Child Development Center

Diave' Daye Child Development Center

Enrollment Packet Checklist

Please Provide the following items to enroll your child in the Day Care Program

Child's Name: _____ **Age:** _____ **DOB:** _____

Parent's Name: _____ **Phone#:** _____

Additional Required Information

- Physical exam form, and Immunization record to be completed by Doctor (PPD/w results and HGB)
- Picture ID for Parent or Guardian and Pick-Up Contacts
- Parents Work Schedule
- Letter to verify that a family is eligible for childcare payment assistance

Diave' Daye Child Development Center – 2813 Lafayette St.
St. Louis, MO 63104 – Phone #314-773-6300
Fax #314-833-3175 - Email Address – weareone@diavedaye.com

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	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE ☐	
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
FATHER'S/GUARDIAN'S NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF THE SAME AS ABOVE ☐	
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL	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 NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
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 ☐ Part Time		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY?	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY?	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	

Diave' Daye CDC
Phone/Fax# 314-773-6300

Day Care Application

Date Received: _____ **Classroom Assignment:** _____

CHILD(REN) LIVE WITH? (Legal Guardian) _____

NUMBER OF PEOPLE IN HOUSEHOLD: _____

LIST ALL OF OTHER MEMBERS OF YOUR HOUSEHOLD:

NAME	RELATIONSHIP	AGE	GRADE	CONTACT#
1.				
2.				
3.				
4.				
5.				

CHILD WILL BE BROUGHT BY: _____ AT _____A.M./P.M.
CHILD WIL BE PICKED UP BY: _____ AT _____A.M./P.M.

I VERIFY THAT ALL INFORMATION PROVIDED ON THIS APPLICATION IS TRUE:

SIGNATURE: _____
RELATIONSHIP: _____

Diave' Daye CDC
2813 Lafayette Street
St. Louis, MO 63104
Phone #314-773-6300
Email: weareone@diavedaye.com

Diave' Daye CDC
My Child's History

CHILD'S NAME: _____ **SEX:** _____ **AGE:** _____
BIRTHDATE: _____ **PHONE NUMBER:** _____
ADDRESS: _____
MOTHER / FATHER / LEGAL GUARDIAN: _____
PHONE NUMBER'S: _____

HEALTH INFORMATION
MEDICATIONS: _____
ALLERGIES: _____
ANY RESTRICITIONS: _____
IF YES, PLEASE STATE: _____

EATING HABITS
WHAT ARE YOUR CHILDS DISLIKES IN FOOD? _____
_____

ANY FOOD RESTRICTIONS? _____
_____

SLEEPING HABITS
WHAT TIME DOES YOUR CHILD GO TO BED AT NIGHT? _____
DOES YOUR CHILD NORMALLY NAP DURING THE DAY? _____
ANY OTHER INFORMATION ABOUT YOUR CHILDS SLEEPING HABITS? _____
_____

TOILET HABITS
DOES YOUR CHILD ASK TO GO TO THE BATHROOM? _____
DOES YOUR CHILD HAVE ACCIDENTS? _____
ANY OTHER HELPFUL INFORMATION ABOUT YOUR CHILDS TOLIET HABITS? _____
_____

GENERAL INFORMATION
NICKNAME: _____
WHO HAS BEEN TAKING CARE OF YOUR CHILD? _____
HAS YOUR CHILD HAD PRIOR DAY CARE EXPERIENCE? _____
HOW DOES YOUR CHILD REACT TO SEPERATION FROM PARENTS? _____
_____
IS YOUR CHILD BY NATURE??
FRIENDLY _____ AGGRESSIVE ____ SHY _____ WITHDRAWN _____

DOES YOUR CHILD HAVE SIBLINGS? ___ YES: ___ NO, IF SO, HOW DO THEY RELATE?
WHAT MAKES YOUR CHILD ANGRY OR UPSET? _____

_____

_____

HOW DOES YOUR CHILD SHOW THEIR FEELINGS? _____

_____

_____

_____

WHAT ARE YOUR CHILDS FAVORITE TOYS AND ACTIVITIES AT HOME? _____

_____

IN WHAT WAY CAN WE HELP WITH YOUR CHILD'S DEVELOPMENT? _____

_____

WHAT DO YOU FIND IS THE BEST WAY TO HANDLE DISCIPLINE? _____

_____

HOW DO YOU REWARD OR REASSURE YOUR CHILD? _____

_____

PARENT / LEGAL GUARDIAN'S

SIGNATURE: _____ DATE: _____

For Office Use Only:

Received on _____

Class Attending _____

Teacher Received: _____

Diave' Daye CDC
2813 Lafayette Street
St. Louis, MO 63104
Phone #314-773-6300
Email: weareone@diavedaye.com

Diave' Daye CDC
Parent Contract and Policy

Parent Responsibilities:

- Parent/Guardian is responsible for paying daycare fees as stated on fee contract.
- If a child misses a day the full weekly fee is still due (See Parent Handbook)
- Parent/Guardian must see that their child attends day care Monday – Friday, arriving no later than 9:30am. When and if an emergency prohibits a family from arriving before 9:30am, the family must contact the day care. Failure to do so will jeopardize childcare services for that day.
- 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 center past 7pm, please refer to page 15 of your Parent Handbook.
- Parent/Guardian, we understand that child(ren) will be required to stay home or be picked up from the center if he/she has a fever, contagious illness, or diarrhea. Children cannot come back to school for at least 24 hours if they had a fever or diarrhea. If child has a contagious illness, they need a doctor's statement to return to the center.
- If the person picking up the child is unfamiliar to the day care staff, the parent/guardian must call the center 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 form.
- Parents must fill out, sign, and date the necessary forms when enrolling their child.
- Parent must arrange for their child's yearly physical exam.
- Parent is urged to attend Parent Meetings, individual conferences and keep appointments with the day care staff.
- Parent must inform the center of changes in employment, salary status (if you are on the sliding scale), address change, phone number changes, and emergency contact changes.
- Parent agrees to notify the day care center at least five days before child is withdrawn.
- Parent must give permission for child to take part in promotional campaigns that may involve picture taking or videotaping.

Day Care Responsibilities:

1. The day care center provides childcare services five days a week except for listed holidays (listed in the Parent Handbook).
2. The daycare is open from 6:00am to 12:00am.
3. The daycare center will provide:
    a. Developmentally appropriate activities and experience based on State License Regulations and our curriculum.
    b. Planned field trips
    c. Emergency accident care while child is in the care of the day care staff
    d. A healthy atmosphere
    e. Breakfast, lunch, dinner and two snacks for AM and PM
    f. A nap or rest time after lunch
4. Every three to six months a scheduled individual parent/teacher conference about the child's progress in the day care center. This conference may take place more often if the parent or day care staff feels it is needed.
5. To provide a copy of Licensing Rules for Child Day Care Centers in MO, to provide staff trained in childcare.
6. To screen staff for child abuse and neglect and criminal record, accessible to parents upon request.
7. 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)

_____ _____

(DAY CARE RESPRESENTATIVE SIGNATURE) (DATE)

DIAVE' DAYE CDC
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.

1. 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, green mucus from nose or mouth
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. This infant must be out of contact with the other infants (from the Daycare) for a complete twenty-four (24) hour period (ex. 9am until 9am).

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 until the parent arrives.

When a child goes home with a communicable disease such as: pink eye, head 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

DIAVE' DAYE CDC AUTHORIZATION SLIP

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 for Diave' Daye or EKZ , 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 especially 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 center the day of change if someone different than the individuals listed below will be picking up my child(ren).

Authorized to take my child home	**Relationship**	**Phone Number**
1.		
2.		
3.		
4.		

Parent/Legal Guardian's Signature: _____

Date: _____

Child Development Center

Infant Safe Sleep Policy

Diave Daye will follow all mandated laws pertaining to infant **Safe Sleep procedures**. All infants under the age of 12 months will be laid on their back for naps. No blankets will be in the bed and nothing over or on the sides of the bed with the child during this time. We are actively doing all we can to prevent **SIDS** in our care. All Staff members will take the mandatory infant safe sleep class Within the first 30 days of hire and every 3 years at a department-approved training regarding the **American Academy of Pediatrics (AAP)** safe sleep recommendations contained in the American Academy of Pediatrics Task Force on Sudden infant Death Syndrome. All members of Staff will have class attended documentation on file in the centers filing system. Copies of policies and procedures will be handed out to the parents after every class or changes made by the state. A copy of documents will be available upon parent's request,

Sudden infant death syndrome **(SIDS)** is the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation has been conducted. Including a complete autopsy, an examination of the death scene, and a review of the clinical history.

Sudden unexpected infant death **(SUIDS)** is the sudden and unexpected death of an infant less than one year in age which the manner and cause of death are not immediately obvious prior to investigation. Causes of sudden unexpected infant death include but are not limited to, metabolic disorders, hypothermia or hyperthermia, neglect, or homicide, poisoning and accidental suffocation..

Missouri Law (210.223.12 RSMo,) requires all licensed child care facilities that provides care for children less than one year of age to implement and maintain written safe sleep policy in accordance with the most recent safe sleep recommendations of the **American Academy of Pediatrics (AAP**). Missouri childcare licensing rules require licensed childcare facilities to provide parent(s) and/ or guardian(s) who have infants in care be provided a copy of the facility's safe sleep policy.

Safe Sleep Practices

All infants under the age of one year will be placed on their back for sleep times. Children will have their own bed or cot for sleeping or napping. All cribs have met the Consumer Product Safety Commission standards and guidelines. Firm mattresses with tight fitted sheets are always to be used and the mattress pads are to be tight and fitted to the sides of the crib. If the child wets the bed during sleep, the bedding must be removed along with the mattress and will be cleaned and sanitized immediately. No covers will be in the crib with them during nap or sleep time. The room will be at a comfortable temperature between 68 degrees and 85 degrees. There will be no loose bedding, clothes, pillows, bumpers pads or any other risk causing materials in the crib. Nothing in the crib to block sight of the infant. Securely fitted clothing such as sleepers, and properly fitted clothes. Pacifiers without a string or anything attaching it to the clothes, will be allowed. Bunkbeds, highchairs, strollers, car seats, swings, bouncers or any other sitting equipment shall be used for sleeping or napping at any time. Supervision of infants will include: staff will be positioned in middle of room, sight and sound of all infants. The lighting will include both natural light and lamp during nap time. The staff will conduct physical checks every 15 to 20 minutes during nap. Physical checks will consist of looking, touching, and listening to infants breathing and repositioning if needed to ensure they are not overheated or in distress. Infant's head will remain uncovered during nap/ sleep times. Any equipment which interferes with the caregiver's ability to see or hear the child who may be distressed will not be used.

No persons shall smoke or otherwise use tobacco products in any area of the childcare facility during the period when children cared for under the license are present.

A doctor's notification will be the only legal exception to the back rule. It must be written by a doctor with alternative sleep positions or special sleeping arrangements noted. The facility must have the doctor's statement on file, and it must be signed by the doctor.

Diave' Daye will continue to work to maintain and train all employees of and all new child safe laws and procedures. We will continue to work with the state licensing department to follow all rules and obtain any learning opportunities. Your children safety is our top priority.

I have read the Infant Safe Sleep Policy; I understand the Missouri Law and the efforts of Diave' Daye to follow the law and any new procedures for child health and safety.

By signing I understand the Infant Safe Sleep Policy that has been stated by Diave' Daye Child Development Center.

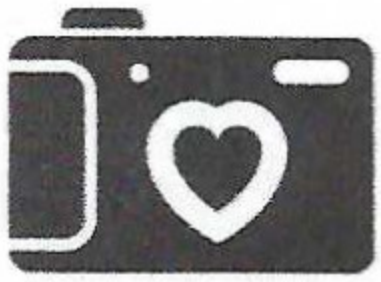
I will inform the Administrator of Diave' Daye of any health issues or concerns pertaining to my child (s).

Parents Name _____

Parents Signature_____

Date Signed _____

Diave' Daye Management Signature_____



Permission to Photograph

I, _____ give permission for Diave' Daye CDC to photograph my child _____for the following purposes:

Type of Use:	Please Circle One Grant Permission	Decline Permission
Still Photographs:	YES	NO
Display in facility and on Bulletin Boards	YES	NO
Social Media	YES	NO
Website	YES	NO
Center Scrapbook	YES	NO
Other:	YES	NO
Videos:		
YouTube Video for Promotional purposes	YES	NO
Center Gatherings	YES	NO
Other:		

Only first names and possibly last initials (In the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form if I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Parent Signature: _____

Date _____

Child Development Center

Brightwheel Program Acknowledgement

To Our Parents,

We would like to keep you informed in an accurate and timely manner; therefore, we have implemented a new program to keep our communication with parents on track. Our staff has been trained to use **Brightwheel. Brightwheel** is an app that ensures all teachers are communicating directly with parents on their child's daily activities; including accidents, incidents, progress, behavior, or any issues that surrounds the care of your child's needs.

Parent Statement:

I acknowledge and accept **Brightwheel** as my form communication concerning my child.

My email address is_____

Parent or Guardian Signature _____

Thank You

Tenesha Bady
CEO

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2020 through June 30, 2021

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	$23,606	5	$56,758
2	$31,894	6	$65,046
3	$40,182	7	$73,334
4	$48,470	8	$81,622

For each additional family member, add $8,288

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

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) XXX-XX-	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

MO 580-1314 (2-11) CACFP-205

This institution is an equal opportunity provider.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION AND CHILDE AND ADULT CARE FOOD PROGRAM

INFANT AND TODDLER FEEDING AND CARE PLAN

THIS SECTION TO BE COMPLETED BY CHILD CARE FACILITY:

The formula provided by this child care facility is: _____.
(Check a box) ☐ **Yes** ☐ **No** This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

Instructions to Parents - Please complete for child who is less than 24 months of age. *Update information as needed. Use a new for or initial/date changes on this form.*

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

FEEDING INFORMATION

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply: ☐ Parent ☐ Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

☐ Yes Explain: _____
☐ No

Does your child use a pacifier? ☐ Yes ☐ No
Note: Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

INFANT FEEDING PREFERENCE (under 12 months)

Mark your preference (check all that apply).

☐ I will provide breast milk for my infant.

☐ I will nurse my infant at the center at these times: _____

The facility's formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

If breast milk is unavailable for a feeding, the facility should: _____

☐ I request that the formula provided by the child care facility be served to my infant

☐ I will provide infant formula for my infant. Name of formula: _____

☐ I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**

☐ I will provide solid foods for my infant.

TODDLER FEEDING PREFERENCE (12 through 23 months)

Check all that apply: ☐ Spoon ☐ Cup ☐ Feeds Self ☐ Feeding Table or Chair

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breast Milk			
Milk			
Table Food			

ARRANGEMENTS FOR SLEEP – Licensing rules require that infants be placed on their back to sleep.

TIME(S) CHILD USUALLY NAPS	LENGTH OF NAP

Additional Instructions Related to Sleeping:

Note: When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) must put the infant to sleep in accordance with such written instructions.

☐ My child is 12 months or older, and I give my permission for my child to sleep on a cot.

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE

DIAPERING INSTRUCTIONS

LIST ANY LOTIONS AND/OR OINTMENTS, ETC. THAT YOU HAVE PROVIDED AND GIVE PERMISSION FOR CAREGIVERS TO USE ON YOUR CHILD

FOR ☐ WET ☐ BOWEL MOVEMENT ☐ RASH ☐ OTHER

☐ I do not want caregivers to use any lotions, powders, ointments or similar items on my child.

I WILL FURNISH THE FOLLOWING BABY SUPPLIES FOR MY CHILD; CLEARLY LABELED WITH MY CHILD'S NAME

SPECIAL INSTRUCTIONS FOR CARE (E.G., RESTRICTIONS, ALLERGIES, ETC.):

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE

SAVE
PRINT
RESET

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

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

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

Diave' Daye CDC
Tuition Agreement

☐ **Verified for payment to Diave' Daye CDC 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 the child(ren) will be in the care of Diave' Daye CDC 100% of the time. Failure to comply with the 90% or perfect attendance monthly may result in one or more of the following:

1. **90-day probation**
2. **Assessment of the fees**
3. **Removal from the program**

_____ Initials required.

Fee Schedule:

- **Infants 6 weeks – 22 months Old = $195.00 weekly**
- **Toddlers 2 – 4 years old = $185.00 weekly**
- **School - Age 5 – 12 years = $135.00 weekly**
- **Before & After Care = $80.00 weekly**
- **Before or After Care = $65.00 weekly**

Tuition verified payment for this child is $_____

Tuition registration $_____ Uniform $_____ Activity fee $_____
Other _____ $_____

Amount due on or 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 agree to pay: $ _____ weekly $ _____ bi-weekly

_____ _____
Parent/Guardian Signature **Date:**

_____
Director's Signature

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

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) XXX-XX-	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

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2023 through June 30, 2024

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	$26,973	5	$65,009
2	$36,482	6	$74,518
3	$45,991	7	$84,027
4	$55,500	8	$93,536

For each additional family member, add $9,509

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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should

Diave' Daye Child Development Center
Tuition Agreement

Verified for payment to Diave' Daye CDC for childcare serviced through the family support division of the State of Missouri.

Beginning __/__/__ Ending __/__/__

Co-payment for your child will be $____ per week PLUS the payment from the Family Support Division of the State of Missouri.

- **Parents are to assure that their child(ren) will be in the care of Diave' Daye CDC 90% of the time. Failure to comply with 90% or perfect attendance monthly may result in one or more of the following:**

*** 90 Day Probation *Assessment of the fees *Removal from the childcare program**

____ Initial Here

Fee Schedule

Infants (6 weeks- 22 months) = $205

Toddlers (2-4 years) = $195 per week

School-Age (5-12 years) = $155 per week

Before Care *or* After care = $65

Before Care *and* After care = $80

I agree to pay weekly $_____ or Bi-weekly $_____

Tuition verified payment for this child $_____

Registration/Application fee $25

Activity fee $30 (covers Aug. – May)

Amount due first day $_____

Parent / Guardian Signature _____ Date: _____
Director's Signature _____ Date: _____

Effective 08/2023