HARRIS-STOWE STATE UNIVERSITY | POTENTIAL, POSSIBILITY AND Power

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

William L. Clay Sr. 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.

Interim Director: Treasia Foster (314)340-5066 fostert@hssu.edu

Enrollment: Tonya Jones (314)340-3347 jonesto@hssu.edu

Administrative Assistant: Emma Fox (314)340-5055 foxe@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. (Check or Money Order)

What to Bring:

You may be wondering what to bring. We provide almost everything your child needs her 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, 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 not be accepted into the program until all fees are paid.

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EECC Fee Schedule

Prepared 08/23/2023

Fee Schedule

Ages	Monthly Tuition
Infants (Birth – 12 Months)	$1,294.00
Toddler I 1 year – 2 years	$1,157.00
Toddler II (2 years – 3 years)	$1,035.00
Pre-K (3 years – 5 years)	$909.00

HSSU Subsidized Fee Schedule (Weekly) on for children enrolled in the State Subsidy

Ages	HSSU Subsidy
Infants	$70.00
Toddler I	$80.00
Toddler II	$80.00
Pre-K	$52.00

No other discounts may be applied for any child/children enrolled in State Subsidy.

State Subsidy is based on the State of Missouri (or State of Illinois) rates. Parent payment varies based on State Subsidy received per child.

Other Fees and Adjustments

Other Fees	Amount
Deposit Fee (Application/Enrollment Fee)	$100.00
Returned Check Fee	$45.00
Late Payment Fee – for unpaid balances that exist on the account by the 5th day of the following month.	$25.00
Diapers	Amount of Adjustment
Adjustments	$1.00
Vacation/Family emergency absence only	Regular rates – limit two weeks
Extended Illness	Week 1 – regular rate Week 2 & 3 – 50% of regular rate Week 4 – regular rate

Late Fees

Late pick-up Fee – first 2 occurrences per school year	$1.00 per minute
Late pick-up Fee – after first 2 occurrences per school year	$5.00 per minute

Payments for Late pick-up fees are due the following morning; chronic abuse may result in termination.

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	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

_____
(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

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William L. Clay Sr. Early Childhood Development Center

Parent Manual

Parent Agreement

I, _____, have read and understood the statements presented in the manual, had the opportunity to speak for clarification, and agree with all statements and agree to abide by the policies and procedures as stated in the William L. Clay Sr. Early Childhood Development Center's parent manual. I also agree to become actively involved, as the primary educator of my child/children, with the Center's Staff as a volunteer, participant in family/teacher conferences, and/or resources/support person to insure the success of the Center's operations.

Please sign and return to the Administrative Assistant for filing, Thank you.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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Medical History Form

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 experience:

☐ Measles ☐ German Measles ☐ Mumps ☐ Chicken Pox ☐ Scarlet Fever ☐ Strep Throat

☐ Rheumatic Fever

☐ Other: _____

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Emergency Contact Information

(Please Print)

Name: _____

Address: _____

_____

Phone: _____ Cell: _____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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 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: _____

_____

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2022 through June 30, 2023

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	$25,142	5	$60,070
2	$33,874	6	$68,802
3	$42,606	7	$77,534
4	$51,338	8	$86,266

For each additional family member, add $8,732

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

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) XXX-XX-	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 ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

CACFP-205

MO 580-1314 (2-11)

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DFS/FINANCIAL ASSISTANCE 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 owes to 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. <u>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.</u>** The Clay Center fees are based on enrollment, and not attendance.

4. It is your responsibility to renew you 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 understood the policies and procedures as stated above and as stated in The Clay Center Parent Manual."

Signature: _____ **Date:** _____

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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

(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: _____

_____

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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 website entries, without payment or any other consideration. Please understand that there are no royalty opportunities offered for appearing in any of Harris-Stowe photographs.

I understand and agree that these materials are property of Harris-Stowe State University and will not be returned, therefore, Harris-Stowe is authorized 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 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 for all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf of my estate, have or may have reason of this authorization.

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

I do not wish to participate in any pictures or videos _____.

Signature: _____

Print Name: _____

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

SAVE PRINT RESET

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

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

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

MO500-3306 (Rev 10-21)

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
Milk			
Table Food			

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/USDAOASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 6329992, 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 mail to U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, by fax (833) 256-1665 or (202) 690-7442, or email at program.intake@usda.gov. This institution is an equal opportunity provider.

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

CACFP 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:_____

This center/home/ministry participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants and children. Participation in this program requires caregivers to follow specific meal patterns according to the age of the child being fed.

Policy requires a center/home/ministry participating in the CACFP to offer formula to infants who are in care during meal service times. Parents/guardian, however, may decline what is offered and supply the infants formula.

Please mark your preference (chose all that apply)	Today's Date _____ Birth – 3 months	Today's Date _____ 4 – 7 months	Today's 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: _____			

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	Today's Date _____ 4 – 7 months	Today's 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 foods for my infant when he/she is ready for it.		

Signature of Parent/Guardian_____ Date_____

1. This form must be kept on file for each infant enrolled for child care.
2. As situations change, such as a medical authority changing the infant's formula, a new form should be completed.
3. This form must be kept current and accurate for each infant enrolled for child care until the infant reaches one year of age or is no longer on infant formula.
4. If the parent/guardian declines the formula and the provider provides meal and/or snack components, the meal may be claimed for reimbursement.
5. If the parent/guardian declines infant meals/snack, meals and snacks may NOT be claimed for reimbursement.

Revised January 2016

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: _____