

The Christian Academy

Nursery –Preschool – Schoolagers



Enrollment Pack

“Train up a child in the way he should go...”
Proverbs 22:6

Dr. Mary Crockett-Smith
Executive Director

The Christian Academy Too
8923 Riverview Drive
St. Louis, MO 63137
314.455.4172

The Christian Academy
11621 W Florissant Ave
Florissant, Mo 63033
(314) 838- DOER (3637)

The Christian Academy

Infant Supply List

- Prepared bottles with Tops (Full Day Required)
- Cot Sheet & Extra Clothes with Name on it (Summer, Spring, Winter, Fall)
- Baby food and cereal when age appropriate
- Diapers (5-7/day or 25-35/week)
- Wipes (2-4/changing or 15-20/day or 40-50/week)
- Diaper ointment (If Applicable)
- Pacifiers (If Applicable)
- Extra formula (for emergency use only)
- Diaper bag (large enough to store empty bottles and clothes that may be sent home)

Please Remember:

- Please label all items with child's first and last name.
- All medication, creams and sunscreens to be applied require a completed medical authorization form and must be kept in their original containers with your child's full name on it.
- All prescriptions must be in the original containers with the patient's name, dosage and prescribed time to be given. The doctor must complete a medical form before medication can be administered.
- Any over the counter medications (Tylenol, Motrin, etc.) require a permission form from your doctor which must include the proper dosage for your child's weight, age and the reason why it is to be administered.



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

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

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	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

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)		

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

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

WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME CHECK WHAT DAYS THE CHILD WILL ATTEND		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
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	

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

<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

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 <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
G	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
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CACFP REQUIREMENT	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, 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/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.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.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
 CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
CACFP ENROLLMENT FORM FOR CHILD CARE CENTERS

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

CHILD'S FULL NAME		DATE OF BIRTH	
PARENT OR GUARDIAN NAME		STREET ADDRESS	
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER ()
NAME OF CHILD CARE CENTER			PHONE NUMBER ()
CENTER CONTACT PERSON'S NAME		CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)	

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE	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.
MON	AM PM	AM PM	
TUES	AM PM	AM PM	
WED	AM PM	AM PM	
THURS	AM PM	AM PM	
FRI	AM PM	AM PM	
SAT	AM PM	AM PM	
SUN	AM PM	AM PM	

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

- | | | |
|---|---|---|
| <input type="checkbox"/> FULL DAY CARE | <input type="checkbox"/> BEFORE SCHOOL CARE | <input type="checkbox"/> EVENING CARE |
| <input type="checkbox"/> HALF DAY - MORNING | <input type="checkbox"/> AFTER SCHOOL CARE | <input type="checkbox"/> OVERNIGHT CARE |
| <input type="checkbox"/> HALF DAY - AFTERNOON | <input type="checkbox"/> BEFORE AND AFTER SCHOOL CARE | |

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

- | | | |
|--|--|--|
| <input type="checkbox"/> BREAKFAST | <input type="checkbox"/> LUNCH | <input type="checkbox"/> SUPPER |
| <input type="checkbox"/> MORNING SNACK | <input type="checkbox"/> AFTERNOON SNACK | <input type="checkbox"/> EVENING SNACK |

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

- | | |
|--|--|
| <input type="checkbox"/> NEW YEARS DAY (JANUARY 1) | <input type="checkbox"/> INDEPENDENCE DAY (JULY 4) |
| <input type="checkbox"/> MARTIN LUTHER KING'S BIRTHDAY (JANUARY) | <input type="checkbox"/> LABOR DAY (SEPTEMBER) |
| <input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY) | <input type="checkbox"/> THANKSGIVING DAY (NOVEMBER) |
| <input type="checkbox"/> MEMORIAL DAY (MAY) | <input type="checkbox"/> CHRISTMAS DAY (DECEMBER 25) |

SIGNATURE OF PARENT OR GUARDIAN	DATE
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ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIALED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM.

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



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):	SNAP (Food Stamp)	TEMPORARY ASSISTANCE
		YEAR MONTH 2 X A MONTH EVERY 2 WEEKS WEEKLY	<input type="checkbox"/>	<input type="checkbox"/>

Eligibility Determination: Free Reduced Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
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The Christian Academy Registration Contract

This agreement is made by and between TCA One and Two _____ Parent(s)/Guardian(s) of _____, The following has been agreed/upon between the two parties beginning _____: I have read and agree to full contents enrollment, I understand that I must follow the termination and vacation policies as it is written in the **Parents' Handbook**. I agree to pay the weekly rate of _____, to be paid the **Monday or before the week begins** for my child(ren). Our arrival time will be _____, and pick up time will be no later than _____ Monday through Friday. Any added time before or after those time will be discussed beforehand and / or will be subject to late pickup fees \$15 for every minute segment.

This agreement shall be in effect until which time parent/guardian or provider has given termination notice in accordance to the Parent Handbook policy or negotiation of a new contract. I agree to pay a registration fee of \$_____ to hold a space until taken and understand that a \$15 late-weekly tuition fee will be added after 6:00pm Monday evening. Tuition not paid Tuesday by 6:00pm will result in suspended enrollment until tuition is paid in full*, Also I understand and agree that my registration fee is nonrefundable and will only hold your space until the date above. In the event I choose not to enroll my child with this provider the registration fee is non-refundable.

Parent(s) Requirement for Communication through Tadpole

Email Address _____ Email Address _____

Parents Must Sign or Parent/Guardian with Sole Custody of the Child(ren)

Parent(s)/Guardian

Date

Mom Phone #

Dad Phone #

*This will include late penalties, as stated in the policy, from date due to date paid, plus legal fees if applicable.



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
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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.

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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
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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.

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 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
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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:

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Special Instructions for Care (e.g., restrictions, allergies, etc.):

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Signature of Parent/Legal Guardian	Date
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The Christian Academy's Infant Safe Sleep Policy

The Christian Academy's infant safe sleep policy shall comply with section 210.223, RSMo, and shall include, but not be limited to:

A. The following safe sleep practices will be followed according to State Rules:

1. The policy shall list the licensee's expectations regarding how and when caregivers are to be trained on safe sleep;

- All TCA caregivers will be trained within 30 days of employment

2. A requirement that children less than one (1) year of age be placed on their backs to sleep;

- TCA requires that all 1 year or younger will be placed on their backs to sleep

3. A requirement that the facility shall receive a written statement from the infant's licensed health care provider stating that the infant requires alternative sleep positions or special sleeping arrangements that differ from those set forth in 19 CSR 30-62.182(2)(C) prior to allowing the infant to be placed in a sleep position that is not on his or her back;

- TCA requires a doctors statement that the infant with alternative sleep positions or special sleeping arrangements that differ from those set forth in 19 CSR 30-62.182(2)(C) prior to allowing the infant to be placed in a sleep position that is not on his or her back;

4. TCA requires supervision of infants during nap/sleep times, to include:

- a. Positioning of staff,
- b. Lighting in the nap room,
- c. Physical checks of the child to ensure he or she is not overheated or in distress, and
- d. Prohibitions against the use of any equipment such as a sound machine that may interfere with the caregiver's ability to see or hear a child who may be distressed.

5. The following requirements for safe sleep environments:

1. The policy shall state that cribs and playpens must have a firm mattress and tight fitting sheets, be free of loose bedding, bumper pads, pillows, and soft toys;
 - TCA requires that cribs and playpens must have a firm mattress and tight fitting sheets, be free of loose bedding, bumper pads, pillows, and soft toys;

2. Shall require infants' heads be uncovered during nap/sleep times;
 - TCA requires infants' heads be uncovered during nap/sleep times;

3. Shall prohibit covering cribs or playpens with blankets or bedding;
 - TCA prohibits covering cribs or playpens with blankets or bedding

- ~~4.~~ Shall prohibit smoking in the child care home during the hours children are in care;
 - TCA prohibits smoking in the child care home during the hours children are in care

5. Shall require giving the parent(s) or guardian(s) of each infant in care a copy of the provider's safe sleep policy upon the child's enrollment.
 - TCA requires that every parent(s) or guardian(s) of each infant in care a copy of the provider's safe sleep policy upon the child's enrollment.

The Christian Academy

IT Individual Care Plan &
Family Information Form

Child:	Date of Birth:
Parent:	Teacher:
Date:	

Arrival

What time will you usually arrive at the center?

What will help you and your child say good-bye to each other in the morning?

Diapering and Toileting

What type of diapers do you use?

How often do you change your child's diaper? When does your child usually need a diaper change?

Are there any special instructions for diaper changes?

Is your child beginning to use the toilet? If so, are there any special instructions for toileting?

Sleeping

How will we know that your child is tired and needs to sleep?

When does your child usually sleep? For how long does he or she usually sleep?

What helps your child to fall asleep?

We put babies to sleep on their backs. Is your baby used to sleeping on his or her back? Y / N

How does your child wake up? _____ Does he or she wake up quickly or slowly?

Does your child like to be taken out of the crib immediately or to lie alone in the crib for a few minutes before being held?

Departure:

What time will you usually come to pick up your child?

What will help you and your child say hello to each other at the end of the day?

Awake Time:

How does your baby like to be held? What position does your baby prefer when awake?

What does your child like to do when awake?

How do you play with your child?

Eating Babies:

Are you breast-feeding or bottle-feeding your baby?

If breast-feeding, will you come to the center to breast-feed? Y / N

If so, at what time?

If not, will you send expressed breast milk?

Bottle-feeding.

What kind of formula do you use?

How do you prepare the bottles?

How much do you prepare at one time?

How much does your baby drink at one time?

Does your baby drink bottles of water during the day? Y / N If so, when and how much?

Is your baby eating solid foods? Y / N If so, which ones?

When? _____ How do you prepare you baby's solid foods?

How much does your baby eat at one time?

How is your baby used to being fed (in what position)?

Does your baby eat any finger foods? If so, which ones?

All Children:

What are some of your child's favorite foods?

What foods does your child dislike?

Is your child sensitive or allergic to any foods? Is so, please list them?

Are there any foods that you don't want your child to eat?



• • • Student Information • • •

Name: _____ Date of birth: _____

Address: _____

Parent/guardian: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Parent/guardian: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Emergency contacts: _____

name phone

name phone

Transportation to and from school:

walks _____ rides bus _____ (# _____) other _____

Allergies: _____

Other medical information: _____

Additional information:

The Christian Academy

Photo Release

Parental/Guardian Consent Photo Release Contract

We are sending you this parental consent form to both inform you and to request permission for your child (ren)'s photo/image. **NO** personally identifiable information will be published on the TCA web site as well as other forms of expressions. **The law requires that we ask for your permission to use information about your child.**

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the management of TCA and such rescission will take effect upon receipt by approved management staff.

Check one of the following choices:

I/We GRANT permission for a photo/image that includes my child(ren) without any other personal identifiers to be published on TCA's public Internet site.

I/We DO NOT GRANT permission for photo/image that includes my child(ren) to be published on TCA's public Internet site.

Child's Name: (please print) _____

Print name of Parent/Guardian: (print)

Signature of Parent/Guardian: (sign)

Relation to Student: _____

Date: _____

The Christian Academy
Enrollment Application

Child's Name _____

Is your child potty trained? _____ What do you say when he/she wants to use the toilet? _____

Does your child need help in: Dress/Undressing _____ Eating _____ Washing Hands _____

Does your child have any special fears or problems? _____

Has your child been cared for by other than parents? _____ If yes, whom? 1. _____

2. _____

Favorite past time activity: _____

Parent Agreement

The Christian Academy opens at 6 am to 9 pm for children age 2 1/2 to 16. Parents are allowed to have their child attend a maximum of a 10 hour day per day.

- A late fee will be charged for late pick-ups.
- I agree to pay in advance each week tuition and/or co-payment.
- I agree that I am enrolling for _____ days per week at a cost of _____.
- I understand and agree that, in the event my account becomes over 7 days due, The Christian Academy will accept my child until the balance is paid current.
- I am aware that a \$10 late charge will be charged for payment received after Monday.
- There is a \$25 fee for return checks.
- I agree to pay a registration fee at the time of enrollment to be renewed each September
- Enrollment fee is not refundable.
- I have received by parent handbook, containing additional polices and procedures.

Parent Signature _____ Date _____

THIS FORM MUST BE RETURNED AND SIGNED BEFORE ACCEPTANCE IS THE ACADEMY

Teacher Form

THE CHRISTIAN ACADEMY
Discipline Policy

It is the policy of The Christian Academy and the State of Missouri that punishment, which includes but is not limited to spanking, slapping, shaking, biting, or pulling hair shall be prohibited. No discipline techniques that may be humiliating, threatening, or frightening to children will be used. Children will not be shamed, ridiculed, or spoken to harshly, abusively, or with profanity.

The Christian Academy does, however, prescribe the following methods as appropriate behavior management:

Verbal Reasoning
Time Out

Parents will be notified if their child(ren) presents unacceptable behavior, such as fighting, biting, yelling, screaming, tantrums, profanity, mischief, violent and destructive play habits, or lack of respect for authority. The Christian Academy will work with parents in correcting any of the above unacceptable behaviors.

Any children consistently disciplined for unacceptable behavior will have up to one month to modify his/her behavior. If there is no change, The Christian Academy has the right to terminate the child's enrollment.

I have read the above policy and will adhere to the following information.

Parent Signature/Legal Guardian

Date

Parent Signature/Legal Guardian

Date

Witness

Date

**THE CHRISTIAN ACADEMY
EMERGENCY MEDICAL & MEDICATION TREATMENT FORM**

In case of an emergency illness or accident, the child(ren) is given first-aid and the parent(s) are notified. If the parent(s) or the child's physician can not be reached, the child(ren) will be taken to the emergency room of the hospital of your choice.

The Christian Academy does not assume responsibility for the payment of hospital, doctor, or ambulance fees.

Parent(s)/Guardian Agreement:

In the event I can not be reached to make arrangements for emergency medical care at the time of an accident or illness, I hereby authorize The Christian Academy to take my child(ren) _____ to:

Child(ren) Name

Doctor or Pediatrician

_____ Christian Hospital Northeast, 11133 Dunn Road, St. Louis, MO 63136

I have read the following statements and will adhere to the following.

Parent Signature/Legal Guardian

Date

Parent Signature/Legal Guardian

Date

Witness

Date

The Christian Academy

Dear Parent(s):

Please read and sign the attached agreement:

I hereby agree to comply with the rules and regulations of The Christian Academy regarding fees, attendance, health, clothing, and other items specified in the Parent's Handbook issued by the Academy each year.

I hereby agree to notify the school two weeks in advance of withdrawal, should such event occur, or pay the difference.

I have read the above statement to the effect that no refund of tuition can be given.

Parent Signature/ Legal Guardian

Date

Parent Signature/ Legal Guardian

Date

Witness

Date

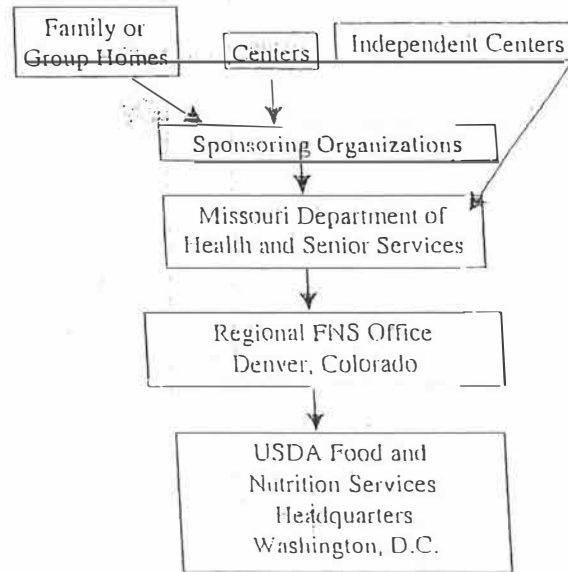
How does CACFP work?

CACFP reimburses participating centers and child care homes for serving nutritious meals. CACFP is administered at the federal level by the Food and Nutrition Service (FNS), an agency of the U.S. Department of Agriculture.

The Missouri Department of Health and Senior Services (MDHSS) administers the CACFP. MDHSS approves sponsoring organizations and independent centers to operate the program on the local level. MDHSS also monitors the program and provides guidance and assistance to assure that sponsors and centers are meeting requirements.

Sponsoring organizations play a critical role in supporting home child care providers and centers, through training, technical assistance, and monitoring. All family or group child care homes must participate through a sponsoring organization. Several types of organizations can be approved to serve as sponsors, e.g., community action groups, nonprofit organizations and churches.

CACFP Network



If you are interested in the CACFP, or have questions about the Program, call 1-800-733-6251 or access our website at: www.dhss.mo.gov/cacfp

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services (800) 733-6251 (voice). TDD users can access the preceding number by calling (800) 735-2966. EEO/AAP services are provided on a non-discriminatory basis.

8/08

The Missouri Child and Adult Care Food Program (CACFP)



Building for the Future

Missouri Department of Health
and Senior Services
Bureau of Community Food and
Nutrition Assistance
September 2008