"Home of
The Bulldogs"

Appleton City R-2 School District
408 West 4th Street
Appleton City, MO 64724
Phone: (660) 476-2161
Fax: (660) 476-5564

High School
(660) 476-2118
Elementary
(660 476-2108

Dear parent;

Thank you for considering early education for your child. We believe early education is critical in the successful growth of a child. To ensure your child is eligible for preschool, a series of paperwork is required. If at any time you have difficulty understanding or completing any of the forms please contact us. We are happy to help.

The Department of Health and Senior Services Section for Child Care Regulation is the governing body that oversees preschool licensure. They require the following documentation:

Required for every child

1. Enrollment Form – MO 580-2994 (11-15)
2. Child Medical Examination Report – MO 580-1878 (9-07)
3. Immunization Record (see sample)
4. Birth Certificate
5. Social Security Card

Required if applicable

1. Individual Plan for Specialized Care - MO 680-2910 (4-08)
2. Medication Authorization – MO 580-1875 (12-06)
3. Permission to leave facility - MO 580-2036 (11-07)
4. Application For Free School Meals

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 YEARS'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	I ☐ 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	I ☐ 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

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

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION 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

MISSOURI
IMMUNIZATION RECORD

OFFICIAL DOCUMENT

Retain this document as proof of immunizations. According to Missouri law, your child must meet the State of Missouri immunization requirements to be enrolled in school or child care.

NAME OF CHILD		
DATE OF BIRTH	DCN (DEPARTMENT CLIENT NUMBER)	
NAME OF PARENTS OR LEGAL GUARDIAN		
ADDRESS		
CITY	STATE	ZIP

ALWAYS KEEP A RECORD

The immunization record plays a vital role in protecting the health of the individual throughout life, for health care providers, school, child care and employers.

Missouri Department of Health and Senior Services • P.O. Box 570
Jefferson City, MO 65102-0570

ALLERGIES / COMMENTS / VACCINE REACTIONS

VACCINE	DATE GIVEN MO / DAY / YR	PHYSICIAN / CLINIC
PNEUMOCOCCAL POLYSACCHARIDE (23 valent)		
INFLUENZA (annual) List mo / day / yr of each vaccine		

TUBERCULIN SKIN TEST

DATE GIVEN MO / DAY / YR	DATE READ MO / DAY / YR	PHYSICIAN / NURSE SIGNATURE	RESULTS
			mm
			mm
			mm

LEAD SCREENING

LEVEL	DATE	LEVEL	DATE	LEVEL	DATE

VACCINE		DATE GIVEN MO / DAY / YR	PHYSICIAN / CLINIC
DTaP, DTP, or DT Diphtheria, Tetanus, Pertussis (Whooping Cough) specify if DT	1		
	2		
	3		
	4		
	5		
POLIO Specify IPV or OPV	1		
	2		
	3		
	4		
	5		
HAEMOPHILUS INFLUENZAE type b (Hib)	1		
	2		
	3		
	4		
HBIG			
HEPATITIS B circle type	1	adult/ped	
	2	adult/ped	
	3	adult/ped	
PNEUMOCOCCAL CONJUGATE	1		
	2		
	3		
	4		
MMR (Measles, Mumps, Rubella)	1		
	2		
VARICELLA (Chickenpox)	1		
	2		
HEPATITIS A	2		
	3		
Tdap/Td Tetanus, Pertussis, Diphtheria Adult (every 10 yrs)		Tdap/Td	
		Tdap/Td	
		Tdap/Td	
		Tdap/Td	
Meningococcal			
Rotavirus	1		
	2		
	3		
HPV (Human Papillomavirus)	1		
	2		
	3		
OTHER			

Missouri Department of Health and Senior Services
Section for Child Care Regulation

INDIVIDUAL PLAN FOR SPECIALIZED CARE

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE	DATE
X	

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

MEDICATION AUTHORIZATION

MEDICATION REQUIREMENT

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

(PROPER NAME OF MEDICATION)

CHILD'S FULL NAME	DATE MEDICATION TAKEN FROM	UNTIL

DOSAGE	TIME(S) OF DAY

POSSIBLE SIDE EFFECTS

SIGNATURE OF PARENT(S) OR GUARDIAN	DATE

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

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 (11-07) 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 (11-07) BCC-18