



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

CHILD'S NAME		SEX	BIRTH DATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		HOME TELEPHONE NUMBER ( )	

OPTIONAL

<b>SCHOOL CHILD ATTENDS</b>	
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	

<b>IDENTIFYING INFORMATION</b>	
MOTHER'S OR GUARDIAN NAME	HOME TELEPHONE NUMBER ( )
ADDRESS <input type="checkbox"/> CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.)	CELL PHONE NUMBER (OPTIONAL) ( )
EMPLOYED BY (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO
ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )
FATHER'S OR GUARDIAN'S NAME	HOME TELEPHONE NUMBER ( )
ADDRESS <input type="checkbox"/> CHECK HERE IF SAME AS CHILD. (OR LIST STREET, CITY, STATE, ZIP CODE.)	CELL PHONE NUMBER (OPTIONAL) ( )
EMPLOYED BY (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO
ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )
	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	RELATIONSHIP

OPTIONAL

<b>PERSONS AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY (ONE REQUIRED)</b>	
NAME	NAME

<b>COMMENTS ON CHILD'S DEVELOPMENT</b> (NOTE ALLERGIES, HABITS, SPECIAL LANGUAGE, ETC.)

<b>TO BE COMPLETED BY CHILD CARE FACILITY (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)</b>	
FACILITY NAME	ADMISSION DATE
ENROLLED FOR (DAYS OF THE WEEK)	FULL TIME/PART TIME
HOURS PER DAY	



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

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE
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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.)

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SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE
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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
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Copy of Immunization Record



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**PARENT'S SPECIALIZED INSTRUCTIONS FOR INFANTS AND TODDLERS**

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED
<b>INSTRUCTIONS TO PARENTS:</b> <ul style="list-style-type: none"> <li>• Please complete for child who is less than 24 months of age.</li> <li>• Update diet information as needed until child is on complete table food. Use a new form or initial/date changes on this form.</li> </ul>		
<b>FEEDING METHOD</b>		
(Check all that apply.)		
<input type="checkbox"/> SPOON <input type="checkbox"/> CUP <input type="checkbox"/> BOTTLE <input type="checkbox"/> WARM BOTTLE <input type="checkbox"/> HOLDS OWN BOTTLE <input type="checkbox"/> FEEDS SELF <input type="checkbox"/> FEEDING TABLE OR CHAIR		
<b>TYPE OF FOOD</b>	<b>FEEDING TIME</b>	<b>KINDS OF FOOD</b>
FORMULA		
WHOLE MILK		
INFANT FOOD		
JUNIOR FOOD		
TABLE FOOD		
<b>ARRANGEMENTS FOR SLEEP</b>		
<i>(The American Academy of Pediatrics and other nationally recognized authorities for infant health advise that infants should be placed on their backs to sleep to reduce the risk of Sudden Infant Death Syndrome.)</i>		
I give permission for my child to sleep on a _____ and I give permission for my child to sleep on a _____		
(PARENT'S SIGNATURE)		(DATE)
<b>DIAPERING INSTRUCTIONS</b>		
I give permission for caregivers to use _____ on my child for:		
<small>(Lotions and/or ointments, etc. that I have provided)</small>		
<input type="checkbox"/> WET <input type="checkbox"/> BOWEL MOVEMENT <input type="checkbox"/> RASH <input type="checkbox"/> OTHER		
<b>SPECIAL INSTRUCTIONS FOR CARE (Restrictions, allergies, etc.)</b>		
PARENT/LEGAL GUARDIAN SIGNATURE		DATE

## CHESTERFIELD CHILDREN'S CENTER

### INFANTS

Diapers  
 Wipes  
 Ointment  
 Formula  
 Jar food  
 Oatmeal  
 Bottles (pre-mixed)  
 Diaper bag  
 Sippy cup  
 Extra clothing

### TWO'S

Diapers  
 Wipes  
 Ointment  
 Back pack  
 2 pairs extra clothing  
 Blanket sheet

### FOUR'S

Back pack  
 2 pairs extra clothing  
 Blanket  
 Sheet

### TODDLERS

Diapers  
 Wipes  
 Ointment  
 Diaper bag  
 2 pairs extra clothing  
 Blanket  
 Sheet

### THREE'S

Diapers/Pull-ups  
 Wipes  
 Ointment  
 Back pack  
 2 pairs extra clothing  
 Blanket  
 Sheet

### PRE-K

Back pack  
 2 pairs extra clothing