

MISSOURI DEPARTMENT OF HEALTH
BUREAU OF CHILD CARE SAFETY & LICENSURE
**CHILD ENROLLMENT FORM FOR
LICENSE-EXEMPT FACILITIES**

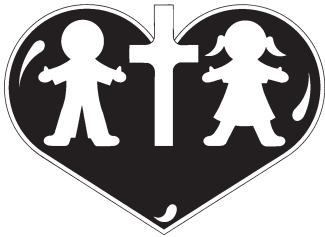
MONDAY_____

TUESDAY_____

WEDNESDAY_____

THURSDAY_____

FRIDAY_____



Peace Lutheran Church
737 Barracksview Road
St. Louis, MO 63125
(314) 892-8844

Peace Lutheran Parent's Day Out
Enrollment form

Child's name:_____ Home Telephone Number: () _____

Child's nickname (for school use, if any):_____ Birthdate:_____

Address_____ (Street, City, State, Zip Code)

Are both parent's living at home with this child?_____ If no, explain:_____

Family Email Address (optional)_____

Mother's name:_____ Home Telephone Number: () _____

Cell Phone Number: () _____

Address_____ (Street, City, State, Zip Code)

Employed by:_____ Hours of Employment: From _____ To _____

Address_____ Business Telephone Number: () _____ (Street, City, State, Zip Code)

Father's name:_____ Home Telephone Number: () _____

Cell Phone Number: () _____

Address_____ (Street, City, State, Zip Code)

Employed by:_____ Hours of Employment: From _____ To _____

Address_____ Business Telephone Number: () _____ (Street, City, State, Zip Code)

EMERGENCY CONTACTS (OTHER THAN PARENT(S) OR DOCTOR)

Name:_____ Telephone Number: () _____

Cell Phone Number: () _____

Address_____ (Street, City, State, Zip Code)

Name:_____ Telephone Number: () _____

Cell Phone Number: () _____

Address_____ (Street, City, State, Zip Code)

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

Name:_____ Name:_____

Brothers & sisters (names & ages): _____

Family's Church (name & location): _____

Child's date of baptism: _____

Is your child allergic to any foods?: _____

Please list any important information we should know about your child that will help us understand him/her better. All information is held in strictest confidence.

How did you hear about our program? _____

I understand that a non-refundable registration fee is required upon enrollment. Enrollment is expected for the entire 9 months. Monthly tuition is due the first session of each month.

Signature: _____ Date: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

PHYSICIAN AND PREFERRED HOSPITAL TO BE USED IN AN EMERGENCY:
I understand that in case of an accident or injury to my child, I will be notified immediately. If my child requires emergency medical care, the physician and preferred hospital to be used are:
Doctor/Clinic: Name: _____ Telephone number:() _____
PREFERRED HOSPITAL: Name: _____ Telephone number:() _____
FIELD TRIPS AND TRANSPORTATION: I ___do ___do not give consent for my child to take part in field trips or excursions with Peace's Early Childhood Program under proper supervision. It is my understanding that I will be notified when such trips are planned.
AGREEMENTS A. I have been informed of the required health and safety inspections and that the inspection forms are available for review. B. When my child is ill, I understand and agree that my child may not be accepted for care.
Parent/Legal Guardian Signature: _____ Date ___/___/___

TO BE COMPLETED BY CHILD CARE FACILITY:

Admission Date: _____ Discharge Date: _____

Paid \$ _____ Date: _____ Check Number _____

(Form to be retained for one year after discharge)

Confirmation _____ Health Form _____

FILING: File form in child's individual record.

Parent's Letter _____