



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>	TELEPHONE NUMBER
	NAME <i>Agape Academy &amp; Child Development Center</i>	<i>(314) 725-5262</i>
ADDRESS (STREET, CITY, STATE, ZIP CODE) <i>7400 Olive Blvd., University City, MO 63130</i>		

<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 ( )

<b>EMERGENCY CONTACT(S) (ONE REQUIRED)</b>	
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	RELATIONSHIP
NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP CODE)	RELATIONSHIP

<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 FROM TO	
DISCHARGE DATE	

CHILD'S NAME

## AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize

Agape' Academy & Child Development Center  
PROVIDER/LICENSEE

to contact the following:

## PHYSICIAN OR CLINIC

(Please list name and phone number of physician and/or clinic.)

NAME

TELEPHONE

( )

ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL

## PREFERRED HOSPITAL

(Please list name and phone number of hospital.)

NAME

TELEPHONE

( )

ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL

## TRANSPORTATION TO AND FROM SCHOOL

I ☐ (DO) ☐ (DO NOT) GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD TO AND FROM SCHOOL.

## FIELD TRIPS

I UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSIONS AND THAT I WILL BE NOTIFIED WHEN THEY ARE PLANNED.

## ACKNOWLEDGEMENTS

- A) I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.
- B) I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CHILD CARE CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.
- C) THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR AND INDIVIDUAL NEEDS.
- D) WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.

PARENT/LEGAL GUARDIAN SIGNATURE

DATE