



Magical Minds Childcare
 4815 Page Blvd Saint Louis, MO, 63113
 314-296-3108
 www.magicalmindsdaycare.org
 contact@magicalmindsdaycare.org

Child's Name: _____ Sex: _____ Birthdate: _____

	Mother	Father
Name:		
Address:		
Email:		
Marital Status:	Married Single Separated Divorced	Married Single Separated Divorced
Employer:		
Home Phone #:		
Work Phone #:		
Cell Phone #:		

Persons with whom the child lives: _____

Child's Doctor: _____ Doctor's Phone #: _____

Child's Dentist: _____ Dentist's Phone #: _____

Individuals to contact in case of an emergency:

Name	Relationship to child	Phone #

Does your child have any food allergies? Yes No

Does your child have any other allergies? Yes No

Does your child have any dietary restrictions? Yes No

Please explain any "yes" answers here: _____

.....
 My child has permission to be released to the following individuals, childcare facilities, or transportation services in addition to emergency contact persons listed above.

(Please notify these individuals that they may be asked to show proof of identity.)

Name	Relationship to child	Phone #

I authorize First Beginnings to secure emergency medical treatment for my child.

Parent's signature: _____ Date: _____

Date of Admission: _____

HEALTH POLICY

The following guidelines are set forth in direct accordance with the Missouri state licensing requirements that Magical Minds is required to adhere to and must be followed precisely by staff and parents. Exceptions to these policies will not be permitted. You may want to keep these guidelines close at hand in the event you should have any questions concerning your child's health condition at any time.

1. Each child enrolled in the program must have completed and on file with Magical Minds, medical and/or health forms including:
 - a. Updated immunizations records (ongoing through age 5)
 - b. Information on childhood allergies
 - c. Indications of chronic illnesses, such as asthma, seizures, sickle cell anemia, etc.
 - d. Special instructions for the child
2. A daily health inspection for any observable illness will be made by the staff. Please relay any bumps, bruises or notable injuries to the staff when dropping your child off each morning.
3. Any child with an infectious or contagious disease [i.e., conjunctivitis (pink eye), measles, mumps, chicken pox, tuberculosis, viral flu, diarrhea, head lice, etc.) shall not attend the childcare program.
4. A child with a contagious or infectious disease requires a physician's note stating that he/she can return to school without the risk of spreading the illness. The director or staff supervisor will refuse to admit any child to the center that is suspected of having any infectious or contagious diseases. If the child appears ill, the director or staff supervisor will also request a note from the physician stating the child is free of any contagious illnesses or diseases.
5. Any child who becomes ill at the center and/or is suspected of having an infectious or communicable disease shall be separated from the other children until the parent or other authorized person comes for the child. That child shall not return to the center until the disease is cured/treated or has diagnosed by a physician or authorized health professional as not being infectious or contagious. The child must be free and clear of symptoms (fever, diarrhea, vomiting, etc.) for 24 hours without medication in order to return. Any child with a fever over 100° will not be allowed to attend the center without a note from a physician or authorized health professional stating the child is not contagious in accordance with Louisiana state licensing requirements.
6. When the staff has contacted you to pick up your child due to illness, the time will be noted on the incident report and you will have 45 minutes for you or another authorized person to pick up your child. After the initial 45 minutes have passed since contact with a parent or guardian, late fees will be assessed at the rate of \$1.00 per minute until the child is in your care. This is to ensure that child/staff ratios are maintained at all times. Please make sure your employer and anyone authorized for picking up your child knows about this policy.
7. Any child at the center must be able to participate in regularly scheduled activities.

Magical Minds Childcare

4815 Page Blvd Saint Louis, MO, 63113

314-296-3108

www.magicalmindsdaycare.com

contact@magicalmindsdaycare.org

- 8. If medication is to be taken by a child, prescription or non-prescription, the medication presented to the teacher **must** remain in the original container. All requirements are in accordance with Louisiana state licensing requirements.
 - a. Written administration instructions, signed and dated by the parent must include:
 - i. Child's name
 - ii. Prescription name and/or number
 - iii. Name of prescribing physician
 - iv. Condition for which medication is prescribed
 - v. Quantity of dose to be given
 - vi. Date(s) and time(s) of administration
 - vii. Any other considerations related to the medication or illness
 - b. The First Beginnings staff must record the following:
 - i. Signature when receiving medication and form
 - ii. Dosage given
 - iii. Note the time and date administered
 - iv. Initials of the administering staff on the medical form
 - c. Medication must not be put into bottles of formula or other drinks brought into the center. This procedure is in direct violation of the Louisiana state licensing requirements and could harm another child if they were to pick up that drink by mistake.

- 9. If your child is injured, a CPR and First Aid certified staff member would take necessary steps to obtain and administer medical care in accordance with governing guidelines and parental consent. These steps may include but are not limited to the following:
 - a. Contacting parent, guardian, family physician, or another parent specified person
 - b. Calling an ambulance or paramedic
 - c. Once emergency medical care has been administered, staff will file an accident report

I, _____, parent/guardian of _____
give consent to First Beginnings Child Development Center to administer measures to provide immediate and potentially lifesaving care to my child:

Parent/guardian signature: _____ Date: _____

Magical Minds Childcare
4815 Page Blvd Saint Louis, MO, 63113
314-296-3108
www.magicalmindsdaycare.org
contact@magicalmindsdaycare.org

Authorization for the Application of Topical Products

Child's name: _____

I give permission for center staff to apply the following topical products to my child whether center provided, or parent provided:

Sunscreen:	Yes	No
Insect repellent:	Yes	No
Diaper rash ointment:	Yes	No
Other: _____	Yes	No

This one-time authorization will remain in effect until a new authorization is signed.

Parent's signature: _____ Date: _____

Magical Minds Childcare
4815 Page Blvd Saint Louis, MO, 63113
314-296-3108
www.magicalmindsdaycare.org
contact@magicalmindsdaycare.org

Consent to Release Information, Recordings or Photographs

Child's name: _____

I give my consent for **Magical Minds Childcare** to release information/photograph(s)/recording(s) of the
aforementioned child from which my child might be identified, except to authorized state and federal agencies.

Parent's signature: _____ Date: _____

INTAKE SHEET

Date: _____

Child's Identification Information

Name:		Nickname:
Sex:	Birthdate:	Name of previous school:

Play and Sociability

How does your child get along with other children?

His/her usual playmates are: Girls Boys Older Younger

What is the usual size of your child's neighborhood playgroup?

Previous group experiences Preschool Playgroup Sunday school
 Other (specify):

How does your child respond to strangers?

Personality and Emotional Development

Is your child affectionate? Yes No If yes, to whom?

Does he/she accept new people easily? Yes No

What are your child's fears?

Is your child usually happy? Yes No

Does your child have any nervous habits? Yes No If yes, explain:

Discipline

When you find it necessary to discipline your child, which parent usually does this and how?

Infants and Toddlers

Has your child had any feeding problems? Yes No If yes, explain:

Have you noticed any allergies or sensitivities to particular foods?

Is your child breast fed or bottle fed? Breast fed Bottle fed

What food is your baby eating now? Fruits Vegetables Cereals Juices Meats
 Milk (formula) Other (specify):

Regarding sleep habits, does your child have a "fussy" time? Yes No
 If yes, when? If yes, how do you handle this "fussy" time?

Do you have special ways of helping your child go to sleep? Yes No
 If yes, please explain.

Does your child use a pacifier or suck his/her thumb or fingers? Yes No

Has toilet training been attempted? Yes No

Is your child's skin highly sensitive? Yes No

Other Information:

Please list some of your child's favorite activities:

Give any other information you believe will be helpful to us in understanding and caring for your child:

Magical Minds Childcare
4815 Page Blvd Saint Louis, MO, 63113
314-296-3108
www.magicalmindsdaycare.org
contact@magicalmindsdaycare.org

Non-Vehicular Excursion Authorization

My child, _____, has my permission to participate in all on-campus activities when the children are walking and accompanied by the staff. These activities include but are not limited to:

- _____ Library Time
- _____ Physical Education
- _____ Holiday Parties
- _____ Movies
- _____ School Pictures
- _____ Field Day
- _____ Water Play Days
- _____ Music

Parent Signature _____ Date _____

Magical Minds Childcare

4815 Page Blvd Saint Louis, MO, 63113

314-296-3108

www.magicalmindsdaycare.org

contact@magicalmindsdaycare.org

Bottle Authorization

I give permission for my child, _____,
to hold his/her bottle for feeding.

Parent signature _____ Date _____

Magical Minds Childcare
4815 Page Blvd Saint Louis, MO, 63113
314-296-3108
www.magicalmindsdaycare.com
contact@magicalmindsdaycare.org
TRANSPORTATION FORM

I, (We), _____ the parent(s), or legal guardian(s) of the child(ren) listed below, give permission for them to be transported to **Magical Minds** via the daycare van.

Child 1: _____ Age: _____

Child 2: _____ Age: _____

Child 3: _____ Age: _____

Child 4: _____ Age: _____

The children should be picked up from the following address.

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number: () _____

The child(ren) attend school and should be picked up from the following location(s).

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone Number: () _____

I, (We), _____ agree to contact Magical Minds prior to the scheduled pickup time if my child(ren) will not attend daycare

Parent/Guardian Signature

Date

Magical Minds Representative

Date



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

FACILITY/PROVIDER NAME MAGICAL MINDS CHILDCARE	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)

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:	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			
	NEW YEAR'S DAY (JANUARY)	MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	PRESIDENT'S DAY (FEBRUARY)	EASTER (MARCH/APRIL)
	MEMORIAL DAY (MAY)	INDEPENDENCE DAY (JULY)	LABOR DAY (SEPTEMBER)	COLUMBUS DAY (OCTOBER)
VETERANS DAY (NOVEMBER)	ELECTION DAY (NOVEMBER)	THANKSGIVING (NOVEMBER)	CHRISTMAS DAY (DECEMBER)	
AUTHORIZATION FOR EMERGENCY MEDICAL CARE				
<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;">_____ 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	

USDA Nondiscrimination Statement

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

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.

**CLICK THE BLUE BUTTON
TO SUBMIT THE FORM**

October 14, 2015