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
8923Riverview 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

School Supply List

Preschoolers:

- 1 sheet and 1 blanket (please mark tags with your child's name).
- one change of clothes for the season (marked with your child's name on each item. A Shirt, pants,underwear and socks.)
- 1 box of 24 ct. crayola crayons*
- 1 box of large crayola crayons*
- 1 pack of pencils*
- 2 boxes of kleenex*
- 2 packets of wet wipes unscented*
- Ziploc bags (1 large and 1 small box)*

*these items are for community use in classrooms

It is **Mandatory** by state law all children have two items of linen for nap. All linen will be sent home every **Friday** to be washed and should be returned the following **Monday**.

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
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 ☐	
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 ☐	
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 militaryrelated 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	HOW IS CHILD RELATED TO CHILD CARE PROVIDER

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

WILL CHILD ATTEND: ☐FULL TIME ☐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	☐	☐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	

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 YEAR'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 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

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 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 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

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, 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/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 DEPARTMENTOF 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
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

WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION.

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

- ☐ FULL DAY CARE
- ☐ HALF DAY – MORNING
- ☐ HALF DAY – AFTERNOON
- ☐ BEFORE SCHOOL CARE
- ☐ AFTER SCHOOL CARE
- ☐ BEFORE AND AFTER SCHOOL CARE
- ☐ EVENING CARE
- ☐ OVERNIGHT CARE

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

- ☐ BREAKFAST
- ☐ MORNING SNACK
- ☐ LUNCH
- ☐ AFTERNOON SNACK
- ☐ SUPPER
- ☐ EVENING SNACK

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

- ☐ NEW YEARS DAY (JANUARY 1)
- ☐ MARTIN LUTHER KING'S BIRTHDAY (JANUARY)
- ☐ PRESIDENT'S DAY (FEBRUARY)
- ☐ MEMORIAL DAY (MAY)
- ☐ INDEPENDENCE DAY (JULY 4)
- ☐ LABOR DAY (SEPTEMBER)
- ☐ THANKSGIVING DAY (NOVEMBER)
- ☐ CHRISTMAS DAY (DECEMBER 25)

SIGNATURE OF PARENT OR GUARDIAN	DATE

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.

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

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)	DATE
	XXX-XX-	/ /
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

MO 580-1314 (2-11) CACFP-205

The Christian Academy
Registration Contract

This agreement is made by and between TCA One and Too _____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.**

Revised January 2018

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

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:

Use with "Class Information Booklet" on page 84.

TCA Emergency Contact Information

Child's Name:_____ Birthdate:_____

Home Address: _____ City: _____ Zip:_____

Mother/Guardian: _____

Home Address:_____ City:_____ Zip:_____

Email:_____ Employment: _____

Contact Person at work (Who usually knows your Whereabouts):_____

Employment # _____ Address:_____

Father/Guardian: _____

Home Address:_____ City:_____ Zip:_____

Email:_____ Employment: ___ -----_____

Contact Person at work (Who usually knows your Whereabouts):_____

Employment #: _____ Address:_____

Emergency Name 1:_____ Cell#:_____

Relationship: _____ Work #_____

Email: _____ Home# _____

Emergency Name 2:_____ Cell#:_____

Relationship: _____ Work #_____

Email: _____ Home# _____

Out-Of-Town
Emergency Name 1:_____ Cell#:_____

Relationship: _____ Work #_____

Email: _____ Home# _____

TCA1 - 11621 W. Florissant Florissant, MO 63034 314.838.3637
TCA2 - 8923 Riverview Drive St. Louis, MO 63137 314.455.7146

TCA Emergency Contact Information

Out-Of-Town
Emergency Name 2:_____ Cell#:_____

Relationship: _____ Work #_____

Email: _____ Home# _____

Person's Authorized to Pick Up

Name:_____ Phone#:_____

Name:_____ Phone#:_____

Name:_____ Phone#:_____

Name:_____ Phone#:_____

Child's Medical Care

Physician's Name: _____ Phone #_____

Hospital:_____

Dentist:_____ Dentist #_____

Child's Health Insurance:_____

ID #:_____ Group #:_____

Policy Holder:_____ Phone #:_____

Special Conditions, Disabilities, Allergies or Medial Info for Emergencies:

_____

_____

_____

Parent/Legal Guardian Consent and Agreement for Emergencies As parent/legal guardian, I give consent to have my child receive first aid by facility staff/teacher and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I agree to review and update this information whenever a change occurs and at least once a year.

Parent/Guardian: _____. Date:_____

Parent/Guardian: _____. Date:_____

TCA1 - 11621 W. Florissant Florissant, MO 63034 314.838.3637
TCA2 - 8923 Riverview Drive St. Louis, MO 63137 314.455.7146

RELEASE AUTHORIZATION FOEM

The Christian Academy is authorized to release my child(s) to:

Name: _____

Relationship: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

~~Driver's License #~~: _____

~~Social Security #~~: _____

***

Name: _____

Relationship: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

~~Driver's License #~~: _____

~~Social Security #~~: _____

Dear Parents

As of June it is Mandatory that we have a work and/or school schedule EVERY WEEK stating the time your child/children will arrive and depart from the center. This statement is a requirement that is necessary for us to maintain the correct teacher to student ratio. If we do not have a current weekly work or school schedule upon the arrival of your child/children we will not be able to accept them. Also, if you are 15 minutes late picking up your child/children a late fee of $15 will be asked upon your arrival or the next day. Please sign this letter and return it to your child's teacher.

Parent Signature:_____

Dear Parents,

As of June, it is Mandatory that we have a work and/or school schedule EVERY WEEK stating the time your child/children will arrive and depart from the center. This statement is a requirement that is necessary for us to maintain the correct teacher to student ratio. If we do not have a current weekly work or school schedule upon the arrival of your child/children we will not be able to accept them. Also, if you are 15 minutes late picking up your child/children a late fee of $15 will be asked upon your arrival or the next day. Please sign this letter and return it to your child's teacher.

Parent Signature:_____

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: _____

Updated on 11-1-2013 CR

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 ½ 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 Tom

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
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***

11621 West Florissant *Florissant, MO 63033* *(314) 838-DOER(3637)*

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

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2020 through June 30, 2021

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	$23,606	5	$56,758
2	$31,894	6	$65,046
3	$40,182	7	$73,334
4	$48,470	8	$81,622

For each additional family member, add $8,288

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

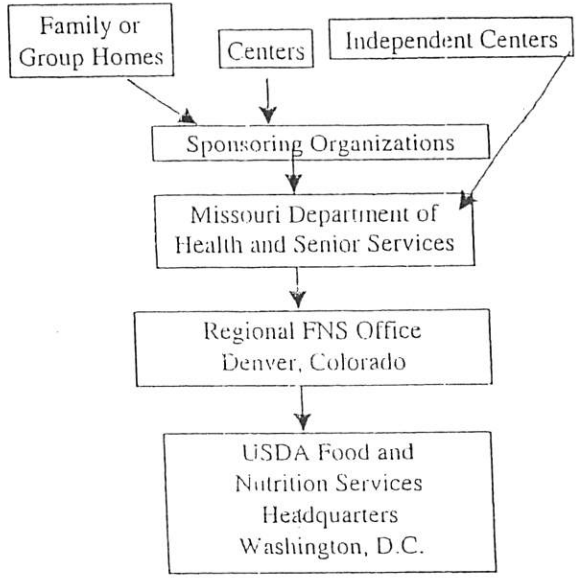
How does CACFP work?

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.

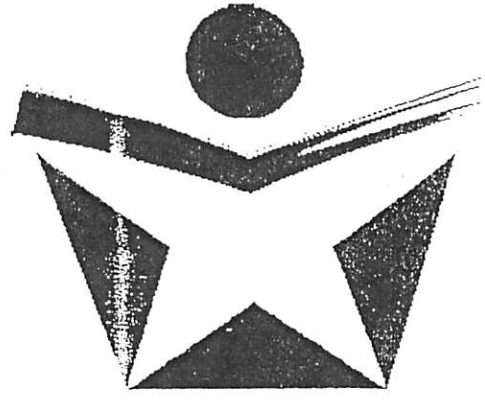
CACFP Network



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

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