MUST HAVE TO REGISTER FOR SACC:

- ☐ Registration Forms
- ☐ Registration Fee ($30)
- ☐ First week payment
- ☐ Immunization Records
- ☐ Parent Handbook
- ☐ DCN Number (must have if applicable)

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

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 THANPARENT (ATLEAST 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 (YOUARE 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 Martin Luther King, Jr.'s Birthday Lincoln's Birthday Washington's Birthday	☐ Easter ☐ Truman Day ☐ Memorial Day ☐ Juneteenth ☐ Independence Day	☐ Labor Day ☐ Columbus Day ☐ Veterans Day ☐ Thanksgiving 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

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.

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2025 through June 30, 2026

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 Size	Yearly Income	Family Size	Yearly Income
1	$28,953	5	$69,653
2	$39,128	6	$79,828
3	$49,303	7	$90,003
4	$59,478	8	$100,178

For each additional family member, add $10,175

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,

Center Owner/Director

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.

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)	DATE
	XXX-XX-	/ /
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

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/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.

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

SCHOOL-AGE CHILD HEALTH REPORT

IDENTIFYING INFORMATION	
CHILD'S NAME	BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.

☐ My child is able to participate in group care but has special health or medical requirements as listed below.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE

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

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

MEDICATION AUTHORIZATION

SAVE
PRINT
RESET

MEDICATION REQUIREMENT

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

(PROPER NAME OF MEDICATION)

CHILD'S FULL NAME	DATE MEDICATION TAKEN FROM	UNTIL

DOSAGE	TIME(S) OF DAY

POSSIBLE SIDE EFFECTS

SIGNATURE OF PARENT(S) OR GUARDIAN	DATE

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

FORM TO BE RETAINED IN CHILD'S RECORD

SCHOOL AGE CHILD CARE PROGRAM
FEE SCHEDULE

Child's Name: _____ Birthdate:_____

School Attending: _____

Parent's Name: _____ Birthdate:_____

DCN # _____ (if applicable)

Please Check One	✓	Part Time (1-2 Days) Members	✓	Part Time (1-2 Days) Community Participant	✓	Full Time (3 Days or more) Members	✓	Full Time (3 Days or more) Community Participant
Before School		$26.00		$38.00		$32.00		$44.00
After School		$32.00		$48.00		$40.00		$55.00
Before & After School		$47.00		$69.00		$58.00		$86.00

Payment Terms:

- Registration Fee: $30 per family, due at registration, along with first week's tuition.
- Weekly fees are paid on Wednesday by electronic funds transfer (EFT) from a specified checking/ savings account, credit or debit card for the current week of service. Should any EFT or charge not be honored, the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, another form of payment must be provided, plus a $10 service charge.
- **Failure to notify the Y a week in advance of any changes to your child's schedule or enrollment will result in the bank draft being processed on the Wednesday of the current week. No refunds will be issued.**

_____ _____

Parent Signature Date

SCHOOL AGE CHILD CARE BANK DRAFT FORM

School name: _____

First Name	MI	Last Name	M/F	Birth Date

Telephone	Cell	Email

Billing Address

Street	City	State	Zip

Payment Terms & Conditions on electronic signature

■ In order to provide for convenient School Age Child Care payments to the YMCA of St. Joseph, we authorize electronic funds transfer (EFT) from this specified checking/savings account, credit or debit card. We will provide a one week written notice for any changes to our account.

■ Should any EFT or charge not be honored, we understand that the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, we will be required provide another form of payment plus a $10 service charge.

Failure to notify the Y a week in advance of any changes to your child's schedule or enrollment will result in the bank draft being processed on the Wednesday of the current week. No refunds will be issued.

Payment Options

Electronic Funds Transfer (EFT): $. beginning (MMYY)

A. ☐ Checking ☐ Savings Bank Name:_____

Account Number

Routing Number

Please attach a voided check

B. Debit/Credit Card: ☐ Visa ☐ MC ☐ Discover ☐ AMEX

Expire Date

I have read and agree to all terms of the YMCA payment terms and conditions.

Signature of Responsible Party	Date

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF ST. JOSEPH THIRD PARTY/DFS FORM RESPONSIBILITY AGREEMENT

This form must be signed and submitted at time of registration.
Only parents with third party billing of DFS/Voc Rehab need to fill out this form.

The YMCA of St. Joseph accepts payment from DFS (Division of Family Services)/Voc Rehab. It is important that you read the fee schedule so you are aware of the rates you will be charged for any YMCA services used which are not covered by your third party funding. This agreement is **REQUIRED** for all families who are subsidized by DFS/Voc Rehab, Third Party agencies, or other individuals. Please read the following carefully.

As a parent or legal guardian of **(child's name)**, I understand and agree to the following:

- I am responsible for payment of the **full weekly tuition fee, due every Wednesday (paid by EFT) for the current week of service,** until official notice of DFS/Voc Rehab qualification is received. I have read the **Parent Handbook and Fee Schedule,** including payment policies, and understand that I am responsible for any fees not covered by DFS/Voc Rehab or third party, **including the $30 per family registration fee.**

- Initially I am responsible for **payment at the full fee for any care I use that is not authorized by DFS/Voc Rehab.**
  This includes, but is not limited to:
  1. Any care that occurs before or after the dates authorized by DFS/Voc Rehab.
  2. Care used on days/times not authorized by DFS/Voc Rehab.
  3. Late pick-up fees
  4. Late payment fees
  5. **ANY** other fees as indicated in YMCA documents including the Parent Handbook.

- I will **contact DFS/Voc Rehab and the YMCA immediately, in writing, if my situation changes (employment status, hours of work or enrollment in school, class schedule, custody issues, living arrangements, change of address).**

- I will provide my caseworker with documentation at least **two weeks before my contract expiration date.** This gives your caseworker time to process your information and provide a new authorization to the Y before your current contract expires.

- Cancellation/Expiration of DFS/Voc Rehab funds **does not automatically cancel or change** my childcare with the YMCA. **I am responsible for completing change/cancellation forms** according to YMCA policies. **If your DFS/Voc Rehab expires,** you will be charged **as a full paying family** until the Y receives a change/cancellation form.

- I understand that **YMCA financial assistance may be available** if I have applied, but do not qualify for DFS/Voc Rehab. Financial assistance **is not retroactive**.

- **I understand that failure to make payments as scheduled can/will result in termination of my care and will result in lack of DFS/Voc Rehab benefits for future providers. Failure to pay all fees in a timely manner may result in disenrollment from the program and your account being sent to collection.**

Expiration Date: _____

Weekly Amount due from parent $_____

Child's Name: _____

Program Location: _____

DCN #_____ (must have at time of registration)

Parent/Guardian Name *(please print)*_____

Parent/Guardian Signature: _____

Date: _____

DVN Numbers

- **Eugene Field –** 000177017
- **Hyde –** 001800028
- **Parkway –** 001800073
- **Pershing –** 001800082
- **Pickett –** 001993231
- **Oak Grove –** 002487385
- **Skaith –** 003003743
- **Mark Twain –** 003077594
- **Lake Contrary –** TBD

ACCOUNT ACCESS AUTHORIZATION

I authorize the following to have access to my child(ren)'s account in the event that the named person(s) is paying the account. I understand by listing the person(s), that they will have access to the account balance for my child(ren). If a person has not been authorized, information about my child(ren)'s account should not be provided.

_____
Name

_____
Name

EXTRA CURRICULAR ACTIVITIES

I give my permission for my child _____, to participate in
Name of Child

_____. The program will run from_____
Name of Program Start Date

to _____, and they will meet every _____ from _____ to _____.
End Date Day of the Week Start Time End Time

_____ My child WILL return to the School Age Child Care program after the activity.

_____ My child WILL NOT return to the School Age Child Care program after the activity.

_____ _____
Parent Signature Date