



CHILD CARE ENROLLMENT FORM

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| FACILITY/PROVIDER NAME Big Adventure's Academy 3 LLC | ADMISSION DATE | DISCHARGE DATE |
| CHILD'S NAME | GENDER | BIRTHDATE |

CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

IDENTIFYING INFORMATION

| | |
|----------------------|------------------|
| PARENT/GUARDIAN NAME | TELEPHONE NUMBER |
|----------------------|------------------|

ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS

EMAIL ADDRESS

| | |
|--------------------|----------------------|
| EMPLOYER OR SCHOOL | WORK/SCHOOL SCHEDULE |
|--------------------|----------------------|

| | |
|---|-----------------------|
| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |
|---|-----------------------|

| | |
|----------------------|------------------|
| PARENT/GUARDIAN NAME | TELEPHONE NUMBER |
|----------------------|------------------|

ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS

EMAIL ADDRESS

| | |
|--------------------|----------------------|
| EMPLOYER OR SCHOOL | WORK/SCHOOL SCHEDULE |
|--------------------|----------------------|

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| EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE) | WORK TELEPHONE NUMBER |
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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)

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email civilrights@dese.mo.gov.

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

RELATED CHILD

| | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | CHILD'S RELATION TO CHILD CARE PROVIDER |
|--|---|

ETHNIC AND RACE 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.) | <input type="checkbox"/> American Indian or Alaskan 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 |
|---|--|-----------------------------------|--|--|-----------------------------------|

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CACFP REQUIREMENT

| Will child attend: <input type="checkbox"/> Full time <input type="checkbox"/> Part time Check what days your child will attend. | | When does your child usually arrive each day? | When does your child usually leave each day? | Describe any changes or variations in usual attendance, including shift changes. |
|---|--------------------------|---|---|---|
| Monday | <input type="checkbox"/> | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |
| Tuesday | <input type="checkbox"/> | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |
| Wednesday | <input type="checkbox"/> | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |
| Thursday | <input type="checkbox"/> | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |
| Friday | <input type="checkbox"/> | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |
| Saturday | <input type="checkbox"/> | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |
| Sunday | <input type="checkbox"/> | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |

MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

Breakfast Morning snack Lunch Afternoon snack Supper Evening snack None

HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

| | | |
|---|---|---|
| <input type="checkbox"/> New Year's Day <input type="checkbox"/> Martin Luther King, Jr.'s Birthday <input type="checkbox"/> Lincoln's Birthday <input type="checkbox"/> Washington's Birthday | <input type="checkbox"/> Easter <input type="checkbox"/> Truman Day <input type="checkbox"/> Memorial Day <input type="checkbox"/> Juneteenth <input type="checkbox"/> Independence Day | <input type="checkbox"/> Labor Day <input type="checkbox"/> Columbus Day <input type="checkbox"/> Veterans Day <input type="checkbox"/> Thanksgiving Day <input type="checkbox"/> Christmas Day |
|---|---|---|

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event 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 the necessary arrangements, or in a critical emergency requiring medical care, I authorize

Big Adventure's Academy 3 LLC

(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

| | |
|------|------------------|
| NAME | TELEPHONE NUMBER |
|------|------------------|

PREFERRED HOSPITAL

| | |
|------|------------------|
| NAME | TELEPHONE NUMBER |
|------|------------------|

ACKNOWLEDGMENTS

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| 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 that 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 at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed. | PARENT/GUARDIAN INITIALS |

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|---------------------------|------|
| PARENT/GUARDIAN 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-05080002-508-11-28-17Fax2Mail.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.