ADMISSION/REGISTRATION DATE_____

DISCHARGE DATE_____

PARENTS' DAY OUT
CHILD ENROLLMENT FORM

PLEASE COMPLETE ALL AREAS, EVEN IF NA HAS TO BE USED.

CHILD'S NAME | GENDER | BIRTHDATE

ADDRESS (STREET, CITY, STATE, ZIP)

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME | HOME PHONE

ADDRESS (STREET, CITY, STATE, ZIP) OR CHECK IF SAME AS ABOVE___ | CELL PHONE

E-MAIL

EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE

EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP) | WORK PHONE

FATHER'S/GUARDIAN'S NAME | HOME PHONE

ADDRESS (STREET, CITY, STATE, ZIP) OR CHECK IF SAME AS ABOVE___ | CELL PHONE

E-MAIL

EMPLOYER OR SCHOOL ATTEND | WORK/SCHOOL SCHEDULE

EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP) | WORK PHONE

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY

(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME | RELATIONSHIP TO CHILD | PHONE NUMBERS (HOME, CELL, WORK)

ADDRESS (STREET, CITY, STATE, ZIP)

NAME | RELATIONSHIP TO CHILD | PHONE NUMBERS (HOME, CELL, WORK)

ADDRESS (STREET, CITY, STATE, ZIP)

COMMENTS ON CHILD'S DEVELOPMENT

(NOTE CHILD'S PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, AND INDIVIDUAL NEEDS)

CHILD'S NAME

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

PARENTS' DAY OUT @ PLATTE WOODS UNITED METHODIST CHURCH

PROVIDER/LICENSEE

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME PHONE

PREFERRED HOSPITAL

NAME PHONE

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 OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THAT THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	**PARENT/GUARDIAN INTIALS**
C.	I HAVE BEEN N9TIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THEREAFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILTIY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	**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.	**PARENT/GUARDIAN INITIALS**
F.	_____ I DO GIVE PERMISSION FOR FIELD TRIP EXCURSIONS. _____ I DO NOT GIVE PERMISSION FOR FIELD TRIP EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN FIELD TRIPS ARE PLANNED.	**PARENT/GUARDIAN INITIALS**
G.	_____ I DO GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD. _____ I DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	**PARENT/GUARDIAN INITIALS**

PARENT'S/GUARDIAN'S 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

IMMUNIZATION RECORD MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

CHILD'S NAME (LAST, FIRST, MI)	DATE OF BIRTH

	DATES GIVEN					
DOSE	**1**	**2**	**3**	**4**	**5**	**6**
DTaP						
DT						
Hib						
Polio						
Hepatitis B						
MMR						
Varicella						
Tdap						
Td						
Pneumococcal						
Hepatitis A						
Influenza						
Meningococcal						
Rotavirus						
HPV						
Other						

NAME OF PHYSICIAN OR RECOGNIZED HEALTH FACILITY (PLEASE PRINT OR TYPE):

MO 580-0818 (7-10) Imm.P.16

DATE	SPECIAL NOTES

IF AN ADVERSE REACTION IS OBSERVED, PLEASE REPORT TO CDC THROUGH VAERS ONLINE: https://vaers.hhs.gov

MO 580-0818 (7-10) Imm.P.16

Health Statement

To be completed by the parent(s) or guardian.

_____ _____

Name of Child Date of Birth

Height _____ Weight _____ Hair Color _____ Eye Color _____

What past illnesses has he/she had? At what age?

_____ Chicken Pox _____ Scarlet Fever _____ Malaria

_____ Mumps _____ Hepatitis A _____ AIDS

_____ Measles _____ Hepatitis B

Other (Please specify): _____

_____

Does your child have frequent colds? _____ Tonsilitis? _____

Ear aches? _____ Stomach Aches? _____

Does he/she vomit easily? _____ Does he/she run a high fever easily? _____

Has your child had any serious accidents? _____ If yes, please explain. _____

_____

Is your child allergic to anything? _____ If so, how does it manifest itself? _____

_____

Do you know what causes his/her allergy? _____

Does your child suffer from any of the following?

_____Asthma _____Hay Fever _____Hives

Is your child diabetic? _____

Has your child ever been hospitalized? _____ If so, what for? _____

PHYSICAL LIMITATIONS

_____Glasses _____Physical Aids (what kind) _____

_____Epilepsy _____Speech or Hearing Disability (specify) _____

_____

Has your child ever been tested for a learning disability or developmental delay? _____

What were the results? _____

_____

Parent's Signature_____ Date_____