

KUMCC Forms Packet Instructions

The forms packet is the same for children attending Preschool and CDO – please only fill out one packet per child and return to KUMCC. Signatures must be signed and not typed.

- **Enrollment Form**
 - Please fill out all boxes
 - You can use “same as above” for addresses
 - If cell phone numbers are the home number please draw a line through the home number box
 - You MUST choose a preferred hospital and include the phone number. *In an emergency, children will likely be taken to the closest hospital.*
 - Pg 2. – persons authorized to take children from the facility
 - Please list PARENTS/GAURDIANS as well as additional people allowed to pick up your child
- **Medical Form (Healthy Child Form)**
 - This must be completed within 30 days of the first date of attendance. It only needs to be completed ONE TIME during your attendance at KUMCC unless something changes. It must be signed by your child’s doctor.
 - Many doctors also have their own version of this form – you can call and ask that they mail it to us.
- **Photo/Email Release**
- **Emergency Card**
 - Please list PARENTS/GAURDIANS as well as additional people allowed to pick up your child
- **NPR – Notice of Parental Responsibility**
 - Print your child’s name at the top and sign your name at the bottom
- **Medical Authorization**
 - Please select if we are able to use hand sanitizer and/or diaper cream on your child.
 - **We do not supply diaper cream, so you should OK the type you send in their backpack**
 - IF your child utilizes an Epi-Pen or AUVI-Q please check these boxes and add a dosage. If they do not, no need to check anything there.
- **Receipt of Handbook:**
 - The handbook is available on our website.

We need a copy of your child’s most up to date immunizations submitted with their paperwork packet



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

CHILD CARE ENROLLMENT FORM FOR LICENSE-EXEMPT FACILITIES

FACILITY/PROVIDER NAME KIRKWOOD UNITED METHODIST CHILDREN'S CENTER		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)			
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 Kirkwood United Methodist Children's Center _____ DAY CARE PROVIDER			
TO CONTACT THE FOLLOWING:			
PHYSICIAN OR CLINIC			
NAME		TELEPHONE NUMBER	
PREFERRED HOSPITAL			
NAME		TELEPHONE NUMBER	

ACKNOWLEDGEMENTS		
A	I HAVE BEEN INFORMED OF THE REQUIRED HEALTH AND SAFETY INSPECTIONS AND THE INSPECTION FORMS ARE AVAILABLE FOR REVIEW.	PARENT/GUARDIAN INITIALS
B	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ADMITTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
C	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
PERSON(S) AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY		
NAME	NAME	
NAME	NAME	
NAME	NAME	
NAME	NAME	
Complete - Preschool Only: Session Applying For (circle and mark 1st & 2nd choice): Y3's MW 9-11:30 _____ TTh 9-11:30 _____ F 9-11:30 _____ Note: Y3's turn 3 by March of the school year. Friday only may be combined with one of the 2 day Y3's classes. 3 / 4 MWF 9-11:30 _____ TTh 9-11:30 _____ MWF 9-1:30 _____ MWF 9-3 _____ Pre-K TWTh 9-11:30 _____ M-Th 9-11:30 _____ M-F 9-11:30 _____ MWF 9-1:30 _____ MWF 9-3 _____ Lunch Bunch 11:30 - 1:30 (mark days requesting): Monday Tuesday Wednesday Thursday Friday		
Early Morning Drop Off 8:00 - 9:00 am (mark days requesting) Ages 2.5 - 5 years Preschool & CDO Monday Tuesday Wednesday Thursday Friday		
Family Church Affiliation: _____		
PARENT/GUARDIAN SIGNATURE		DATE
FORM TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE. FILING: FILE FORM IN CHILD'S INDIVIDUAL RECORD.		



KIRKWOOD UNITED METHODIST CHILDREN'S CENTER

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

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.)

PLEASE ATTACH IMMUNIZATION RECORDS

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

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

Photography/Publicity Release

Periodically, we take photographs or videos of the children to document events and activities. Children are not identified. These photos appear in forms such as display panels throughout the school, videos, brochures, our website, or Facebook pages of KUM Children's Center, Kirkwood United Methodist Church or our community partner, Kirkwood Area Every Child Promise. Parents, children, KUM Children's Center, KUMC and KAEChP do not receive compensation for the child's appearance. Ownership of the photos or videos remains with KUM Preschool.

I understand the statement and **(please check one for each)**

- **I do _____ or I do NOT _____** give permission for my child's photo to be used in print form and displayed throughout the school as described above.
- **I do _____ or I do NOT _____** give permission for my child's photo/video to be used on digital media as described above.

Parent/Legal Guardian Signature

Date

Email Information

Please **PRINT** all information. Email addresses will be used for communication from KUM Preschool.

Teachers may share an E-mail list with other parents in your child's class, therefore, addresses may be accessible to other parents in the KUM Children's Center Programs.

I agree to use the KUM Children's Center E-mail data for purposes only related to the preschool.

By signing this you agree to have your E-mail published in the Preschool Buzz Book and/or Class Lists and used for school wide E-mail blasts. The Buzz Book format only allows for one E-mail address, but if you would like to add another for E-mail blasts you may do so below.

Signed _____

Child's Name _____

Parent's Name _____

Email Address _____

KUM Children's Center

Emergency Card

Child's Name _____ Telephone _____
(Last) (First) (Middle)

Home Address _____ Zip _____ Date of Birth _____

Father's Name _____ Phone (work) _____ (cell) _____

Mother's Name _____ Phone (work) _____ (cell) _____

Allergies (Food/Medications) _____

If parents cannot be reached, name two persons to call in case of emergency:

Name _____ Phone _____

Name _____ Phone _____

Child's Physician _____ Phone _____

Child's Name: _____

PERSON(S) AUTHORIZED TO TAKE CHILD FROM CHILD CARE FACILITY	
NAME	NAME
NAME	NAME
NAME	NAME
NAME	NAME



Name: _____

RELIGIOUS ORGANIZATION CHILD CARE FACILITY NOTICE OF PARENTAL RESPONSIBILITY

LEGAL NAME OF FACILITY Kirkwood United Methodist Children's Center (CDO and Preschool)		DVN 000248075
PHYSICAL ADDRESS (STREET, CITY, STATE, ZIP CODE) 201 W. Adams Kirkwood, MO 63122		
FACILITY TELEPHONE NUMBER 314-966-5223	FACILITY E-MAIL ADDRESS jenny@kirkwoodumc.org	

INSPECTIONS

Section 210.211 RSMo exempts this religious organization child care facility from state licensing and supervision by the Department of Elementary and Secondary Education (DESE). It is state inspected only for fire, health, and sanitation requirements as indicated below. Inspections are available on the Show Me Child Care Provider Search and can be accessed at <https://dese.mo.gov/childhood/child-care/find-care>

NAME OF AGENCY AND TYPE OF INSPECTION	ADDRESS	TELEPHONE NUMBER	INSPECTION	DATE
Office of Childhood - Child Care Compliance	220 S. Jefferson Ave. St. Louis, MO 63103	(314) 877-0210	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	10/14/25
Fire Marshal's Office (Fire Safety Inspection)	PO Box 644 205 Jefferson St. Jefferson City, MO 65101	(573) 751-2930	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	7/31/25
Local Health Office or DHSS (Sanitation Inspection)	220 S. Jefferson Ave. St. Louis, MO 63103	(314) 877-0210	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	9/10/25

STANDARD STAFF/CHILD RATIOS ESTABLISHED BY THIS FACILITY

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 staff member for every	4
2 to 4 years of age	1 staff member for every	8
5 years of age and older	1 staff member for every	14

STAFF/CHILD RATIOS FOR LICENSED CENTERS

AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 staff member for every	4
2 years of age	1 staff member for every	8
3 and 4 years of age	1 staff member for every	10
5 years of age and older	1 staff member for every	16

TOTAL NUMBER OF CHILDREN ENROLLED BY THIS FACILITY: 202

BACKGROUND CHECK REQUIREMENTS

Section 210.254 RSMo requires notification that background checks have been conducted under the provisions of section 210.1080 RSMo.

Section 210.1080 RSMo specifies criminal background checks for child care staff members. The requirements for religious organizations operating a child care facility are as follows:

- Facilities operated by a religious organization that receive federal funds for providing care for children must have qualifying background screening results for child care staff members as defined in 210.1080.1(1) RSMo.
- Facilities operated by a religious organization and that do not receive federal funds for providing care for children are not required to have qualifying background screening results for all child care staff members pursuant to 210.1080.9 RSMo.
- Child care staff members of facilities operated by a religious organization that receive federal funds for providing care for children, with disqualifying background screening results are prohibited from being on the premises during child care hours.
- Facilities operated by a religious organization that receive federal funds for providing care for children, must request criminal background checks for child care staff members every 5 years, as defined in 210.1080.1(1) RSMo.

BACKGROUND CHECKS HAVE BEEN CONDUCTED AS REQUIRED BY SECTION 210.1080 RSMO.

☒ Yes ☐ No

FACILITY DISCIPLINE AND EDUCATIONAL PHILOSOPHY/POLICIES

THE DISCIPLINARY PHILOSOPHY AND POLICIES OF THIS FACILITY ARE:

In the Kirkwood United Methodist Children's Center Parent Handbook on page 8. (Also available on our website.)

THE EDUCATION PHILOSOPHY AND POLICIES OF THIS FACILITY ARE:

In the Kirkwood United Methodist Children's Center Parent Handbook on page 4. (Also available on our website.)

REQUIRED SIGNATURES

Section 210.254, RSMo requires the facility to furnish two copies of this document to a parent(s) upon enrollment of a child. Parents acknowledge by signature that they have read and accepted the information contained in this document. One copy of this signed document is given to the parent(s); the other copy is retained in the child's record at the facility.

PARENT(S)	DATE
PRINCIPAL OPERATING OFFICER/FACILITY DIRECTOR	DATE
INDIVIDUAL RESPONSIBLE FOR THE RELIGIOUS ORGANIZATION - PASTOR, MINISTER, PRIEST, ETC.	DATE

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

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 FROM
9/8/2026-7/31/2027

Hand Sanitizer
(any brand)

Diaper Rash Cream
Brand _____

Epi-Pen

AUVI-Q

CHILD'S FULL NAME

DOSAGE

TIME(S) OF DAY

As Needed

POSSIBLE SIDE EFFECTS

SIGNATURE OF PARENT(S) OR GUARDIAN

DATE

FORM TO BE RETAINED IN CHILD'S RECORD

Required Document: Sign and Return

RECEIPT OF KUMCC HANDBOOK

The undersigned acknowledge that they have accessed and read the KUMCC Handbook (online), and further do agree to abide by the policies, rules, and regulations contained therein. It is further understood that other additional policies, rules, and regulations not specifically referred to herein may be reasonably necessary for admission or retention of a child in the program. KUMCC Handbook is available online at www.KUMChildrensCenter.org or you may request a paper copy.

Print Child's Name _____

Parent/Legal Guardian Signature _____

Date _____