HARRIS-STOWE STATE UNIVERSITY
COLLEGE OF EDUCATION

COLLEGE OF EDUCATION
3026 Laclede Avenue | St. Louis, MO 63103
(314) 340-5078 Office | (314) 340-3690 Fax
www.hssu.edu

WILLIAM L. CLAY EARLY CHILDHOOD DEVELOPMENT CENTER

Introductory Letter for Parent Enrollment Application Packet

Welcome!!!

We are ecstatic that you are joining the Clay Center family. Here are a few things to help you get acquainted.

First, be sure you read the Parent Manual.
You can access it on http://www.hssu.edu. From there you must scroll to the bottom where it says William L. Clay Early Childhood Center and click on ***Parent Manual.*** It contains all of the information that you will need to know. If you have any questions, please do not hesitate to contact.

Director Dr. Jodi Jordan: 314-340-5066 *(jordanj@hssu.edu)*
Assistant Director Patty Smith: 314-340-5107 *(smithp@hssu.edu)*
Administrative Assistant Yolanda Bell: 314-340-5055 *(belly@hssu.edu)*

Three steps to begin enrolling your child:

1. Please contact us to check the waiting list and schedule a tour.
2. Fill out and print application and the last page of the parent handbook.
3. Bring the completed application and we will discuss the next step.

Note: A non-refundable application fee of $100.00 is required. (credit or debit card only)

What to Bring:
You may be wondering what to bring. We provide almost everything your child needs here at the Clay Center, but there are a few things that we require you to bring for the comfort of your child. Examples include: breastmilk, diapers, pacifiers, extra clothing, etc.

Daily:
Please be sure to sign your child in/out on a daily basis. The sign in/out sheets are located either inside or outside your child's classroom in a convenient location.

Financial Policies Tuition Policy Effective July, 2018:
Tuition at the Clay Center is based on enrollment, not attendance. All monthly fees are due on the 1st day of the current month and must be paid by the 5th day of the month. If fees are paid after the 5th day of the month, a $25.00 late payment charge will be added to your account. If fees are not paid by the 10th day of the month, your child will not be accepted into the program until all fees are paid.

ECC Fee Schedule—FY 2018-2019:

Ages	**Monthly Tuition**
Infants (Birth to 12 Months)	$1,232.00
Toddler 1 (1year)	$1,102.00
Toddler 2 (2 years)	$986.00
Pre-K (3 years – 5 years)	$866.00

Arrivals/Departures:
The Center is open from 6:00 a.m. to 6:00 p.m. Please respect the hours of operation. Each parent/guardian must accompany the child into the child's classroom and sign in/out daily. Full name and times of arrival and departure will be required. (Please see details on page 6 and 13 of the Parent Manual).

We appreciate being of service to you and your child.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

SAVE PRINT RESET

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

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 NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ YES ☐ NO — HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐FULL TIME OR ☐PART TIME		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MONDAY	☐	AM PM	AM PM	
TUESDAY	☐	AM PM	AM PM	
WEDNESDAY	☐	AM PM	AM PM	
THURSDAY	☐	AM PM	AM PM	
FRIDAY	☐	AM PM	AM PM	
SATURDAY	☐	AM PM	AM PM	
SUNDAY	☐	AM PM	AM PM	

CACFP REQUIREMENT

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

☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☐ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☐ COLUMBUS DAY (OCTOBER)
☐ VETERANS DAY (NOVEMBER)	☐ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ 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 ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

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 THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES 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 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 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

CACFP REQUIREMENT

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

PARENTAL AGREEMENT (CONTINUATION)

List any chronic or medical challenges that your child has, e.g., seizures, asthma, diabetes, heart disease, respiratory illness, drug reaction, etc.

Describe any allergies, including any foods that have caused adverse reactions or any food not given to the child for health or religious reasons (use separate sheet if necessary).

Has your child come in contact with tuberculosis?

☐ YES ☐ NO IF YES, WHEN?

Check the illnesses your child has experienced:

☐ Measles ☐ German Measles ☐ Mumps ☐ Chicken Pox

☐ Scarlet Fever ☐ Strep Throat ☐ Rheumatic Fever

☐ Other _____

Harris-Stowe State University
College Of Education

Emergency Contact Information:
(Please Print)

Name: _____

Address: _____

_____

Phone #: _____ Cell #: _____

The following person(s) are authorized to pick up my child:

_____
_____
_____
_____

The following person(s) **ARE NOT** allowed to pick up my child:

_____
_____
_____
_____

PARENTAL AGREEMENT
In the unlikely event that my child is in need of emergency medical care and I, or other designated contacts cannot be reached, the staff of the Clay Early Childhood Development/Parenting Education Center has my permission to seek proper medical care for my child(ren) while all efforts are made to make parental contact.

(Doctor) Name: _____ Phone #: _____

Address: _____

(Dentist, if applicable)

(Doctor) Name: _____ Phone #: _____

Address: _____

Preferred Hospital: _____

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 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.

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	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

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐ MONTH ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐ FOOD STAMP ☐ TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
▶	

HARRIS-STOWE STATE UNIVERSITY

WILLIAM L. CLAY, SR. EARLY CHILDHOOD DEVELOPMENT AND PARENTING CENTER

Child Care Contract

The Clay Center agrees to provide care and programming for (child's name) _____
Last First MI

I/we, the Parent(s)/Guardian(s) (print name): (1) _____
Last First MI

(2) _____
Last First MI

Social Security # (1) _____ Social Security # (2) _____

(Initial next to each statement)

____ I (we) agree to following all policies and procedures in the Parent Manual.
____ I (we) agree to update the emergency contact/parent consent form information whenever changes occur.
____ I am (we are) guarantor(s) of this account and I am (we are) fully responsible for payment of amounts due.
____ I (we) understand fees are based on enrollment, not attendance and if applicable, the Clay Center will adjust my account according to the Parent Manual.
____ I (we) understand past due amounts may be sent to a collection agency and I (we) am (are) responsible for all fees including collection costs and fees for delinquent accounts.
____ I (we) understand, if applicable, as a Harris-Stowe State University student(s) a past due balance owed for services rendered at the Clay Center will result in a billing hold placed on my (our) student account which will prevent me (us) from having access to an official student records as well as prevent enrollment in future classes.
____ I (we) know that childcare for my child will be discontinued if I (we) do not maintain payments in advance of my account balance.
____ I (we) acknowledge that rates are subject to change and that the Clay Center reserves the right to make corrections to the rates and amounts charged for services.
____ I (we) understand that my (our) monthly rate may change on my (our) child's birthday. Date of Birth: _____

I (we) agree to remit payment by the 10th of the month.

I (we) verify that all the information above is correct.

Parent/Guardian Signature (1): _____ Date: _____

Parent/Guardian Signature (2): _____ Date: _____

Address: _____ Date: _____

HARRIS-STOWE STATE UNIVERSITY

OFFICE OF COMMUNICATION AND MARKETING

Video/Photograph Release Form

Date _____

I hereby release and grant the institution of Harris-Stowe State University permission to use my photograph in any and all of its publications, including Web site entries, without payment or any other consideration. Please understand that there are no royalty opportunities offered for appearing in any Harris-Stowe photograph.

I understand and agree that these materials are property of Harris-Stowe State University and will not be returned, therefore, Harris-Stowe is authorize to edit, publish and copy the photograph for the purpose of publicizing and promoting Harris-Stowe and any of its events and programs. In addition, I waive the right to be view, inspect or approve any final versions of the photo, prior to its appearance in any publication, advertisement or brochure.

I hereby hold harmless and release and forever discharge Harris-Stowe from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning, and impact of this release.

Signature _____

Printed Name _____

If the person signing is under 18 years of age, a parent or guardian must give written consent on behalf of this person _____

3026 LACLEDE AVENUE ST. LOUIS, MISSOURI 63103 (314) 340-3391 FAX: (314) 340-3575

HARRIS-STOWE STATE UNIVERSITY

WILLIAM L. CLAY, SR. EARLY CHILDHOOD DEVELOPMENT/PARENTING EDUCATION CENTER

DFS/FINANCIAL ASSISTANT FORM

Recipients of financial assistance for childcare from the Missouri Division of Family Services are eligible to receive services from The Clay Center as we are contracted to provide services for the State of Missouri. Our policies and procedures regarding the use of this program are outlined below.

1. Before a child may enroll, a Child Care Provider Approval/Change Notice, with the Center listed as the Provider, must be on file in order for services to begin at a subsidized or "reduced" rate.

2. If you must enroll a child before a Child Care Provider Approval/Change Notice is on file, you are responsible for the payment of the weekly fee.

3. The Clay Center fees are higher than the Missouri Division of Family Services (DFS) rate. A co-pay rate will be paid directly to The Clay Center. Balances owed The Clay Center may vary depending on your child's scheduled attendance. DFS pays for 5 absences per month. Absences include illnesses and holidays. **Weather and unforeseen circumstances are not included in the five allotted absences. If your child is absent more than those allotted days, you are required to pay for the balance due that was not paid by DFS.** The Clay Center fees are based on enrollment, and not attendance.

4. It is your responsibility to renew your Child Care Provider Approval/Change Notice authorization in a timely manner. The Clay Center reserves the right to increase your weekly rate without a Child Care Provider Approval/Change Notice. The Clay Center reserves the right to terminate services due to non-payment of weekly fees.

"I have read and understand the policies and procedures as stated above and as stated in The Clay Center Parent Manual."

Signature: _____ **Date:** _____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

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

HARRIS-STOWE STATE UNIVERSITY
William L. Clay, Sr.
Early Childhood Development/Parenting Education Center
Parent Manual

Parent Agreement

I, _____, have read and understood the statements presented in the manual, had opportunities to ask questions for clarification, and agree with all statements and agree to abide by the policies and procedures as stated in the William L. Clay Early Child Development/Parenting Education Center Parent Manual. I also agree to become actively involved, as the primary educator of my child (ren), with the Center's staff as a volunteer, participant in family/teacher conferences, and/or resource/support person to insure the success of the Center's operations.

Please sign and return to administrative assistant for filing. Thanks.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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

INFANT FEEDING PREFERENCE – CENTERS

Name of infant _____ Date of Birth _____

_____ will feed your infant breastmilk provided by you and / or we
(name of provider)
will provide iron fortified infant formula.

The formula we provide is: _____

Please mark your preference (choose all that apply)	Date Birth – 3 months	Date 4 – 7 months	Date 8 – 11 months
I will bring expressed breastmilk for my infant.			
I will come to the center to breastfeed my infant.			
I want the center to provide formula for my infant.			
I will bring formula for my infant. Please list kind of formula you will bring: _____			

This center is participating in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when your baby is developmentally ready for them.

Please mark your preference	Date 4 – 7 months	Date 8 – 11 months
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.		
I will bring solid food for my infant when he / she is ready for it.		

First Signature of Parent / Guardian _____ Date _____

Second Signature of Parent / Guardian _____ Date _____

Third Signature of Parent / Guardian _____ Date _____

Missouri Department of Health and Senior Services
Section for Child Care Regulation and Child and Adult Care Food Program

INFANT AND TODDLER FEEDING AND CARE PLAN

THIS SECTION TO BE COMPLETED BY CHILD CARE FACILITY:

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

Instructions to 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

Feeding Information

Type of Food	Feeding Time	Kinds of Food	Amount of Food
Breast Milk			
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
Breast Milk			
Milk			
Table Food			

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

SHP-159J 02/15

Missouri State Highway Patrol

REQUEST FOR CHILD ABUSE OR NEGLECT / CRIMINAL RECORD

TYPE OF SERVICE (Check **ALL** that apply) See reverse side for further instructions.	TYPE OF DAYCARE PROVIDER
☐ (1) CD Central Registry Child Abuse Search Only - No Charge ☐ (2) Name Search - ($13.00) and CD Central Registry Child Abuse Search ☐ (3) Fingerprint Search & CD Central Registry Child Abuse Search ☐ $14.00 (Authorized Statute 210.487) ☐ $20.00 (All other request)	☐ (1) License ☐ (2) License Exempt ☐ (3) Registered

IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign.

APPLICANT'S NAME (Last, First, MI, Jr., Sr., III)				
MAIDEN NAME	DATE OF BIRTH (MM/DD/YY)	STATE OF BIRTH	SEX	RACE
ALIAS NAME(S)	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER / STATE		

ADDRESSES FOR PAST 5 YEARS

STREET	CITY	STATE	STREET	CITY	STATE

Have you ever been found guilty to or been convicted of any criminal act in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been found guilty to or been convicted of any criminal offense in this state or any state.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Identify charges, attach separate page, if necessary.)

Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Children's Division in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been substantiated as a perpetrator in any child abuse or neglect report.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Attach separate page, if necessary.)

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law.

SIGNATURE OF APPLICANT **(REQUIRED IN INK)**	DATE
SIGNATURE OF REQUESTOR (Required in Ink)	DATE
TITLE OF CHILD CARE PROVIDER	TELEPHONE
STATE AGENCY	STATE VENDOR OR CONTACT NO. (If applicable)

CHECK APPROPRIATE BOX

☐ CHILD CARE RELATED EMPLOYMENT	☐ DOH / CCB CHILD CARE BUREAU	☐ SCHOOLS / PUBLIC AND PRIVATE
☐ CHILD CARE RELATED VOLUNTEER	☐ DMH / DMH VENDOR	☐ CD CONTRACT PROVIDER
☐ CD LICENSURE	☐ HEALTH CARE	☐ OTHER _____

COMPLETE RETURN ADDRESS (REQUIRED ON EACH APPLICATION)
Complete your mailing label below
Confidential Mail

AGENCY NAME
ATTENTION
ADDRESS
CITY, STATE, ZIP CODE

SEND FEE & FORM TO:

Missouri State Highway Patrol
Criminal Justice Information Services Division
P.O. Box 9500
Jefferson city, MO 65102

The purpose of this form is to provide information available to child care agencies including volunteer agencies. The records you receive will be based on the search options you select. The Missouri State Highway Patrol will respond when you choose option 2 or 3. The Missouri Children's Division will respond when you choose option 1, 2, or 3. Direct questions regarding criminal records to the Missouri State Highway Patrol (573-526-6153); direct questions regarding child abuse or neglect to the Children's Division (573-526-1438, TT: 1-800-735-2466).

The information on this form, and responses generated as a result of this form, are confidential. Any person disclosing the information in violation of 43.540, 589.400, RSMo. and/or 210.150 RSMo. is guilty of a class A misdemeanor.

For information on how to participate in the Child Abuse/Neglect Central Registry examination program, submit a written request from the CEO, owner, director, etc. of your child care related group or organization to: **Director, Children's Division, P.O. Box 88, Jefferson City, MO 65103.**

PROCESSING FEE SCHEDULE INFORMATION (43.527 AND 43.530 RSMo.)

By checking boxes 1 thru 3 on the front page of this form, the following applies:

1. CD Central Registry Child Abuse Search Only - No Charge Provides information obtained from the Children's Division Central Registry only. The Children's Division (CD) Central Registry screening will reflect information contained in the CD database. Any questions about the accuracy of that information should be directed to the CD office in the residential county of the applicant or the county of employment if the applicant is not a Missouri resident.
   a) Complete the request form.
   b) Mail completed form to: **Missouri Children's Division, Background Screening / Investigations Unit, P.O. Box 88, Jefferson City, MO 65103.**

2. Name Search - $13.00 Provides open records obtained from the Missouri Criminal Record Repository and information from Missouri Children's Division Central Registry.
   a) Complete the request form.
   b) Make a check or money order for $13.00 payable to "State of Missouri Criminal Records System."
   c) Mail completed form and check or money order to: **Missouri State Highway Patrol, Criminal Justice Information Services Division, P.O. Box 9500, Jefferson City, MO 65102.**

3. Fingerprint Search - $14.00/$20.00 Provides open and closed records with positive identification obtained from the Missouri Criminal Records Repository and information from Missouri Children's Division Central Registry.
   a) Complete the request form.
   b) Obtain fingerprints on: Applicant card FD-258. Official taking fingerprints must verify identity of person fingerprinted with an official id such as a driver's license and sign the card as the person taking the fingerprints. Complete the rest of the card as applicable.
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SPACE RESERVED FOR MSHP/CD RESPONSE STAMP

SHP-159J 02/15

Missouri State Highway Patrol

REQUEST FOR CHILD ABUSE OR NEGLECT / CRIMINAL RECORD

TYPE OF SERVICE (Check ALL that apply) See reverse side for further instructions.	TYPE OF DAYCARE PROVIDER
☐ (1) CD Central Registry Child Abuse Search Only - No Charge ☐ (2) Name Search - ($13.00) and CD Central Registry Child Abuse Search ☐ (3) Fingerprint Search & CD Central Registry Child Abuse Search ☐ $14.00 (Authorized Statute 210.487) ☐ $20.00 (All other request)	☐ (1) License ☐ (2) License Exempt ☐ (3) Registered

IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign.

APPLICANT'S NAME (Last, First, MI, Jr., Sr., III)				
MAIDEN NAME	DATE OF BIRTH (MM/DD/YY)	STATE OF BIRTH	SEX	RACE
ALIAS NAME(S)	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER / STATE		

ADDRESSES FOR PAST 5 YEARS

STREET	CITY	STATE	STREET	CITY	STATE

Have you ever been found guilty to or been convicted of any criminal act in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been found guilty to or been convicted of any criminal offense in this state or any state.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Identify charges, attach separate page, if necessary.)

Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Children's Division in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been substantiated as a perpetrator in any child abuse or neglect report.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Attach separate page, if necessary.)

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law.

SIGNATURE OF APPLICANT (REQUIRED IN INK)	DATE
SIGNATURE OF REQUESTOR (Required in Ink)	DATE
TITLE OF CHILD CARE PROVIDER	TELEPHONE
STATE AGENCY	STATE VENDOR OR CONTACT NO. (If applicable)

CHECK APPROPRIATE BOX

☐ CHILD CARE RELATED EMPLOYMENT	☐ DOH / CCB CHILD CARE BUREAU	☐ SCHOOLS / PUBLIC AND PRIVATE
☐ CHILD CARE RELATED VOLUNTEER	☐ DMH / DMH VENDOR	☐ CD CONTRACT PROVIDER
☐ CD LICENSURE	☐ HEALTH CARE	☐ OTHER _____

COMPLETE RETURN ADDRESS (REQUIRED ON EACH APPLICATION)
Complete your mailing label below
Confidential Mail

AGENCY NAME
ATTENTION
ADDRESS
CITY, STATE, ZIP CODE

SEND FEE & FORM TO:

Missouri State Highway Patrol
Criminal Justice Information Services Division
P.O. Box 9500
Jefferson city, MO 65102

MO 821-0353 (9-16)

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SPACE RESERVED FOR MSHP/CD RESPONSE STAMP

William L. Clay Early Childhood Development/Parenting Education Center Infant/Toddler Safe Sleep Policy

The purpose of the Safe Sleep Policy is to maintain a safe sleep environment that reduces the risk of sudden infant death syndrome (SIDS) and sudden unexpected infant deaths (SUIDS) in children less than one year of age. Missouri law (§ 210.223.1, RSMo.) requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent safe sleep recommendations of the American Academy of Pediatrics (AAP). Missouri child care licensing rules require licensed child care facilities to provide parent(s) and/or guardians(s) who have infants in care be provided a copy of the facility's safe sleep policy. Sudden Infant Death Syndrome (SIDS) is the unexpected death of an infant, or child younger than twelve months, for whom no cause of death can be determined based on an autopsy, an investigation of the place where the infant died, and a review of the infant's medical history. We believe that a safe sleep environment for infants helps lower the chances of an infant dying from SIDS, and that parents and child care providers can work together to provide a safe sleep environment. The Clay Center will implement the following safe sleep practices.

Safe Sleep Practices

1. All caregivers will receive in-person or online training on infant safe sleep based on AAP safe sleep recommendations. This training must be completed within 30 days of employment or volunteering and will be completed every three years
2. Infants will always be placed on their **backs to sleep**, unless there is a signed *Alternate Sleep Position Waiver*- Health Care Professional Recommendation in the infant's file. A waiver notice will be posted at the infant's crib.
3. When babies can easily turn over from the back to the stomach, they will be placed to sleep on their backs and then allowed to adopt the sleep position they prefer. This is in accordance with the American Academy of Pediatrics (AAP) recommendations.
4. Sleeping infants shall have a supervised nap period. When infants are in their cribs, they will be within sight and hearing of staff at all times. Infant rooms will maintain lighting adequate for easy visibility of sleeping infants during naptimes (shades will remain open should the lights be turned off). A staff member will physically walk to cribs to check on the sleeping infants approximately every ten minutes in order to see them if they have difficulty during napping or when they awaken.
5. Staff will reduce the risk of overheating by not over-dressing or over-wrapping the infants. Caregivers will provide physical checks of children to ensure that they are not overheated or in distress.
6. All parents/guardians of infants cared for in the facility will receive a written copy of our Infant/Toddler Safe Sleep Policy before enrollment, will review the policy with staff, and sign a statement saying they received and reviewed the policy.
7. The temperature in the room where the infant(s) sleep will be kept between 68-75°F and monitored by the thermometer kept in the infant sleeping room.
8. To promote healthy development, awake infants will be given supervised "tummy time" for exercise and for play.

Safe Sleep Environment

9. Infants' heads will not be covered with blankets or bedding. Infants' cribs will not be covered with blankets or bedding.
10. No loose bedding, pillows, bumper pads, etc. will be used in cribs.
11. Toys and stuffed animals will be removed from the crib when the infant is sleeping. When indicated on the Infant and Toddler Feeding and Care Plan or with written parent consent, pacifiers will be allowed in infants' cribs while they sleep. The pacifier cannot have cords or attaching mechanisms.
12. Sitting devices such as car safety seats, strollers, swings, infant carriers, infant slings, and other sitting devices will not be used for sleep/nap time. Infants who fall asleep anywhere other than a crib, portable crib, or playpen must be placed in the crib or playpen for the remainder of their sleep or nap time.
13. Each infant will sleep have his or her own crib. Only one infant will be in a crib at a time, unless we are evacuating infants in an emergency. A safety-approved crib with a firm mattress and tight fitting sheet will be used.
14. Home monitors or commercial devices marketed to reduce the risk of Sudden Infant Death Syndrome (SIDS) shall not be used in place of supervision while children are napping and sleeping. Equipment, such as sound machines, which can interfere with the caregiver's ability to see or hear a child in distress, will not be used at the Clay Center.
15. No smoking is permitted in the infant room or on the premises.

Distribution: Parents and staff will review the policy. One copy signed by parent(s)/guardian(s) will be given to parent(s)/guardian(s) and one copy will be kept in child's facility record.

I, the undersigned parent or guardian of _____ (child's full name/enrollment date), do hereby state that I have read and received a copy of the facility's Infant/Toddler Safe Sleep Policy and that the facility's director (or other designated staff member) has discussed the facility's Infant/Toddler Safe Sleep Policy with me.

Signature of Parent or Guardian: _____ Date: _____

Signature of Child Care Provider: _____ Date: _____