



## Afterschool Program 2024

Dear Parent,

Thank you for your interest in Emmanuel Family & Child Development Center Afterschool/Summer School Program. We are eager to offer your scholar quality services.

The following items are required to enroll your child:

- Enrollment Form
- Immunization Record
- Medical Examination (Physical form to be signed by Parent)
- Emergency Contact/ Pick Up Form
- CACFP - - Income Eligibility Form
- Parent and Child Social Security Cards
- Child's Proof of Birth
- Parent ID
- Proof of Residency
- Proof of income
- Copy of Work/School Schedule

Child care subsidy: to continue service before/after the summer program you must have state assistance. Please contact your Caseworker (1 855-373-4536) and provide EFCDC **DVN# 002795042**



**CHILD CARE ENROLLMENT FORM**

FACILITY/PROVIDER NAME		ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME		GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)			
<b>IDENTIFYING INFORMATION</b>			
MOTHER'S/GUARDIAN'S NAME		TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>			
E-MAIL ADDRESS			
EMPLOYER OR SCHOOL		WORK/SCHOOL SCHEDULE	
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)		WORK TELEPHONE NUMBER	
FATHER'S/GUARDIAN'S NAME		TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>			
E-MAIL ADDRESS			
EMPLOYER OR SCHOOL		WORK/SCHOOL SCHEDULE	
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)		WORK TELEPHONE NUMBER	
<b>EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED</b>			
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)			
<b>COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, &amp; INDIVIDUAL NEEDS)</b>			

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email [civilrights@dese.mo.gov](mailto:civilrights@dese.mo.gov).



**RELATED CHILD**

<input type="checkbox"/> YES <input type="checkbox"/> NO	HOW IS CHILD RELATED TO CHILD CARE PROVIDER
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**CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED**

**CACFP  
REQUIREMENT**

WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		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 INCLUDING SHIFT CHANGES
CHECK WHAT DAYS THE CHILD WILL ATTEND				
MONDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
TUESDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
WEDNESDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
THURSDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
FRIDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
SATURDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	
SUNDAY	<input type="checkbox"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	

**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**

<input type="checkbox"/> NEW YEAR'S DAY (JANUARY)	<input type="checkbox"/> MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	<input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY)	<input type="checkbox"/> EASTER (MARCH/APRIL)
<input type="checkbox"/> MEMORIAL DAY (MAY)	<input type="checkbox"/> INDEPENDENCE DAY (JULY)	<input type="checkbox"/> LABOR DAY (SEPTEMBER)	<input type="checkbox"/> COLUMBUS DAY (OCTOBER)
<input type="checkbox"/> VETERANS DAY (NOVEMBER)	<input type="checkbox"/> ELECTION DAY (NOVEMBER)	<input type="checkbox"/> THANKSGIVING (NOVEMBER)	<input type="checkbox"/> 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 ARRANGEMENT, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

\_\_\_\_\_ (LIST CHILDCARE FACILITY NAME HERE)

TO CONTACT THE FOLLOWING:

**PHYSICIAN OR CLINIC**

NAME	TELEPHONE NUMBER
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**PREFERRED HOSPITAL**

NAME	TELEPHONE NUMBER
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**ACKNOWLEDGEMENTS**

<b>A</b>	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
<b>B</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
<b>C</b>	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
<b>D</b>	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
<b>E</b>	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
<b>F</b>	I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
<b>G</b>	I <input type="checkbox"/> DO <input type="checkbox"/> 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
<b>CACFP REQUIREMENT</b>	FIRST ANNUAL UPDATE	PARENT/GUARIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARIAN SIGNATURE	DATE

### USDA Nondiscrimination Statement

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint>, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;
- 2) Fax: (202) 690-7442; or
- 3) Email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.



**Child and Adult Care Food Program  
Parent Letter – Non-Pricing Child Care Centers  
July 1, 2023 through June 30, 2024**

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.

<b>Family Size</b>	<b>Yearly Income</b>	<b>Family Size</b>	<b>Yearly Income</b>
1	\$26,973	5	\$65,009
2	\$36,482	6	\$74,518
3	\$45,991	7	\$84,027
4	\$55,500	8	\$93,536

For each additional family member, add \$9,509

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

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

This institution is an equal opportunity provider.

12/09/2022



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION  
**PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD**

SAVE

PRINT

RESET

**IDENTIFYING INFORMATION**

CHILD'S NAME	BIRTHDATE
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**HEALTH STATEMENT (CHECK ONE)**

- My child is in good health, is able to participate in group care, has no special health or medical requirements.
- My child is able to participate in group care but has special health or medical requirements as listed below.

**SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS**

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE
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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 BUREAU OF 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 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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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
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
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eligibility Determination: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Paid								
SIGNATURE OF CENTER REPRESENTATIVE							DATE	





### School Records Release Form

Directions to the applicant/parent:

Please complete these records form so that Emmanuel Family and Child Development Center may obtain records from your child's school.

Students Name: (Last, First, Middle) \_\_\_\_\_  
Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize \_\_\_\_\_ (name of School) to release and provide copies of the following documents to Emmanuel Family & Child Development Centers staff.

\_\_\_\_\_  
**Parent/Guardian signature** **Date**

Directions to the sending school

Please include the following documents if available:

- Official transcripts- including standardized achievements, intelligence, aptitude test scores, grade cards, MAP test scores and an explanation of your grading system.
- Health records/immunization records
- Teacher and/or counselor observations and comments or recommendation.
- Results of any special academic or psychological evaluation with document of special needs and copy of IEP.
- Record of extracurricular activities