



Annual Enrollment Checklist

The following items need to be completed and returned to the Early Childhood Office no later than Friday, August 5th.

	Child Enrollment Form
	Annual \$25 Registration Fee
	School Counseling Services Consent (JF&CS)
	Child Medical Exam Report
	Immunization Record
	Individualized Plan for Specialized Care (if needed)
	Medication Authorization (if needed)
	MDHSS Enrollment and Income Eligibility Form



Child's Enrollment Form

Child's Name: _____ Gender: _____ Birthdate: _____

Address: _____ Zip Code _____ Home Phone: _____

E-mail(s): _____ Religion (optional): _____

Identifying Information

Parent's/Guardian Name _____ Home Phone: _____

Address: _____ Zip Code _____ Cell Phone: _____

Employer or School: _____ Schedule: _____

Employer Address: _____ Work Phone: _____

Parent's/Guardian Name _____ Home Phone: _____

Address: _____ Zip Code _____ Cell Phone: _____

Employer or School: _____ Schedule: _____

Employer Address: _____ Work Phone: _____

Emergency Contacts

Name _____ Relationship to Child: _____ Phone: _____

Address: _____ Zip Code _____ Other Phone: _____

Yes No Authorized to take child from facility

Name _____ Relationship to Child: _____ Phone: _____

Address: _____ Zip Code _____ Other Phone: _____

Yes No Authorized to take child from facility

Comments on Child's Development

Notes on Child's Personal Development, Behavior, Patterns, Habits, and Individual Needs: _____

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 **The Jewish Community Center Early Childhood Center** to contact the following:

Physician or Clinic Name: _____ Phone: _____

Preferred Hospital Name: _____ Phone: _____

Insurance Information

Insurance Provider: _____ ID# _____ Medicaid# _____

****To be completed by office staff****

Admission Date: _____ Discharge Date: _____

Full Day Half Day Quarter Day
 Monday Tuesday Wednesday Thursday Friday

Consents and Acknowledgements

I have received a copy of the JCC ECC's policies pertaining to the admission, care and discharge of children.	Initials:
I have been informed that a copy of the licensing rules for group child care homes and centers is available at the JCC ECC for review.	Initials:
The JCC ECC and I have agreed on a plan for continuing communication regarding my child's development, behavior and individual needs.	Initials:
When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.	Initials:
I understand that, before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemptions from immunizations.	Initials:
I have been provided a copy of the JCC ECC Parent Manual. I have read, understand and agree to abide by the policies contained therein.	Initials:
I have read and understand the JCC ECC's swimming policy, as stated in the Parent Manual.	Initials:
<p>The JCC Early Childhood Center works closely with Jewish Family and Children Services and The Belle Center throughout the year. Consultants from these agencies will be at school working with teachers, children, and families. We consult these professionals to address behavior and educational plans for individual children. The consultants may observe in the classroom, interact with the children and discuss strategies with staff that will benefit the entire class. The consultant's and contact information are available to all families through the Early Childhood Office. You may contact the director if you wish to speak directly to the consultants about any questions or concerns you might have about your child(ren). Occasionally, one of the consultants may request a meeting with a family to discuss specific educational and/or behavioral concerns. The expressed, written permission of a parent or legal guardian is required prior to any focused effort on behalf of a child. All information and recommendations will be shared first with the family and only beyond the family when a specific release of information is requested and signed by the child's legal guardian (HIPPA).</p> <p>I understand that staff from the Jewish Family and Children Services and Belle Center will be observing in the classrooms.</p>	Initials:
<p>I understand I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.</p> <p>In case of emergency, I give my consent for the JCC staff, or designated person, to contact emergency medical services to attend to my child. I understand that every effort to contact me will be made and that I am responsible for any expense incurred as a result of this emergency including ambulance services. I authorize the JCC staff, or designated person, to provide to the attending medical technicians, physicians, hospital or clinic the relevant data, judged necessary for treatment, from my child's JCC medical records.</p>	Initials:
I understand that I must give written permission for field trips/excursions and that I will be notified, in advance, when they are planned.	Initials:
I <input type="checkbox"/> Do <input type="checkbox"/> Do not consent for the facility to transport my child.	Initials:
I <input type="checkbox"/> Do <input type="checkbox"/> Do not consent for the JCC ECC to apply sunscreen to my child.	Initials:
I <input type="checkbox"/> Do <input type="checkbox"/> Do not consent to have my child photographed/videotaped for publicity purposes by the JCC ECC.	Initials:
I <input type="checkbox"/> Do <input type="checkbox"/> Do not consent to have my child photographed/videotaped for internal use (classroom, Activit-e, etc)	Initials:
I <input type="checkbox"/> Do <input type="checkbox"/> Do not consent for my child to be treated/assessed by a registered nurse while at the JCC ECC.	Initials:
<p>I <input type="checkbox"/> Do <input type="checkbox"/> Do not consent for my child to participate in the screenings marked below.</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Dental <input type="checkbox"/> Speech/Language</p>	Initials:
Parent's/Guardian Signature:	Date



Consent for Services and Consent for Limited Release of Information

The Early Childhood Center has an agreement with Jewish Family & Children's Service (JF&CS) to provide school-based consulting services to students in the district. School-based consulting services will be provided by a master-level child, youth, and family therapist. JF&CS staff specializes in treating youth and families coping with psychosocial stressors such as school attendance and truancy, divorce, grief, family conflicts abuse/violence, substance abuse, poor social skills, behavior concerns, and relationship problems.

I, _____ Parent/Legal Guardian of _____ give consent for school-based consultation services to be provided by JF&CS. In connection with such services, I authorize and agree that JF&CS may make limited release and disclosure of personal information to The Early Childhood Center personnel for such purposes as education, service planning, and/or coordination/integration of services.

Confidentiality: I understand that all information obtained by a school-based consultant is confidential except under the following circumstances:

- A) Disclosures mandated by federal, state, or local law (I.e., suspicion or knowledge of child abuse/neglect).
- B) Disclosures specifically ordered by a court of law.
- C) Disclosures to prevent a serious threat to health or safety, for example, when there is imminent risk or serious threat of physical harm to self or others (including suicidal or homicidal thoughts).

In addition:

D) For consulting services provided in a group session, JF&CS will inform participants of the need to respect the privacy rights of all other participants and will stress that there should be no disclosure to others of information learned or acquired during the course of a group session. I understand that JF&CS cannot control the conduct or actions of other group members; and hence makes no representation or agreement concerning their conduct.

E) For confidentiality as it relates to Quality Improvement activities of the agency, JF&CS uses outcome questionnaires, surveys and service plans to measure the impact and benefit of services. Clients and staff complete these measures at varying intervals depending on the services being provided. All data collected is maintained in a secure, confidential manner. The results from outcome measures are used to continuously monitor progress, to assess areas of risk, and to ensure clients are receiving the greatest possible benefit from services. Summarized client information and statistical data are also used for reports to all JF&CS stakeholders, for grant writing, and employee training. In addition, because JF&CS's consultation services are funded primarily through the St. Louis County Children's Services Fund, client demographic data may be released and used by the CSF and its subcontractors for the purposes of measuring client satisfaction with services. In such cases no client records or case documentation will be released without this written consent.

F) For confidentiality as it relates to cellular phone conversations, JF&CS acknowledges that there may be times when a school based consultant needs to speak with a parent/guardian and either the consultant or the parent/guardian is using a cellular phone. Understanding that cellular phones are less secure in the transfer of information than landlines, the consultant will make every effort to conduct these calls in a private place and only discuss necessary and pertinent information.

*Copies of JF&CS's Notice of Privacy Practices and Client Rights and Responsibilities are available for your review at www.jfcs-stl.org.
*This release will be valid for one year from the date signed and may be revoked at anytime.

Signature of Parent/Legal Guardian Print Names of Parent/Legal Guardian Date

Signature of Witness Print Name of Witness Date

Optional: I wish the school-based consultant to contact me at _____ (phone) or at _____ (email) regarding questions I have.





Child Medical Exam Report

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 exam of the child on
____ / ____ / _____ (date),

This child can participate in a JCC Early Childhood program. This child has no special needs unless specified below. (The date of the medical exam needs to be within in the last 12 months).

Conditions Requiring Specialized Care

Complete this section only if the 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. **If this section is completed, the 'Individual Plan for Specialized Care' form must also be completed.**

Immunization Record (Required)

Please attach proof of completed age-appropriate immunizations or exemptions from immunizations. A copy of all immunizations must be on file before a child's first day of attendance.

Physician or Registered Nurse Information

Signature of or registered nurse under the supervision of a physician:

Date:



Physician or Nurse's Name (Please Print):

Name and Address of Clinic, Group, Practice or Other (may use stamp):

If nurse is being supervised by a physician, indicate the physician's name (please print):

Telephone Number:



Individual Plan for Specialized Care

This form should only be completed if the child has identified conditions requiring specialized care (as noted on the Child Medical Exam Report)

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 who is this treatment to be administered?

Symptoms/Indicators/Possible Problems Relating to Child's Condition/Treatment/Health Problems that can Result in an Emergency

Physician's or Nurse Authorization

Signature of or registered nurse under the supervision of a physician:

Date:



Physician or Nurse's Name (Please Print):



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES (MDHSS)
 COMMUNITY FOOD AND NUTRITION ASSISTANCE – CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM FOR CHILD CARE CENTERS

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

CHILD'S FULL NAME		DATE OF BIRTH	
PARENT OR GUARDIAN NAME		STREET ADDRESS	
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER ()
NAME OF CHILD CARE CENTER			PHONE NUMBER ()
CENTER CONTACT PERSON'S NAME		CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)	

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE	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.
MON	AM PM	AM PM	
TUES	AM PM	AM PM	
WED	AM PM	AM PM	
THURS	AM PM	AM PM	
FRI	AM PM	AM PM	
SAT	AM PM	AM PM	
SUN	AM PM	AM PM	

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

- | | | |
|---|---|---|
| <input type="checkbox"/> FULL DAY CARE | <input type="checkbox"/> BEFORE SCHOOL CARE | <input type="checkbox"/> EVENING CARE |
| <input type="checkbox"/> HALF DAY – MORNING | <input type="checkbox"/> AFTER SCHOOL CARE | <input type="checkbox"/> OVERNIGHT CARE |
| <input type="checkbox"/> HALF DAY – AFTERNOON | <input type="checkbox"/> BEFORE AND AFTER SCHOOL CARE | |

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

- | | | |
|--|--|--|
| <input type="checkbox"/> BREAKFAST | <input type="checkbox"/> LUNCH | <input type="checkbox"/> SUPPER |
| <input type="checkbox"/> MORNING SNACK | <input type="checkbox"/> AFTERNOON SNACK | <input type="checkbox"/> EVENING SNACK |

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

- | | |
|--|--|
| <input type="checkbox"/> NEW YEARS DAY (JANUARY 1) | <input type="checkbox"/> INDEPENDENCE DAY (JULY 4) |
| <input type="checkbox"/> MARTIN LUTHER KING'S BIRTHDAY (JANUARY) | <input type="checkbox"/> LABOR DAY (SEPTEMBER) |
| <input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY) | <input type="checkbox"/> THANKSGIVING DAY (NOVEMBER) |
| <input type="checkbox"/> MEMORIAL DAY (MAY) | <input type="checkbox"/> CHRISTMAS DAY (DECEMBER 25) |

SIGNATURE OF PARENT OR GUARDIAN	DATE
---------------------------------	------

ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIALED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM.

FIRST ANNUAL UPDATE	PARENT SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT SIGNATURE	DATE



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 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 for your child(ren), fill out this form and return it to your 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 food stamps 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 food stamp case number or Temporary Assistance case number for all of the children listed in Part 1.

NAME	BIRTH DATE	FOSTER CHILD	FOOD STAMP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

PART 2 HOUSEHOLD AND INCOME INFORMATION

List all other members of the household besides the children listed in Part 1. For each household member, 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.

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER
	MONTHLY	MONTHLY	MONTHLY	MONTHLY

PART 3 RACIAL ETHNIC INFORMATION

Please check the race or ethnic identity of the participant. You are not required to answer this question.

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic or Latino
 Native Hawaiian or Other Pacific Islander
 White
 YES NO

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	DATE
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER

Section 9 of the National School Lunch Act requires that, unless your children's food stamp or Temporary Assistance case number is provided, you must include 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 a social security number is not mandatory, but if a social security number is 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 food stamp or welfare office to determine current certification for receipt of food stamps 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 - DO NOT WRITE BELOW THIS LINE

Monthly Income Conversion Weekly x 4.33 Every 2 Weeks x 2.15 Twice a Month x 2

TOTAL HOUSEHOLD SIZE:	MONTHLY INCOME:	FOOD STAMP:	TEMPORARY ASSISTANCE:
-----------------------	-----------------	-------------	-----------------------

Eligibility Determination: Free Reduced Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
------------------------------------	------