I choose. I understand that late fees will be accessed, and I agree to pay:
\$ weekly
\$ bi-weekly
Parent/Guardian Signature Date: Director's Signature



Dear parent/guardian, Exclusive Kidz Zone +

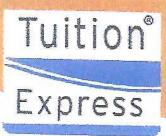
Diave' Daye Child Development Center is pleased to offer MyProcare, a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.

Log in today!

- 1. Go to MyProcare.com.
- 2. Enter your email address (the email you have on file with Diave' Daye Child Development Center) and choose **Go**.
- 3. Enter the confirmation code sent to your email, choose a password, and press Go.
- 4. Then you may:
 - a. View your child's schedule, time card, immunizations and more.
 - b. Use the Pay button to make a payment with your card.

Thank you!

Diave' Daye Child Development Center and MyProcare



Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

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