WILLIAM L. CLAY EARLY CHILDHOOD DEVELOPMENT CENTER

Welcome!!!

We are ecstatic that you are joining the Clay Center family. Here are a few things to help you get acquainted.

First, be sure you read the Parent Manual.

You can access it on hssu.edu. From there you will need to scroll to the bottom where it says William L. Clay Early Childhood Center and click on *Parent Manual.* It contains all of the information that you will need to know. If you have any questions, please do not hesitate to contact:

Director Dr. Jodi Jordan: 314-340-5055 (jordanj@hssu.edu) or

Assistant Director Don Hutcherson: 314-340-5107 (hutcherd@hssu.edu)

What to Bring:

You may be wondering what to bring. We provide almost everything your child needs here at the Clay center, but there are a few things that we require you to bring for the comfort of your child. Examples include: breastmilk, diapers, pacifiers, extra clothing, etc.

Daily:

Please be sure to sign your child in/out on a daily basis. The sign in/out sheets are located either inside or outside your child's classroom in a convenient location.

Payments:

There are plenty of options for payments. Even though we charge by the month, you have the choice to pay weekly, semi-monthly, or monthly.

- If you may weekly by sure to pay every Monday.
- If you pay semi-monthly, be sure to pay on the 15th and 30th of each month.
- If you pay monthly, be sure that you pay your balance by the 5th day of the next month.

Failure to Pay:

Failure to make your payments in a timely manner will result in late charges and/or collection activity. We give you until the 5th day of the following month to pay. Example. October's monthly tuition is due by November 5th. If there is still a balance after the 5th of the month, you will start to accrue late charges. Late charges are $25 per month for each month that your child's account holds a balance.

Promptness:

Please be prompt when picking up your little ones to avoid the late pick up penalty. (Please see details on page 12 of the Parent Manual).

If you have any questions regarding details about your account, please contact Accounting at 314-340-3329 and ask for Mary Ellen Dee or Benisha Dorris.

We appreciate being of service to you and your child.

HARRIS-STOWE STATE UNIVERSITY

WILLIAM L. CLAY, SR. EARLY CHILDHOOD
DEVELOPMENT/PARENTING EDUCATION CENTER

ENROLLMENT PACKET CHECKLIST

___ ENROLLMENT FORM *

___ VIDEO RELEASE FORM

___ FOOD PROGRAM FORMS (4 pages)*

___ PARENTAL AGREEMENT FORM (2 pages)

___ CONTRACT*

___ DSF/FINANCIAL ASSISTANT FORM(IF APPLIES)*

___ PARENT MANUAL (return last page)

___ PHYSICAL EXAM FORM

___ IMMUNIZATION RECORDS

___ INFANT FEEDING PREFERENCE (IF APPLIES)*

___ PARENT'S SPECIALIZED (ONLY INFANT/1yr Old)

ALL THINGS WITH AN (*) BY IT NEEDS TO BE COPIED AND GIVEN TO THE

ACCOUNTING OFFICE ASAP

10 N. COMPTON AVE. • ST. LOUIS, MISSOURI 63103 • (314) 340-5055/5066 • FAX: (314) 340-5120

HARRIS-STOWE STATE UNIVERSITY

William L. Clay, Sr. Early Childhood Development/Parenting Education Center Enrollment Application

Date of Enrollment_____

PERSONAL INFORMATION

CHILD'S LAST NAME	CHILD'S FIRST NAME	CHILD'S M.I.

DATE OF BIRTH	GENDER	HOME TELEPHONE
____/____/____	☐ FEMALE ☐ MALE	( )

ADDRESS	CITY	STATE	ZIP CODE

Mother or Guardian Information #1

MOTHER'S OR GUARDIAN'S LAST NAME	MOTHER'S OR GUARDIAN'S FIRST NAME	M.I.

ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

HOME TELEPHONE	BUSINESS TELEPHONE	CELL PHONE (OPTIONAL)
( )	( )	( )

E-MAIL ADDRESS

EMPLOYER (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO

EMPLOYER OR SCHOOL ADDRESS	CITY	STATE	ZIP CODE

Father or Guardian Information #2

FATHER'S OR GUARDIAN'S LAST NAME	FATHER'S OR GUARDIAN'S FIRST NAME	M.I.

ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

HOME TELEPHONE	BUSINESS TELEPHONE	CELL PHONE (OPTIONAL)
( )	( )	( )

E-MAIL ADDRESS

EMPLOYER (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO

EMPLOYER OR SCHOOL ADDRESS	CITY	STATE	ZIP CODE

Family Demographic Information

RACE

☐ ASIAN ☐ BLACK ☐ WHITE ☐ NATIVE AMERICAN

☐ PACIFIC ISLANDER ☐ MULTIRACIAL ☐ UNSPECIFIED ☐ OTHER

SPECIFY HOME LANGUAGE

RELIGION

FAMILY STRUCTURE

☐ MARRIED ☐ LIVING JOINTLY ☐ SHARED CUSTODY ☐ SINGLE PARENT

☐ OTHER_____

OPTIONAL

EMERGENCY CONTACT INFORMATION (REQUIRED)

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME	
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD	
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME	
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD	
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME	
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD	
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME	
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD	
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

EMERGENCY CONTACT'S LAST NAME		EMERGENCY CONTACT'S FIRST NAME	
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER (OPTIONAL) ( )	RELATIONSHIP TO CHILD	
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP CODE

PERSONS AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY

LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME
LAST NAME	FIRST NAME

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of an 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 **Harris-Stowe State University's William L. Clay, Sr. Early Childhood Development/Parenting Education Center** (DVN# 002144478) to contact the following:

PHYSICIAN OR CLINIC		TELEPHONE NUMBER ( )	
ADDRESS	CITY	STATE	ZIP CODE
PREFERRED HOSPITAL		TELEPHONE NUMBER ( )	
ADDRESS	CITY	STATE	ZIP CODE

CHILD'S DOCTOR'S FIRST NAME	CHILD'S DOCTOR'S LAST NAME		
TELEPHONE NUMBER ( )			
ADDRESS	CITY	STATE	ZIP CODE
CHILD'S DENTIST'S FIRST NAME	CHILD'S DENTIST'S LAST NAME		
TELEPHONE NUMBER ( )			
ADDRESS	CITY	STATE	ZIP CODE

FAMILY INFORMATION

Please list the names, ages and genders of the other children in the family.

LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE
LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE
LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE
LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE

FAMILY INFORMATION (CONTINUED)

LAST NAME	FIRST NAME
AGE	GENDER ☐ FEMALE ☐ MALE

ANNUAL INCOME (BELOW $65,860 FOR FOOD SERVICE INFORMATION ONLY) $

COMMENTS ON CHILD'S DEVELOPMENT

Please provide any additional information about the child that may be helpful to his or her teacher.

PLAY HABITS
EATING HABITS
SLEEPING PATTERN
FEARS
LIKES/DISLIKES
SPECIAL LANGUAGE
OTHER
PREVIOUS EXPERIENCE IN CHILD CARE ☐ YES ☐ NO

List any chronic or medical challenges that your child has, e.g., seizures, asthma, diabetes, heart disease, respiratory illness, drug reaction, etc.

Describe any allergies, including any foods that have caused adverse reactions or any food not given to the child for health or religious reasons (use separate sheet if necessary).

Has your child come in contact with tuberculosis?

☐ YES ☐ NO	IF YES, WHEN?

Check the illnesses your child has experienced:

☐ Measles ☐ German Measles ☐ Mumps ☐ Chicken Pox
☐ Scarlet Fever ☐ Strep Throat ☐ Rheumatic Fever
☐ Other _____

TRANSPORTATION TO AND FROM SCHOOL

DO YOU GIVE PERMISSION TO THE FACILITY TO TRANSPORT YOUR CHILD TO AND FROM SCHOOL? ☐ YES ☐ NO			
SCHOOL CHILD ATTENDS		TELEPHONE ( )	
ADDRESS	CITY	STATE	ZIP CODE

FIELD TRIPS

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

ACKNOWLEDGMENTS

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 HE OR SHE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.

AUTHORIZATION AND VERIFICATION

This application must be accompanied with a signed medical statement and updated immunization record at the time of admission to child care and is to be renewed annually. At the time of admission, the undersigned parent or guardian understands that care will be billed at the rate of $_____, based on _____ hours per week. A nonrefundable fee of $100 is required at the time of enrollment of which $50 will be applied to the first payment. Please make checks payable to Harris-Stowe State University. Further, I certify that the facts contained in this application are true and complete to the best of my knowledge.

PRINT NAME	
SIGNATURE	DATE ____/____/_____

APPLICATION SUBMISSION

Please return all completed applications to William L. Clay, Sr. Early Childhood Development/Parenting Education Center Director Patricia Johnson either in person by going to Room 207 of the early childhood center or by mailing the application and check to:

Dr. Patricia Johnson
Harris-Stowe State University
10 North Compton Avenue, Room 207
St. Louis, MO 63103

TO BE COMPLETED BY CHILD CARE FACILITY (FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)

FACILITY NAME	ADMISSION DATE
ENROLLED FOR (DAYS OF THE WEEK)	FULL TIME/PART TIME
HOURS PER DAY FROM TO	DISCHARGE DATE

Updated October 25, 2010

HARRIS-STOWE STATE UNIVERSITY

OFFICE OF COMMUNICATIONS AND MARKETING

Video/Photograph Release Form

Date _____

I hereby release and grant the institution of Harris-Stowe State University permission to use my photograph in any and all of its publications, including Web site entries, without payment or any other consideration. Please understand that there are no royalty opportunities offered for appearing in any Harris-Stowe photograph.

I understand and agree that these materials are property of Harris-Stowe State University and will not be returned, therefore, Harris-Stowe is authorize to edit, publish and copy the photograph for the purpose of publicizing and promoting Harris-Stowe and any of its events and programs. In addition, I waive the right to be view, inspect or approve any final versions of the photo, prior to its appearance in any publication, advertisement or brochure.

I hereby hold harmless and release and forever discharge Harris-Stowe from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning, and impact of this release.

Signature _____

Printed Name _____

If the person signing is under 18 years of age, a parent or guardian must give written consent on behalf of this person _____

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

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME HARRIS- STOWE STATE UNIVERSITY	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 ☐	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 ☐	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)

CACFP REQUIREMENT

RELATED CHILD

☐ YES ☐ NO | HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

	CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐ FULL TIME OR ☐ 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	☐	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	

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☑ BREAKFAST ☐ MORNING SNACK ☑ LUNCH ☑ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☑ NEW YEARS'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 ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

Harris-Stowe State University

DAY CARE PROVIDER OR HOME PROVIDER

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 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	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

HARRIS-STOWE STATE UNIVERSITY

WILLIAM L. CLAY, SR. EARLY CHILDHOOD DEVELOPMENT AND PARENTING EDUCATION CENTER

The Clay Center agrees to provide care and programming for (child's name)_____
Last First MI

I/we, the Parent(s)/Guardian(s) (printed name): (1)_____
Last First MI

(2)_____:
Last First MI

Social Security # (1) _____ Social Security # (2) _____

(Initial next to each statement)

- ___ I (we) agree to following all policies and procedures in the Parent Manual.
- ___ I (we) agree to update the emergency contact/parent consent form information whenever changes occur.
- ___ I am (we are) guarantor(s) of this account and I am (we are) fully responsible for payment of amounts due.
- ___ I (we)understand fees are based on enrollment, not attendance and if applicable, the Clay Center will adjust my account according to the Parent Manual
- ___ I (we) understand past due amounts may be sent to a collection agency and I (we) am (are) responsible for all fees including collection costs and fees for delinquent accounts.
- ___ I (we) understand, if applicable, as a Harris- Stowe State University student(s) a past due balance owed for services rendered at the Clay Center will result in a billing hold placed on my(our) student account which will prevent me(us) from having access to an official student records as well as prevent enrollment in future classes.
- ___ I (we) know that childcare for my child will be discontinued if I (we) do not maintain payments in advance of my account balance.
- ___ I (we) acknowledge that rates are subject to change and that the Clay Center reserves the right to make corrections to the rates and amounts charged for services.
- ___ Understand if I(we) am(are) an employee(s) or become an employee(s) of HSSU, HSSU will automatically have a contingency authorization to deduct Clay Center balance from my paycheck(s).
- ___ I (we) understand that my(our) weekly rate may change on my(our) child's birthday Date of Birth: _____

I (we) agree to remit payment of my child's tuition in advance of services provided: (please select one option):

_____ Weekly _____ Bi-Weekly _____ Monthly

I (we) verify that all the information above is correct.

Parent/Guardian signature (1) :_____ Date:_____

Parent/Guardian signature (2) :_____ Date:_____

Address:_____ Date:_____

Director / Assistant Director Signature:_____ Date:_____

Weekly rate: $_____ Co Pay: $_____

INTERNAL USE ONLY:

Date application fee paid: _____ Eligible for 10%Discount ____ ____ Head Start: ____ ____ HSSU student: ____ ____
Y N Y N Y N

Child I.D. #: _____

Parent I.D. #: _____

Verified State Assistance Eligibility: _____
The Clay Center Administration

DFS approval letter: _____ DFS Begin date _____ DFS End date _____
Date Received

First day of attendance: _____ Last day of attendance: _____

10 N. COMPTON • ST. LOUIS, MISSOURI 63103 • (314) 340-5066/5055 • FAX: (314) 340-5120

HARRIS-STOWE STATE UNIVERSITY

WILLIAM L. CLAY, SR. EARLY CHILDHOOD
DEVELOPMENT/PARENTING EDUCATION CENTER

Intent to Pay

I/we,_____, agree to pay tuition for our child(ren),_____,
(Please Print) (Please Print)

on the following cycle.

Please check (√) one.

_____ Weekly

_____ Monthly

_____ Other (Specify)

_____ _____
(Signature) (Date)

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HARRIS-STOWE STATE UNIVERSITY

WILLIAM L. CLAY, SR. EARLY CHILDHOOD DEVELOPMENT/PARENTING EDUCATION CENTER

July 1, 2011

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 your income is higher than the amount listed for your family size, you do not need to complete the income application.

Family Size	Income	Yearly Family Size	Yearly Income
1	$20,147	5	$48,415
2	$27,214	6	$55,482
3	$34,281	7	$62,549
4	$41,348	8	$69,616
		For each additional	+7,067

To apply for free or reduced-price meal benefits for your children, you must complete the attached form. Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided. You should notify the center if any family member(s) of the household becomes unemployed. A child may be eligible for free or reduced-price meals during the period of unemployment. This application is valid for twelve months from the date it is signed by the center representative.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination write to USDA, Director, Office of Civil Rights, 1400 independence Avenue, S.W., Washington, DC 20250-9410 or call 1-800-795-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.

Sincerely,

Dr. Jodi Jordan
Center Director

William L. Clay, Sr. Early Childhood Development/Parenting and Education Center

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INFANT FEEDING PREFERENCE – CENTERS

Name of infant _____ Date of Birth_____

_____ will feed your infant breastmilk provided by you and / or we
(name of provider)
will provide iron fortified infant formula.

The formula we provide is: _____

Please mark your preference (choose all that apply)	Date Birth – 3 months	Date 4 – 7 months	Date 8 – 11 months
I will bring expressed breastmilk for my infant.			
I will come to the center to breastfeed my infant.			
I want the center to provide formula for my infant.			
I will bring formula for my infant. Please list kind of formula you will bring: _____			

This center 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 your baby is developmentally ready for them.

Please mark your preference	Date 4 – 7 months	Date 8 – 11 months
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.		
I will bring solid food for my infant when he / she is ready for it.		

First Signature of Parent / Guardian _____ Date_____

Second Signature of Parent / Guardian _____ Date_____

Third Signature of Parent / Guardian _____ Date_____

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)	BIRTH DATE	FOSTER CHILD	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

PART 2 HOUSEHOLD AND INCOME INFORMATION

List all members of the household 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	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 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 a social security number is not mandatory, but if a social security number is 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

HARRIS-STOWE STATE UNIVERSITY

WILLIAM L. CLAY, SR. EARLY CHILDHOOD DEVELOPMENT/PARENTING EDUCATION CENTER

NAME OF CHILD: _____

PARENTAL AGREEMENT

To comply with licensing requests and expectations, the following must be read and signed by parents to complete the application currently on file in the Clay Early Childhood Development/Parenting Education Center.

1. Children in the Center will not be taking field trips away from the Harris-Stowe State University campus. However, nature walks around the campus, visits to the library for occasional story readings, and attending children's performances (3, 4, and 5 year olds only) in the Emerson theater, planned and executed by the Harris-Stowe State University Players, will constitute field trips for our children. I understand that my signature provides permission for my child (ren) to participate in such campus outings.

2. In the unlikely event that my child is in need of emergency medical care and I, or other designated contacts cannot be reached, the staff of the Clay Early Childhood Development/Parenting Education Center has my permission to seek proper medical care for my child (ren) while all efforts are made to make parental contact.

(Doctor) Name: _____ Phone: _____

Address: _____

(Dentist, if applicable)
Name: _____ Phone: _____

Address: _____

Preferred Hospital: _____

3. I do understand that the Clay Early Childhood Development/Parenting Education Center does not, under any circumstance, allow children to ride in any form of transportation (baby buggies not included) while in the care of the Center.

Emergency Contact Information:

Name: _____

Address: _____

_____

Phone # :_____(c) _____

The following persons are authorized to pick up my child:

_____

_____

_____

The following person(s) **ARE NOT** allowed to pick up my child:

_____

_____

Mother:

Work/School Name: _____

Address: _____Phone_____

Hours: _____

Father:

Work/School Name: _____

Address: _____

Hours: _____

Signature(s):_____ Date: _____

_____ Date: _____

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

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