MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

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 ☐ 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 (LAST 4 DIGITS ONLY) XXX-XX-	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 ❑	MONTH ❑	2 X A MONTH ❑	EVERY 2 WEEKS ❑	WEEKLY ❑	SNAP (Food Stamp) ❑	TEMPORARY ASSISTANCE ❑

Eligibility Determination: ❑ Free ❑ Reduced ❑ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

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

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	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
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

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)		

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

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☐ 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.)	☐ American Indian or Alaskan native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

Will child attend: ☐ Full time ☐ 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	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Tuesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Wednesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Thursday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Friday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Saturday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Sunday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ 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

☐ New Year's Day	☐ Easter	☐ Labor Day
☐ Martin Luther King, Jr.'s Birthday	☐ Truman Day	☐ Columbus Day
☐ Lincoln's Birthday	☐ Memorial Day	☐ Veterans Day
☐ Washington's Birthday	☐ Juneteenth	☐ Thanksgiving Day
	☐ Independence Day	☐ 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

_____
(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

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 ☐ do ☐ 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 ☐ 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 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

PARENT/GUARDIAN 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

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, audiotape, 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/ad-3027.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.

DEVELOPMENTAL CENTER OF THE OZARKS

APPLICATION and CONSENT for SERVICES

I am requesting the Developmental Center of the Ozarks to provide the following services for:

Name of Individual to Receive Services

THERAPY SERVICES

☐ First Steps (birth to 3) ☐ Private (Non First Steps) ☐ Contract

REQUESTED THERAPY	REQUESTED LOCATION
☐ ABA/Behavioral ☐ Occupational Therapy ☐ Physical Therapy ☐ Special Instruction ☐ Speech Therapy	☐ In Home ☐ In Center ☐ Other, please specify:

CHILDREN'S SERVICES

☐ Child Care Services ☐ Other: _____

ACKNOWLEDGEMENTS

The Program Handbook and Parental Rights Handout is included in the enrollment information. It includes the Notices of Privacy Practices, several Consent and Releases, Grievance Procedure, Rights, etc. It is important that you review the Handbook and keep it for future reference. By signing below, I acknowledge I have been given the opportunity to review this information, have had adequate explanation given and have had my questions answered.

If you ever have any questions, please call 417-829-0896 (Executive Director), 417-829-0898 (Assistant Executive Director)

Emergency Medical Treatment is given for emergency treatment/first aid and notification of the physician on record if needed or for specific orders. Ambulance/paramedics will be called as determined by treating staff when parent or guardian is not present.

Legally Responsible Person:
Relationship:
Date:

DEVELOPMENTAL CENTER OF THE OZARKS
ENROLLMENT/ RE-ENROLLMENT
THERAPY & CHILDCARE

Instructions
All blanks **MUST** be filled in. Please write "NA" (Not Applicable) if appropriate. Attach pages for comments or additional information.

General Information

Individual's Name:			**Date of Birth:**	
Address:			**Gender:** ☐ **Male** ☐ **Female** ☐ **Other**	
City: **State:** **Zip:**			**Phone #:**	
School District: ☐ Springfield R-12 ☐ Other:			**City of Birth:**	
Height:	**Weight:**	**Identifying Marks:**	**Hair Color:**	**Eye Color:**
Language Understood:		**Language at home:**		
Mo Health Net #:		**Medicare #:**		
Culture/Ethnicity:		**Race:**	**Religion:**	

Service Coordinator	**DFS Case Worker**
Name:	**Name:**
Phone:	**Phone:**

Parent/Guardian Information

RELATIONSHIP TO INDIVIDUAL	**RELATIONSHIP TO INDIVIDUAL**
☐ **Mother** ☐ **Foster Parent** ☐ **Guardian** ☐ **Father** ☐ **Other:**_____	☐ **Father** ☐ **Foster Parent** ☐ **Guardian** ☐ **Mother** ☐ **Other:**_____
Name:	**Name:**
☐ Same as above. If different, please complete:	☐ Same as above. If different, please complete:
Home Address:	**Home Address:**
City/State/Zip:	**City/State/Zip:**
Primary Phone: ☐ **Cell** ☐ **Home** ☐ **Message**	**Primary Phone:** ☐ **Cell** ☐ **Home** ☐ **Message**
Alternate Phone: ☐ **Cell** ☐ **Home** ☐ **Message**	**Alternate Phone:** ☐ **Cell** ☐ **Home** ☐ **Message**
E-Mail Address:	**E-Mail Address:**
Employer or School Attending:	**Employer or School Attending:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Work/School Phone #:	**Work/School Phone #:**
Work E-Mail Address:	**Work/School E-Mail Address:**
Work/School Hours:	**Work/School Hours:**

Legal Documentation (Required)

☐ Check this box if a Court Order or other legal document is attached naming any person not allowed visitation or custody.
☐ Check this box if a document is attached showing legal guardianship of the individual named above.
☐ Check this box if a document is attached limiting contact or visitation.

EMERGENCY INFORMATION

Emergency Contact(s), other than parent(s) or doctor, TWO required.
*** If in Foster Care, the Children's Division assigned Case Worker or Court Appointed person and their title MUST be listed.**

Emergency Contact #1	**Emergency Contact #2**
Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Home Phone:	**Home Phone:**
Cell Phone:	**Cell Phone:**
Relationship to Individual:	**Relationship to Individual:**

Medical Information

Physician:	**Address:**	**Telephone:**
Current Immunizations: ☐ Yes ☐ No	**Date of Last Examination:**	**Date of last TB testing:**
Specialist:	**Address:**	**Telephone:**
Reason for care:		
Therapists:	**Address:**	**Telephone:**
Reason for care:		
Assistive Devices: ☐ **Braces (AFO/SMO)** ☐ **Wheelchair** ☐ **Walker** ☐ **Other**		
Supportive Devices: ☐ **Glasses** ☐ **Hearing Aids** ☐ **Communication Device** ☐ **Other**		

HOSPITAL PREFERENCE (Check Only One)

☐ Cox South, 3801 S. National Ave., Spfld, MO (417) 269-6000 ☐ Mercy, 1235 E. Cherokee, Spfld, MO (417) 820-2000 ☐ Other:	**Comments**

INDIVIDUAL'S DAYCARE INFORMATION (THERAPY ONLY)

Daycare:	**Contact Person:**
Address:	**Phone #:**

Signature:	**Date:**

I authorize DCO staff to be able to communicate using any contact information given in the <u>Parent/Guardian</u> and/or <u>Daycare</u> sections via phone/fax/voicemail/text/email/public facing media platform. (i.e. Zoom) I understand that these forms of communication will result in the information being insecure. Documents can be picked up by Parent/Guardian. I understand that this means that person(s) not authorized to view it could access my Protected Health information.

I understand that this Release of information will automatically expire in one (1) year or if the individual receiving services is discharged, whichever occurs first.

I understand that I can revoke this authorization at any time with a written request to DCO at 1545 E. Pythian, Springfield, MO 65802 or by giving the written request directly to a staff person.

_____ **Relationship**: _____ **Date**: _____
Parent, Guardian, Legally Responsible Person

Signature of Case Worker if Foster Care: _____ **Date**: _____

Privacy Officer Approval: _____ **Date**: _____

DEVELOPMENTAL CENTER OF THE OZARKS
INDIVIDUAL and FAMILY INFORMATION (ECCE)

Individual's Name:

SIGNIFICANT INFORMATION TO KNOW & UNDERSTAND THE INDIVIDUAL BETTER

Previous Experience Away from Home? ☐ Yes ☐ No
If yes, please describe:
Describe reactions away from home or familiar persons:
☐ Quiet, but adjusted well ☐ No problem ☐ Needed some comforting at first
Identifying Marks:

PLEASE DESCRIBE THE FOLLOWING

Favorite inside activities?
Favorite outside activities?
Favorite books?
Favorite table activities?
Favorite games?

EATING

Please indicate independence level: ☐ Is fed ☐ Needs help ☐ Does not need help	
What utensils are used? ☐ Spoon ☐ Fork ☐ Knife	
What foods are very disliked?	**What are favorite foods?**

FOOD & DRUG ALLERGIES

Describe any food & drug allergies:

MEDICATION

Describe any medications taken on a regular basis:

COMMUNICATION

Please indicate level of communication ☐ Eye/Hand points ☐ Babbles/Goes to item ☐ Talks/Goes to item. **Understands:** ☐ **English** ☐ **Spanish** ☐ **Sign Language** ☐ **Other:**

SELF HELP/ADAPTIVE BEHAVIOR

Indicate level of restroom use: ☐ In Diapers ☐ Timed Schedule ☐ Regular Accidents ☐ Independent
How much help is needed? ☐ In Diapers ☐ Assist with all clothing ☐ Fasteners Only
Dressing/Undressing: ☐ Total Assistance ☐ Removes simple items ☐ Removes all items ☐ Puts on simple items ☐ Dresses self
Personal Hygiene: ☐ Total Assistance ☐ Washes face/hands with Assist ☐ Totally Independent

NAPPING/RESTING

Describe any special resting requirements:

FAMILY

(Please attach any additional information)

Please provide any cultural, ethnic or other beliefs you feel important for the child's teacher to know.

Please provide any family/friend information you feel important for the child's teacher to know.

HOME

Typical bedtime?	Get up in the morning?
Most energetic time of day?	Time of day most tired?
Any specific stresses of which we should be aware?	

Name	Lives in the home							
Parent	☐ Yes	☐ No	Sibling	☐ Yes	☐ No	Other	☐ Yes	☐ No
Parent	☐ Yes	☐ No	Sibling	☐ Yes	☐ No			

BEHAVIOR & SOCIAL INTERACTIONS

Indicate social interactions:	☐ Watches others	☐ Some interactions	☐ Often interacts
Is sharing/taking turns a problem?	☐ Sometimes	☐ Most of the time	☐ All of the time
Reaction when angry or frustrated?	☐ Nothing	☐ Cries	☐ Tantrums
Other *(Please describe)*:			
What will usually help to calm when very upset?			
Is there anything which is particularly upsetting or frustrating?			
What makes him/her laugh or happy?			
How does your child learn best: ☐ **Seeing** ☐ **Doing** ☐ **Hearing**			

DEVELOPMENTAL HISTORY

Walking	Describe Age at onset/current:
☐ Yes ☐ No	Gross motor (moving/walking) concerns. If yes, please describe:
Talking	Describe Age at onset/current:
☐ Yes ☐ No	Language/Communication concerns. If yes, please describe:
Describe any strong preferences	

OTHER INFORMATION

Any other information which would help us understand this child:

Signature of Person Completing Form:	Relationship:	Date:

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: _____.

(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.

Toddler Feeding Preference (12 through 23 months)

Check all that apply: ☐Spoon ☐Cup ☐ Feeds Self ☐ 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.

☐ 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 ☐Wet ☐Bowel Movement ☐Rash ☐Other

☐ 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

DEVELOPMENTAL CENTER OF THE OZARKS

AUTHORIZATION TO PICK UP INDIVIDUALS

NAME: _____BIRTHDATE: _____

ADDITIONAL PERSONS AUTHORIZED TO PICK UP:

1. _____ 3. _____

2. _____ 4. _____

5. _____ 6. _____

The following individuals **DO NOT**** have authorization to pick up the above-named person:
Legal documentation must be attached if restricting biological parents or parent of record.

1. _____

2. _____

3. _____

****NOTE:** If the above individual(s) is one of the parents or legal guardian, we must have appropriate documentation, such as a court approved visiting restriction, restraining order, or other legal document, to prevent contact or picking up. If the individual(s) does indicate the desire to leave, DCO staff will attempt to prevent them from leaving while another staff calls you and/or 911.

Unless notified otherwise, our staff will allow the above named individual(s) to leave with and/or have contact with their Service/Support Coordinator, Case Worker, Residential Staff (if applicable), and immediate family members.

_____	_____	_____
Relationship	Legally Responsible Person	Date

_____	_____
Caseworker	Service/Support Coordinator

NOTE: No individual will be voluntarily released to an authorized person who is obviously incapacitated due to alcohol, substance abuse, or mental condition. If the authorized person insists on picking up the individual served, staff will immediately contact 911 to report the incident.

DEVELOPMENTAL CENTER OF THE OZARKS
MEDICAL RELEASE

Name of Child:	**Birthdate:**

Medical Diagnosis/condition:
Treatment Requested During Program Hours:

Medication:	**Dosage:**	**Time:**	**Start Date:**	**End Date:**	**Side Effects**

Equipment Necessary for Treatment:		
Contact Person/Company if Equipment Requires Corrections/Replacement:		
Who Will Be Responsible for Training DCO Staff:		
Name:	**Relationship:**	**Phone:**

The following release is required if a medical condition is present or occurs which requires equipment, medication, or specialized treatments:

I agree that DCO may contact the physician(s) in regard to the specified diagnosis/condition, significant illness, very high temperature, or critical injury.

I agree that Program staff may contact the physician of record for current Medical/medication orders.

I agree to provide the equipment indicated by my physician.

I understand that the DCO Program is licensed/accredited, but may not be able to meet the specific needs of my son/daughter/ward. As such, the enrollment is on a trial basis (typically two weeks) You will receive daily notes indicating positive comments or concerns. At the end of the trial period a meeting will be held to discuss continued enrollment.

I understand that if the condition or treatment increases or reaches a level which cannot be provided in a group environment, I will be notified and discharge plans made.

Reminder Note: If an individual becomes ill such as temperature, vomitting, diarrhea, or is obviously ill, they may not attend. If already present, the family, guardian, or designated individual will be contacted to pick them up as soon as possible. This is a licensing and health department policy which at Developmental Center of The Ozarks applies to all Programs.

_____ _____

Parent/Guardian Date

DEVELOPMENTAL CENTER OF THE OZARKS
MEDIA and INFORMATION RELEASE – AUTHORIZATION

DCO has several media events each year in which we highlight individuals attending our Programs. If you authorize the use of pictures or video, you have the right to revoke the authorization at any time by completing the bottom portion of this form and sending it to the Privacy Officer at the above address. We are also expanding our services to conduct them virtually. This release will also give permission for our individuals to participate in those activities depending on program**.** Actions already taken based on this authorization, prior to revocation will **not** be affected. Services are in no way affected by the authorization of this release.

MEDIA RELEASE

Events where pictures/photographs/video may include:

1. Annual Report – published one (1) time annually to individuals, families, and donors.
2. Brochures – used to highlight the Agency services and/or specific Programs. Distributed to those having an interest, touring the Program, or inquiring about services.
3. Annual Campaign Letter – annual letter announcing the new year for contributions to donors, foundations and other contributors.
4. Pictures taken for the above reasons may be used on the DCO website/social media depicting the appropriate Program.
5. Numerous marketing and fundraising efforts take place annually which support all DCO Programs.
6. Public Service Announcements and video for news reports/articles may include videotaping of you, son, daughter, or ward interactions in a specific Program and/or activity. It may be used in conjunction with a special event or to provide information about the Developmental Center and its Programs.
7. Virtual services conducted via Zoom or another platform. These will not be recorded and will offer live interaction.

☐ Yes, you have permission to send me information through email, text, video, voice mail, fax and phone.
☐ No, you do not have permission to send me information through email, text, video, voice mail, fax and phone.

☐ Yes, you have permission to take and use pictures for the specific purposes listed above including DCO's social media accounts.
☐ No, you do not have permission to take or use pictures.

This Authorization is good for one (1) year from the date signed below unless revoked by the legally responsible party. Please indicate below and return this release if we have permission to include pictures. If you do not return this release, we will **not include** yourself, son, daughter, or ward in the event.

I understand that I can revoke this authorization at any time with a written request to DCO at 1545 E. Pythian,

Springfield, MO 65802 or by giving the written request directly to a staff person.

Name of Individual: _____

Signature of Legal Representative: _____ Date: _____

Privacy Officer: _____ Date: _____

NOTICE OF REVOCATION

I, _____ (Individual or Legal Representative) hereby revoke my authorization of this disclosure of information. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected. I also understand that I can revoke my approval at any time in the future if I communicate in writing to the Program Coordinator or Secretary.

Signature of Legal Representative: _____ Date: _____

Signature of Privacy Officer (acknowledging revocation): _____ Date: _____