



2416 Swope Parkway - Kansas City, MO 64130
(816) 921-3164 Fax – (816) 861-1270

Dear Parent(s),

Thank you for your interest in Emmanuel Family & Child Development Center. We are eager to offer your child(ren) quality childcare services.

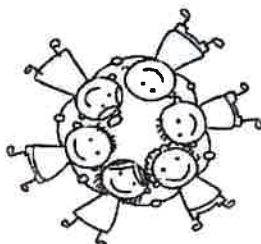
The following items are required to enroll your child:

- ☐ \$30 Registration Fee (This fee is per family and is due on or before the start date.)
- ☐ Enrollment Form
- ☐ Immunization Record
- ☐ Medical Examination Report
- ☐ Infant & Toddler Feeding Care Plan
- ☐ Income Eligibility Form (Please complete one per family.)
- ☐ Photography and Videotaping Release
- ☐ Childcare Payment Agreement
- ☐ Authorization for Pick-up
- ☐ Parent Consent to Evaluation
- ☐ Parent & Child's Social Security Cards
- ☐ Child's Medical Insurance Card
- ☐ Parent/Guardian Photo ID
- ☐ Foster Child Placement Papers
- ☐ Current Picture of your child

After your child has been accepted for enrollment you will receive a Parent Handbook. Please refer to the Parent Handbook for the policies and procedures of the Center.

If you are receiving state assistance from the state for childcare services you will need to notify your case worker immediately with EFCDC DVN#, which is 001478584. The number to childcare authorization services is 1-855-373-4636. If you are paying for childcare services privately, please see the office about the fee schedule.

Once again, thank you for your interest in our Center. We hope to welcome you and your family to our Center soon!





MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE
CHILD CARE ENROLLMENT FORM

SAVE**PRINT****RESET**

FACILITY/PROVIDER NAME Emmanuel Family & Child Development Center	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE <input type="checkbox"/>	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

**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 NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

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

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RELATED CHILD☐ YES ☒ NO HOW IS CHILD RELATED TO CHILD CARE PROVIDER?**CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED**

CACFP REQUIREMENT	CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: <input type="checkbox"/> FULL TIME OR <input type="checkbox"/> PART TIME		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 INCLUDING SHIFT CHANGES.
	MONDAY	<input type="checkbox"/>	AM PM	AM PM	
	TUESDAY	<input type="checkbox"/>	AM PM	AM PM	
	WEDNESDAY	<input type="checkbox"/>	AM PM	AM PM	
	THURSDAY	<input type="checkbox"/>	AM PM	AM PM	
	FRIDAY	<input type="checkbox"/>	AM PM	AM PM	
	SATURDAY	<input type="checkbox"/>	AM PM	AM PM	
	SUNDAY	<input type="checkbox"/>	AM PM	AM PM	

CACFP REQUIREMENT	CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY			
	<input type="checkbox"/> BREAKFAST	<input type="checkbox"/> MORNING SNACK	<input type="checkbox"/> LUNCH	<input type="checkbox"/> AFTERNOON SNACK
	<input type="checkbox"/> SUPPER		<input type="checkbox"/> EVENING SNACK	<input type="checkbox"/> 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 checked="" type="checkbox"/> COLUMBUS DAY (OCTOBER)	
<input checked="" type="checkbox"/> VETERANS DAY (NOVEMBER)	<input checked="" type="checkbox"/> ELECTION DAY (NOVEMBER)	<input type="checkbox"/> THANKSGIVING (NOVEMBER)	<input type="checkbox"/> CHRISTMAS DAY (DECEMBER)	
AUTHORIZATION FOR EMERGENCY MEDICAL CARE				
<p>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.</p> <p>IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE</p> <p style="text-align: center;">Emmanuel Family & Child Development Center</p> <p style="text-align: center;">DAY CARE PROVIDER OR HOME PROVIDER</p> <p>TO CONTACT THE FOLLOWING:</p>				
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 HOMES 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	<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	<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	
CACFP REQUIREMENT	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE	
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE	
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE	



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



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: Enfamil w/ Iron

(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

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.

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal and, where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. USDA is an equal opportunity provider and employer.

Toddler Feeding Preference (12 through 23 months)			
Check all that apply: <input type="checkbox"/> Spoon <input type="checkbox"/> Cup <input type="checkbox"/> Feeds Self <input type="checkbox"/> 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	
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.			
<input type="checkbox"/> 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 <input type="checkbox"/> Wet <input type="checkbox"/> Bowel Movement <input type="checkbox"/> Rash <input type="checkbox"/> Other			
<input type="checkbox"/> 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	



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Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2016 through June 30, 2017

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	Yearly Income	Family Size	Yearly Income
1	\$21,978	5	\$52,614
2	\$29,637	6	\$60,273
3	\$37,296	7	\$67,951
4	\$44,955	8	\$75,647

For each additional Family Member, add +\$7,696

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,

Emmanuel Family & Child Development Center

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

This statement implementation date is November 2015.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM
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 <input type="checkbox"/>	MONTHLY <input type="checkbox"/>	2 X A MONTH <input type="checkbox"/>	EVERY 2 WEEKS <input type="checkbox"/>	WEEKLY <input type="checkbox"/>
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 <input type="checkbox"/>	ASIAN <input type="checkbox"/>	BLACK OR AFRICAN AMERICAN <input type="checkbox"/>	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/>	WHITE <input type="checkbox"/>
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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
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 <input type="checkbox"/>	MONTH <input type="checkbox"/>	2 X A MONTH <input type="checkbox"/>	EVERY 2 WEEKS <input type="checkbox"/>	WEEKLY <input type="checkbox"/>	SNAP (Food Stamp) <input type="checkbox"/>	TEMPORARY ASSISTANCE <input type="checkbox"/>
Eligibility Determination: <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Paid									
SIGNATURE OF CENTER REPRESENTATIVE								DATE	



FAMILY & CHILD DEVELOPMENT CENTER

2416 Swope Parkway - Kansas City, MO 64130

816-921-3164 FAX 816-861-1270

Photography & Videotaping Release

From time to time Emmanuel Family & Child Development Center or its subsidiaries, or the news media may videotape or photograph your child and/or their class.

By signing my name on this document, I acknowledge and agree:

- That Emmanuel Family & Child Development Center or its subsidiaries have my permission to allow the recording of my child's likeness or photograph for future use.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to my child's participation in activities which may result in such photography or videotaping.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to the use of such photography or videotaping.
- That I and/or my child will receive no financial or in-kind compensation for the use of my child's likeness or image by Emmanuel Family & Child Development Center or its subsidiaries as well as the media.
- This authorization in no way guarantees that my child's likeness or image will be used.

If I do not wish for my child's likeness or image to be used according to such above-stated conditions, I acknowledge and agree that I will provide the Director with written notification of such intent, prior to my child's enrollment within Emmanuel Family & Child Development Center, or at a later date if need should arise.

I hereby authorize my child to participate in activities which may be videotaped or photographed, and acknowledge my understanding and agreement to the terms and conditions stated with this document.

Child's Name

Parent or Guardian Signature & Date



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816-921-3164 FAX 816-861-1270

Childcare Agreement For:

Child's Name and Date of Birth

Child's Name and Date of Birth

Child's Name and Date of Birth

I understand the hours of the program for which I have registered my child and agree to adhere to them promptly. I also understand that I must escort my child into the building and leave him/her in the care of a staff member. The staff will release the child only to the parents or to the persons designated that is 18 years or old.

I further agree to read the Center's guidelines when received and to adhere to those guidelines as stated. I acknowledge that I understand and have received a copy of the Center's current prices and payment policies, including but not limited to the following policies:

- A. All registration fees, activity fees, co-pays, and tuition are non-refundable in whole or in part. I have been informed that the payment is due promptly on Mondays and is late after Friday, at which time late fees may be assessed. EFCDC has the right to terminate the contract due to repeated late payments, returned checks, or in the event that the child(ren)'s behavior endangers the other children or the Provider.
- B. If I receive state childcare assistant, I know I am responsible for making sure that my case remains open during the duration of my child's attendance at the Center or I will be charged full tuition for my children. If my childcare case does close and my children have attended the center after it closes I am responsible for paying full tuition for my children.
- C. Because my child's spot is reserved, I am responsible for payment of tuition/copy even if my child is absent due to sickness, vacation, or any other reason. I understand that a collection agency will be used to collect any monies not paid on this account in the event that I withdrawal my child(ren) from the Center leaving a remaining balance.
- D. I may take up to 2 weeks (as a block of 5 consecutive days each) vacation credit (non-cumulative from year to year) without obligation for tuition if my child has been enrolled for 12 consecutive months on a continuing basis, and provided that I give the Center two weeks' notice of vacation.
- E. Late fees are charged for late payments and pickups.

The Director and staff are available for individual conferenced concerning your child's adjustment to and progress in the school program. If any special problems arise in the school affecting your child, such occurrences will be promptly brought to your attention. In the event of withdrawal from the program, 2 weeks withdrawal notice is required; your regular tuition/co-pay charges continue during this 2 week notice period. A new registration fee will be due upon re-enrollment.

The agreed upon fee for childcare is \$ _____ per week, Overtime services may be provided at the discretion of EFCDC and at the rate of \$ _____ per hour.

Parent or Guardian Signature

Date

Parent Social Security Number

EFCDC Representative

Date



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Authorization for Pick-Up

Child's Name _____

Parent's Name _____

Home #: _____

Work #: _____

Cell #: _____

Person(s) listed below are authorized by the parent/guardian to take their child(ren) from the facility.

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

EF CDC Office Staff will check each person for identification. We will not allow any child to be removed from the Center without proper authorization.



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Parent Consent to Evaluation:

The first five years are very important for your child because this time sets the stage for success in school and later in life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please sign below indicating that you agree to have your child participate in the screening/ monitoring programs used at Emmanuel Family & Child Development Center.

- The Ages & Stages Questionnaires (ASQ-3)
- The Department of Education and Second Education Core Competencies (DESE)
- The Devereux Early Childhood Assessment Development Screenings (DECA)
- Rockhurst University Speech and Language Therapy

Parent or Guardian Signature & Date

Child's Name

Child's Date of Birth

Child's Primary Care Physician



Health Department
City of Kansas City, Missouri

Childhood Lead Poisoning Prevention (816) 513-6048

2400 Troost Avenue, Suite 3400
Kansas City, Missouri 64108

What does lead do to Children?

Lead affects all body systems, but especially the brain and nervous system causing problems such as hyperactivity, learning difficulties, impaired growth, lower IQ.

Where is lead? Everywhere-but particularly:

Lead-based paint, contaminated soil, dust, air, water, hobby supplies, folk medicine, and poorly glazed pottery.

Precautions you can take:

Good nutrition, frequent hand washing and housecleaning to remove lead-contaminated dust, safe clean-up and disposal of paint chips, avoidance of folk remedies and poorly glazed pottery.

CONSENT FORM

I give permission for my child to have a lead screening blood test. I understand this procedure involves a finger stick to obtain a few drops of blood. The test will be performed by nurses from the Kansas City, Missouri Health Department and results may be released to your child's day care program.

****(Please Print)****

Child's Name: _____ Today's Date: _____

Sex: _____ Race: _____ Date of Birth: _____ Medicaid #: _____

Address: _____
Street City State Zip code

Phone#: _____ Signature - Parent/Guardian: _____

Alt. Phone#: _____ Print Parent/Guardian Name: _____

For office use only:

Date of Screening: _____

Screening Site: _____ RN: _____



UMKC School of Dentistry
Department of Pediatric Dentistry

Dear Parent/ Guardian:

We are pleased to have your child's school as part of our program for Oral Health Care with the UMKC-School of Dentistry. In order for us to provide care for your child, we REQUIRE the Parent/Legal Guardian to fill out and sign the following forms and return them to the school nurse/coordinator. Children will have their turn on a first come, first serve basis. We recommend that you complete and return these forms as soon as possible.

1. Child's Health History
2. Parental Consent Form
3. Form on HIPPA regulations (Privacy and Confidentiality Act)

I appreciate your cooperation. If you have any questions please contact your school nurse/coordinator or Ms. Monica Rolf (816) 235-2145.

Sincerely,

Dr. Brenda Bohaty
Chair, Department of Pediatric Dentistry
UMKC School of Dentistry



University of Missouri-Kansas City
School of Dentistry

E.O. 2nd 3rd 4th Grad. N/Acc
ENDO PERIO OPER FIXED
PARTIAL DENTURE - FULL DENTURE

**REGISTRATION FORM
(RE-REGISTRATION FORM)**

Assign to _____

Accepted _____
(Faculty Signature)

Student No. _____

Patient's Number _____ Date _____

Name _____
(Last) (First) (Middle Initial)

Address _____
(Street and Number) (City) (State) (Zip)

Phone Numbers () _____ () _____
(Home) (Work) Date of Birth _____

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Am. Indian ☐ Mixed

Marital: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Dental Insurance: ☐ No ☐ Yes If yes, please list: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY OR PARENT OR LEGAL GUARDIAN'S NAME AND ADDRESS IF DIFFERENT FROM CHILD'S:

Name _____
(Last) (First) (Middle Initial)

Address _____
(Street and Number) (City) (State) (Zip)

Relation _____ Phone Number () _____

Past patient at UMKC Dental Clinic? ☐ No ☐ Yes When _____ List previous name _____

Reason for present visit _____

Best day for appointments: ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri.

Referred by: ☐ Dentist ☐ Relative ☐ Friend ☐ Other Name: _____

Have you ever had or do you now have any of the following?

	Yes	No		Yes	No
Heart trouble _____			Stroke (438.00) _____		
Heart attack (MI) (414.80) _____			Epilepsy (345.90) _____		
Rheumatic fever (390.00) _____			Venereal disease (099.90) _____		
Heart murmur (785.20) _____			Arthritis (718.90) _____		
High blood pressure (401.00) _____			Emotional problems _____		
Emphysema (510.90) _____			Psychiatric treatment _____		
Tuberculosis (011.90) _____			Skin disease _____		
Asthma (493.90) _____			AIDS (042.90) _____		
Diabetes (250.00) _____			HIV+ (044.90) _____		
Ulcers (533.90) _____			Cancer (199.1) _____		
Intestinal trouble _____			Lupus (695.40) _____		
Hepatitis B (070.30) _____			TMD/TMJ (524.60) _____		
Hepatitis (other) (070.50) _____			Other (Please list) _____		
Liver disease _____					
Kidney or bladder disease _____					
Bleeding problems (459.00) _____					
Sickle Cell Anemia (282.60) _____					

Please answer these questions:

	Yes	No
Have you ever taken Fenfluramine and/or Dexfenfluramine (Fen-Phen or Redux)? _____		
Do you drink alcoholic beverages? _____		
Do you smoke or use tobacco? (305.10) _____		
Do you have any allergies? _____		
Are you allergic or sensitive to any medicines? _____		
Are you allergic to latex? _____		
Do you now or have you ever taken cortisone? _____		
Have you had any difficulty with tooth extractions? _____		
Are you taking any medicines now? _____		
Are you currently under the care of a physician? _____		
Have you ever been in a hospital as a patient? _____		
Have you ever had radiation treatments? _____		
Will you consider being in a research project? _____		
WOMEN: Are you or might you be pregnant? _____		
Does your mouth feel dry when eating a meal? _____		
Do you sip liquids to aid in swallowing dry foods? _____		
Does the amt. of saliva in your mouth seem too little? _____		

To the best of my knowledge the above is complete and correct. I hereby give permission for dental treatment to be accomplished and for the development of photographic recordings of the conditions and treatment for the advancement of Dental Science through use in professional publications, lectures or television presentations.

Signature (patient, parent or guardian)

Date



UMKC SCHOOL OF DENTISTRY
Department of Pediatric Dentistry

PARENT'S CONSENT FORM

Please complete all information.

CHILD'S NAME _____ Date of Birth: _____

SCHOOL _____ GRADE: _____

PHONE _____ ROOM NUMBER: _____

I, _____ give my consent for
(Parent or Legal Guardian- print please)

_____ to receive free dental services consisting of:
(Child's Name -- print please)

Clinical dental examination
Toothbrush prophylaxis

I hereby and on behalf of _____ who is under the age of eighteen
(Child's Name)
(18) years, consent that above named child may participate in this program sponsored by
the University of Missouri-Kansas City School of Dentistry.

(Parent/Legal Guardian's Signature)

Date: _____

University of Missouri Kansas City School of Dentistry

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:**

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

UMKC SCHOOL OF DENTISTRY POTENTIAL RISKS AND LIMITATIONS OF DENTAL TREATMENT

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus the following information is routinely supplied to anyone considering dental treatment in our school. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings and problems of growth and development, extensive dental disease, genetics, and patient cooperation, achieving perfection is not always possible. You will be treated by a dental student (supervised by faculty) who will do everything within his/her capacity to insure the best possible care.

Throughout life, teeth are constantly changing. Regular examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal are a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected infected or dead tooth may flare up during any dental treatment and may require endodontics (root canal) treatment to maintain it. It may even have to be removed.

There is also a risk during or following treatment, that soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions that may surface during treatment. Decay, which may appear small on x-ray, may be larger than anticipated and result in much more extensive treatment.

INFORMED CONSENT

I understand that during treatment any of the above problems occasionally can occur. These can include, but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that to achieve a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

- | | |
|---|----------------------------|
| 1. Strict adherence to instructions. | 3. Excellent oral hygiene. |
| 2. Cooperation in keeping appointments. | 4. Proper diet controls. |

I understand that there is no warranty or guarantee for my result and/or care. I understand that I can, at any time, ask for and receive a full recital of all possible risks related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification, who are constantly late for their appointments, who continue to excessively cancel their appointments, who fail to practice acceptable oral hygiene, or who are uncooperative with students and staff providing care.

I also understand that records, photographs and/or video recordings may be made during my treatment and will be used for the advancement of dentistry through use in professional publications, lectures or television presentations. However, my identity will not be disclosed without my expressed permission.

I understand as a service to patients, UMKC School of Dentistry provides courtesy appointment reminder calls and possibly other important calls that may be placed using a prerecorded message. By providing your telephone number, you consent to receiving such calls at this number.

**University of Missouri-Kansas City School of Dentistry
Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW
HEALTH INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW
YOU CAN GET ACCESS TO THIS INFORMATION**

**PLEASE REVIEW IT CAREFULLY. THE PRIVACY
OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Changes in our privacy practices and the new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request and on our website at dentistry.umkc.edu.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment:

We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:

We may use and disclose your health information to obtain payment for services we provide to you. This includes disclosures to companies with which we have business associate agreements.

Healthcare Operations:

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to person(s) identified by you, for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures of your health information permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends:

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, unless you object.

Persons Involved in Care:

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with any opportunity to object to this. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Disaster Relief:

We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services:

We will not use your health information for marketing communications without your written authorization.

Required By Law:

We may use or disclose your health information when we are required to do so by law. These include but are not limited to public health activities, workers' compensation, judicial and administrative proceedings, coroners and medical examiners activities and law enforcement.

Abuse or Neglect:

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. In accordance with the applicable law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security/Military/Correctional:

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose, as required by law, protected health information to correctional institution or law enforcement officials having lawful custody of an inmate or patient.

Alternative Communication:

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will accommodate reasonable requests.

Amendment:

You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Right to Notification of a Breach:

We will notify you if there has been a breach of your health information unless we determine that there is a low probability that your information has been compromised.

Electronic Notices:

You may receive this Notice on our web site or by electronic mail (e-mail); you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Linda M. Wells, DMD, MBA

Telephone: 816-235-2137

Fax: 816-235-5472

E-Mail: wellslm@umkc.edu

Address: 650 East 25th Street
Kansas City, Missouri 64108

September 18, 2013

Para Su Familia y Amigos:

Nosotros le debemos divulgar la información de su salud a usted, como está descrito en la sección de Derechos al Paciente de esta Notificación. Nosotros podremos divulgar la información de su salud a un miembro de familia, amigo u otra persona con el propósito de ayudarle con su tratamiento de salud o con pagos para su tratamiento, pero nosotros lo haremos sólo si usted está de acuerdo.

Personas Envueltas en Cuidado:

Nosotros podemos usar o divulgar la información de su salud para notificar o asistir en la notificación (esto incluye identificar o localizar) a un miembro de familia, su representante personal u otra persona responsable por su cuidado, o su localización, su condición general o muerte. Si usted está presente, entonces antes del uso o divulgación de la información de su salud, nosotros le vamos a proveer con una oportunidad para oponer dichos usos o divulgaciones. En el evento de circunstancias de su incapacidad o en casos de emergencia, nosotros vamos a divulgar su información de salud basados en una determinación usando nuestra opinión profesional divulgando solo la información de su salud que sea revelante a la persona directamente envuelta con su cuidado de salud. Nosotros también utilizaremos nuestro juicio profesional y nuestra experiencia con prácticas comunes para hacer inferencias razonables que sean de su mejor interés y que permitan a una persona recoger sus recetas, suplicios médicos, radiografías y otras formas similares de información de salud.

Medidas de Desastres:

Nosotros podremos usar o divulgar la información de su salud para asistir y colaborar con las medidas de ayuda del gobierno en casos de desastre.

Publicidad de Servicios Relacionados a la Salud:

Nosotros no utilizaremos la información de su salud para comunicaciones publicitarias sin su autorización escrita.

Requisito por Ley:

Nosotros podemos usar o divulgar la información de su salud cuando estemos requeridos a hacerlo por ley. Esto incluye pero no está limitado a actividades de salud pública, compensación por trabajo, procedimientos judiciales y administrativos, actividades de médicos forenses, y aplicación de la ley.

Abuso o Negligencia:

Nosotros podremos divulgar la información de su salud a autoridades apropiadas si creemos razonable que usted sea víctima de abuso, negligencia o violencia doméstica o posible víctima de otro crimen. Nosotros podremos divulgar la información de su salud a la extensión necesaria para prevenir amenazas a su salud o seguridad o la salud o seguridad de otros.

Seguridad Nacional:

Nosotros podremos divulgar la información de su salud a autoridades militares de las Fuerzas Armadas bajo algunas circunstancias. Nosotros podremos divulgar a oficiales federales autorizados información de salud requerida para inteligencia legítima y otras actividades de seguridad nacional. Nosotros podremos divulgar a instituciones correccionales u oficiales de la ley que tengan custodia bajo ley de información de salud de un recluso o paciente bajo algunas circunstancias.

Secretaría de HHS (Salud y Servicios Humanos):

Nosotros divulgaremos la información de su salud a la Secretaría del Departamento de Salud y Servicios Humanos de los Estados Unidos cuando es requerida para investigación o para determinar cumplimiento con HIPAA u otras leyes.

Investigación:

En algunas situaciones limitadas, la ley nos permite que usemos la información de su salud sin su autorización para investigaciones relacionados a la salud. La Escuela dental (UMKC) y sus practicantes sirven como investigadores en conexión con ciertas pruebas clínicas. Nuestra participación puede ser de beneficio para usted, para lograrlo nosotros tendremos que revisar su expediente dental periódicamente y determinar si califica/elegible para participar en algunos estudios de investigación. Solamente nuestro personal clínico revisará su expediente dental durante estos análisis y no incluirá ninguna información de salud privada/confidencial. Los investigadores también podrán utilizar su información de salud cuando sus investigaciones hayan sido aprobadas por un comité de revisión institucional (IRB) y exista una garantía para la privacidad de su información de salud.

Recuerdos de Citas:

Nosotros podremos usar o divulgar la información de su salud para proveerle a usted con un recordatorio de citas (como mensajes de voz, tarjetas postales o cartas por correo).

Nosotros apoyamos su derecho a la privacidad de la información de su salud. No tomaremos represalias de ninguna forma si usted decide presentar oficialmente una queja con nosotros o con el Departamento de Salud y Servicios Humanos de U.S.

Oficial de Contacto: Linda M. Wells, DMD, MBA

Teléfono: 816-235-2137

Número de Fax: 816-235-5472

Correo electrónico: wellsim@umkc.edu

Dirección: 650 East 25th Street
Kansas City, Missouri 64108

Septiembre 18, 2013