EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER
4736 Prospect Ave. Kansas City, MO 64130
816-921-3164 | 816-861-1270 (FAX)

Dear Parent,

Thank you for your interest in Emmanuel Family & Child Development Center. We are eager to offer your scholar quality childcare services!

The following items are required to enroll your child:

- ☐ $30 Enrollment Registration Fee
- ☐ Enrollment Form
- ☐ Immunization Record (Student **WILL NOT** Be able to start without updated records)
- ☐ Medical Examination (Physical must be within the last 12 months)
    - **PLEASE READ: 30-Day health requirement letter**
- ☐ Emmanuel Medical/Dental Release of Information Form
- ☐ Swope Medical & Dental Registration/Consent Form (income eligibility-if needed)
- ☐ Emergency Contact/ Authorization for Pick-Up Form
- ☐ Parent consent to evaluation
- ☐ Infant/Toddler feeding form
- ☐ Infant Safe Sleep Policy
- ☐ Media Consent form (photograph/videotaping release)
- ☐ Women, Infants, and Children (WIC) Registration Form
- ☐ Happy Bottoms Registration form
- ☐ Current photo of student enrolling
- ☐ Child Care Payment Agreement
- ☐ CACFP - - Income Eligibility Form (Provide **SNAP/TANF DVN#** per enrolling family)
- ☐ Parent and Child Social Security Cards
- ☐ Child's Medical Insurance
- ☐ Child's Proof of Birth/ Proof of Pregnancy
- ☐ Foster Child Placement Document (if applicable)
- ☐ Parent/Guardian Photo ID
- ☐ Proof of Residency (e.g. Utility bill, lease, MO Property tax receipt with current address)
- ☐ Proof of income
- ☐ Copy of Work/School Schedule

Orientation will be scheduled upon your child's acceptance for enrollment and you will receive a Parent Handbook. Please refer to the Parent Handbook for all policies and procedures of the center. **Child care subsidy**: Please contact your Caseworker **(1 855-373-4536)** and provide EFCDC **DVN# 002795042.** All payments (private/Co-pay) are accepted at the front desk. Initial payment must be made before the Start Date and DUE on Friday of each week.

Thank you for you interest in our center. We hope to welcome you and your Scholar(s) into Emmanuel Family and Child Development Center very soon!

Office use only: Initial and Date after orientation is completed
Enrollment Director/Advocate: _____ Date:_____
Billing Specialist:_____ Date_____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME Emmanuel Family and Child Development Center	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit www.dese.mo.gov/veterans-services.

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	CHILD'S RELATION TO CHILD CARE PROVIDER

ETHNIC AND RACE 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 Alaskan native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

Will child attend: ☐ Full time ☐ Part time Check what days your child will attend.		When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
Monday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Tuesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Wednesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Thursday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Friday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Saturday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Sunday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	

MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack ☐ None

HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ New Year's Day	☐ Easter	☑ Labor Day
☐ Martin Luther King, Jr.'s Birthday	☑ Truman Day	☑ Columbus Day
☑ Lincoln's Birthday	☐ Memorial Day	☑ Veterans Day
☑ Washington's Birthday	☐ Juneteenth	☐ Thanksgiving Day
	☐ Independence Day	☐ Christmas Day

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event 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 the necessary arrangements, or in a critical emergency requiring medical care, I authorize

Emmanuel Family and Child Development Center

(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

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 home 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 that 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 at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN 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

USDA Nondiscrimination Statement

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 contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW Washington,
   D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

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MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

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

SAVE
PRINT
RESET

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

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

&

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
CHILD AND ADULT CARE FOOD PROGRAM

INFANT AND TODDLER FEEDING AND CARE PLAN

FOR CHILD CARE FACILITY USE

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 and reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

INSTRUCTIONS (FOR PARENTS)

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

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about militaryrelated services in Missouri or visit www.dese.mo.gov/veterans-services.

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
Breastmilk			
Milk			
Table Food			

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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

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2024 through June 30, 2025

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	$27,861	5	$67,673
2	$37,814	6	$77,626
3	$47,767	7	$87,579
4	$57,720	8	$97,532

For each additional family member, add $9,953

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

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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)	DATE
	XXX-XX-	/ /
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

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FAMILY & CHILD DEVELOPMENT CENTER

Authorization for Pick-Up:

Child's Name _____

Parent's Name _____

Home #: _____

Work #: _____

Cell #: _____

Person(s) listed below are authorized by the parent/guardian to take their child(ren) from the facility.

1. Name:_____Relationship to Child: _____

   Address:_____ Phone#: _____

2. Name:_____Relationship to Child: _____

   Address:_____ Phone#: _____

3. Name:_____Relationship to Child: _____

   Address:_____ Phone#: _____

4. Name:_____Relationship to Child: _____

   Address:_____ Phone#: _____

EFCDC Office Staff will check each person for identification. We will not allow any child to be removed from the Center without proper authorization.

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER

Parental Consent to Evaluation:

The first five years are very important for your child because this time sets the stage for success in school and later in life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please sign below, indicating that you agree to have your child participate in the screening/monitoring programs used at Emmanuel Family and Child Development Center.

- The Ages & Stages Questionnaires (ASQ-3)
- The Department of Education and Second Education Core Competencies (DESE)
- The Devereux Early Childhood Assessment Development Screenings (DECA)
- Rockhurst University Speech and Language Therapy

Parent or Guardian Signature & Date

Child's Name

Child's Date of Birth

Child's Primary Care Physician

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER

Infant Safe Sleep Policy

All childcare providers at Emmanuel Family & Child Development Center will follow safe sleep recommendations for infants to reduce the risk of Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID), and the spread of contagious diseases.

All infant parents will receive a copy of this written policy of the safe sleep policy upon the child's enrollment.

1. Infants will always be put to sleep on their backs.
2. Infants will be placed on a firm mattress, with a fitted crib sheet, in a crib that meets the Consumer Product Safety Commission safety standards.
3. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, positioning devices, or extra bedding will be in the crib or draped over the side of the crib.
4. Sleeping areas will be ventilated and at a temperature that is comfortable for a lightly clothed adult. Infants will not be dressed in more than one extra layer than an adult.
5. If additional warmth is needed, a one-piece blanket sleeper or sleep sack may be used.
6. The infant's head will remain uncovered for sleep. Bibs and hoods will be removed
7. Sleeping infants will be actively observed by sight and sound.
8. Infants will not be allowed to sleep on a couch, chair cushion, bed, pillow, or in a car seat, swing, or bouncy chair. If an infant falls asleep anywhere other than a crib, the infant will be moved to a crib right away.
9. An infant who arrives asleep in a car seat will be moved to a crib.
10. Infants will not share cribs.
11. Infants may be offered a pacifier for sleep, if provided by the parent
12. Pacifiers will not be attached by a string to the infant's clothing, and will not be reinserted if they fall out after the infant is asleep.
13. When able to roll back and forth from back to front, the infant will be put to sleep on his back and allowed to assume a preferred sleep position.
14. In the rare case of a medical condition requiring a sleep position other than on the back, the parent must provide a signed waiver from the infant's physician.
15. Our child care program is a smoke-free environment
16. Our child care program supports breastfeeding.
17. Awake infants will have supervised "TummyTime".
18. All staff will take and then retake the safe sleep training every 3 years
19. Supervision of infants during nap times, to include:
    a. Staff will position themselves near children who are napping;
    b. Lighting in the nap room;
    c. Physical checks of the child to ensure he or she is not overheated or in distress; and
    d. Prohibitions against the use of any equipment, such as a sound machine, that may interfere with the caregiver's ability to see or hear a child who may be distressed.

Please sign and date below acknowledging your receipt of this notice.

Parent Signature _____ Date:_____

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER

Photography & Videotaping Release

From time to time, Emmanuel Family & Child Development Center or its subsidiaries, or the news media, may videotape or photograph your child and/or their class.

By signing my name on this document, I acknowledge and agree:

- The Emmanuel Family & Child Development Center or its subsidiaries have my permission to allow the recording of my child's likeness or photograph for future use.
- That Emmanuel Family and Child Development Center or its subsidiaries are under no obligation to provide notification before my child's participation in activities which may result in such photography or videotaping.
- That Emmanuel Family and Child Development Center or its subsidiaries are under no obligation to provide notification before the use of such photography or videotaping.
- That I and/or my child will receive no financial or in-kind compensation for the use of my child's likeness or image by Emmanuel Family and Child Development Center or its subsidiaries, as well as the media.
- This authorization in no way guarantees that my child's likeness or image will be used.

If I do not wish for my child's likeness or image to be used according to such above-stated conditions, I acknowledge and agree that I will provide the Director with written notification of such intent before my child's enrollment within Emmanuel Family and Child Development Center, or at a later date if needed.

I hereby authorize my child to participate in activities which may be videotaped or photographed, and acknowledge my understanding and agreement to the terms and conditions stated within this document.

Child's Name:_____

Parent or Guardian Signature _____ Date: _____

KCMO Health Department
Childhood Lead Poisoning & Prevention Program

2400 Troost Ave, Suite 3400
Kansas City, MO 64108

What does lead do to Children?

- Lead affects all body systems, but especially the brain and nervous system causing problems such as hyperactivity, learning difficulties, impaired growth, lower IQ.

Where is lead? Everywhere-but particularly:

- Lead-based paint, contaminated soil, dust, air, water, hobby supplies, folk medicine, and poorly glazed pottery.

Precautions you can take:

- Good nutrition, frequent hand washing and housecleaning to remove lead-contaminated dust, safe clean-up and disposal of paint chips, avoidance of folk remedies and poorly glazed pottery.

What is a hemoglobin test?

- Hemoglobin is a protein in red blood cells. The hemoglobin test is primarily used to detect various types of anemia, a common condition that occurs when the amount of healthy red blood cells in a person's blood is too low. Anemia in children is most often caused by deficiencies of nutrients like iron in a child's diet and can cause considerable effects on growth and ability to perform mentally and physically.

CONSENT FORM

I give permission for my child to have a lead screening blood test and/or a hemoglobin blood test. I understand this procedure involves a fingerstick to obtain a few drops of blood needed for the test. The test will be performed by nurses from the Kansas City, Missouri Health Department and results may be released to your child's day care program.

****(Please Print)****

Child's Name:_____ Date of Consent:_____

Date of Birth:_____ Sex:_____ Race:_____ Ethnicity: Hispanic or Non-Hispanic

Address:_____
Street City State Zip code

Phone#:_____ **Print** Parent/Guardian Name:_____

Alt. Phone#:_____ **Signature** of Parent/Guardian:_____

Primary Care Physician:_____ Medicaid #:_____

For Health Department use only: Test date:_____

- O Lead
- O Hgb Hgb result:_____ Performed by:_____

SWOPE HEALTH
KIDSCARE

Community/School-Based Services Patient Registration

Organization / Event / Site: Emmanuel Family and Child Dev

☐ MARC / MAHS

Services Requested: ☐ Medical ☐ Dental

Child

Name (Last, First, MI) _____ Date of Birth ____/____/____

Address _____

City, State, Zip _____

County _____

Phone _____

Gender: ◯ Male ◯ Female ◯ Other _____

Soc. Security # _____

Race: ☐ Af Amer/Black ☐ Caucasian ☐ Asian
☐ Native Amer ☐ Alaska Native ☐ Native Hawaiian
☐ Pacific Islander ☐ More than one race (check all that apply)
☐ Other _____

Ethnicity: ☐ Decline ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Parent/Caregiver ☐ Address & Home phone Same as Child

Name (Last, First, MI) _____ Date of Birth ____/____/____

Relationship to Child: _____

Address _____

City, State, Zip _____

Home Phone _____

Work Phone _____

Place of Employment _____

Social Security # _____

Email _____

Is your family experiencing homelessness? ☐ No ☐ Yes

Language: ☐ English ☐ Spanish ☐ Interpreter Requested. Language:

Health Insurance (Child)

☐ Do you have health insurance for your child? ☐ No ☐ Yes ☐ I would like help obtaining Medicaid for my child or family.

☐ I would like to enroll in Swope Health's Sliding Fee Discount program or receive more information about financial assistance.

Medicaid

☐ Missouri ☐ Kansas

DCN #: _____

☐ Home State ☐ Healthy Blue
☐ United Healthcare (UHC)
☐ Sunflower
☐ Other: _____

Commercial Health Insurance

☐ Parent/Caregiver Above is Policy Holder

Policy Holder: _____

Relationship to Patient: _____

Company: _____

Group #: _____

ID # _____

Commercial Dental Insurance

☐ Parent/Caregiver Above is Policy Holder

Policy Holder: _____

Relationship to Patient: _____

Company: _____

Group #: _____

ID # _____

[Please provide us with a copy of the front and back of the insurance card.]

My child*: ☐ Takes Medications ☐ Has Medical Conditions ☐ Has Food Allergies ☐ Has Allergies to Medications or Anesthetics

*If you answered yes, please complete the KidsCARE Health Questionnaire.

☐ I do not have a primary care provider (medical clinic) for my child's health care. ☐ I would like Swope Health to be my child's PCP

Your child's Mobile or School-Based Clinic visits may include the services listed below. (Select any services that you DO NOT want)

Dental Visit: ☐ Dental Exam ☐ Dental X-rays ☐ Cleaning ☐ Fluoride Application ☐ Sealants ☐ SDF

Medical Visit: ☐ Unclothed Physical Exam (Gown) ☐ Lead and Hemoglobin Blood Test (Finger Stick) ☐ Immunizations

☐ I am voluntarily registering my child at Swope Health and consent to screening, and/or diagnostic and treatment services provided by (or at the direction of) a physician, Nurse Practitioner, Dentist, or other qualified health care professional of Swope Health. I will receive information advising me of my child's health needs. I authorize the release of information for any applicable insurance coverage.

☐ I authorize Swope Health to share my child's health information required for enrollment with my child's school or center.

☐ I wish to designate a representative to accompany my child during the Mobile or School-Based visit in my absence. (Please complete the Consent for Care in Absence of Parent Form). Name of Representative: _____

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