Extraordinary Kids Preschool

Enrollment Packet – Infants & Toddlers

1804 Boone's Lick Rd.
St. Charles, MO 63301
Phone: (636) 946-8440

Extraordinary Kids Preschool

What's in This Packet?

Welcome to Extraordinary Kids Preschool! We're so glad you're here. Choosing care for your child is a big decision—and we're honored that you're considering us. Our team is dedicated to creating a safe, nurturing, and joyful place where your child can learn, grow, and thrive.

This packet contains everything needed to complete your child's enrollment. Some of the forms are required by the State of Missouri, while others help us get to know your child and outline the policies that help our school run smoothly.

Here's what we need from you: Please take a few moments to carefully read and fill out each form. Some may not apply to your child—like our Specialized Care Plan—so feel free to skip those unless we ask you to complete them. If you're unsure about anything, we're just a phone call or visit away and always happy to help.

Once you've completed the packet, return it to the office. We'll review it and be in touch to confirm your child's official start date. Your child's spot is not guaranteed until we receive all completed paperwork.

Thank you again for trusting us with your child. We look forward to partnering with you in this next exciting stage of your family's journey.

Extraordinary Kids Preschool

¿Qué hay en este paquete?

¡Bienvenidos a Extraordinary Kids Preschool! Estamos muy contentos de que estén aquí. Elegir quién cuidará a su hijo(a) es una decisión muy importante—y nos sentimos honrados de que nos estén considerando. Nuestro equipo está comprometido a brindar un lugar seguro, cariñoso y alegre donde su hijo(a) pueda aprender, crecer y prosperar.

Este paquete contiene todo lo necesario para completar la inscripción de su hijo(a). Algunos formularios son requeridos por el Estado de Missouri y otros nos ayudan a conocer mejor a su hijo(a) y explicar nuestras políticas.

¿Qué necesitamos de usted? Tómese unos minutos para leer y completar cada formulario con cuidado. Algunos tal vez no apliquen a su hijo(a)—como el Plan de Atención Especializada—y pueden ser omitidos a menos que se le indique lo contrario. Si tiene dudas o necesita ayuda, puede llamarnos o venir a la oficina—siempre estamos aquí para ayudarle.

Una vez que haya completado el paquete, por favor devuélvalo a la oficina. Lo revisaremos y nos pondremos en contacto para confirmar la fecha oficial de inicio de su hijo(a). El lugar no estará garantizado hasta que recibamos todos los formularios completados.

Gracias nuevamente por confiar en nosotros. Esperamos acompañarlos en esta nueva y emocionante etapa para su familia.

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

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 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
CHILD AND ADULT CARE FOOD PROGRAM

INFANT AND TODDLER FEEDING AND CARE PLAN

FOR CHILD CARE FACILITY USE

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 and reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

INSTRUCTIONS (FOR 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

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about militaryrelated services in Missouri or visit www.dese.mo.gov/veterans-services.

FEEDING INFORMATION

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
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
Breastmilk			
Milk			
Table Food			

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: mail:U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; or email: Program.Intake@usda.gov. This institution is an equal opportunity provider.

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

Extraordinary Kids Preschool

Authorization For Emergency Care and Transportation

Child's Name: _____

If, at any time, due to such circumstances as an injury or sudden illness or other unforeseen emergency, medical treatment is necessary, I authorize Extraordinary Kids Preschool #___ to take whatever emergency measures they deem necessary for the protection of my child while in their care.

I understand that a natural or deliberate disaster or emergency may result in the need for my child to be transported to another location for safety.

I understand that this may involve contacting a doctor, interpreting and carrying out his or her instructions, and transporting my child to a hospital or doctor's office, including the possible use of an ambulance located at

_____

_____

Or the doctor contacted will be

_____

_____

I understand that this may be done prior to contacting me, and that any expense incurred for such treatment, including ambulance fees, is my responsibility.

Parent/Guardian Signature Date

Extraordinary Kids Preschool #___

Extraordinary Kids Preschool

INFANT SAFE SLEEP POLICY

Facility Name: Extraordinary Kids Preschool # _____ Facility DVN: _____

Date Adopted: February 6, 2023

Purpose: The purpose of the Safe Sleep Policy is to maintain a safe sleep environment that reduces the risk of sudden infant death syndrome (SIDS) and sudden unexpected infant deaths (SUIDS) in children less than one year of age. Missouri law (S 210.223.1, RSMo,) requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent safe sleep recommendations of the American Academy of Pediatrics (AAP). Missouri child care licensing rules require licensed child care facilities to provide parent(s) and/or guardians(s) who have infants in care be provided a copy of the facility's safe sleep policy.

Sudden infant death syndrome is the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and a review of the clinical history.

Sudden unexpected infant death is the sudden and unexpected death of an infant less than one year of age in which the manner and cause of death are not immediately obvious prior to investigation. Causes of sudden unexpected infant death include, but are not limited to, metabolic disorders, hypothermia or hyperthermia neglect or homicide, poisoning, and accidental suffocation.

Child care providers can maintain safer sleep environments for infants that help lower the chances of SIDS. Our goal is to take proactive steps to reduce the risk of SIDS in child care and to work with parents to keep infants safer while they sleep. To do so, this facility will practice the following safe sleep policy:

Safe Sleep Practices

1. Infants, less than one (1) year age, will always be placed on their backs to sleep. When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements, 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. Caregivers will put the infant to sleep as specified in the written instructions.

2. When infants can easily turn from their stomachs to their backs and from their backs to their stomachs, they shall be initially placed on their backs, but shall be allowed to adopt whatever positions they prefer for sleep. The American Academy of Pediatrics recommends that infants are placed on their back to sleep, but when infants can easily turn over from their back to their stomach, they may adopt whatever position they prefer for sleep. We will follow this recommendation by the American Academy of Pediatrics.

3. Sleeping infants shall have a supervised nap/sleep period. The caregiver shall be positioned where he or she can hear and see the infant, The caregiver shall physically check on the infant frequently during napping or sleeping and shall remain in close proximity to the infant in order to hear and see them if they have difficulty during napping/sleeping or when they awaken.

4, Equipment such as a sound machine, that may interfere with the caregiver's ability to see or hear a child who may be distressed, is prohibited.

5. Steps will be taken to keep infants from overheating by regulating the room temperature, avoiding excess bedding, and not over-dressing or over-wrapping the infant. Infants should be dressed appropriately for the environment, with no more than one (1) layer more than an adult would wear to be comfortable in that

environment. Caregivers will conduct physical checks of the infant to ensure the infant is not overheated or distressed.

6. The lighting in the room must allow the caregiver/teacher to see each infant's face. to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier (if used).

7. An caregivers will receive in-person or online training on infant safe steep based on AAP safe sleep recommendations. This training must be completed within 30 days of employment or volunteering and will be completed every three years.

Safe Sleep Environment

1. Room temperature will be kept at no less than 68'F and no more than 85'F when measured two feet from the floor. Infants are supervised to ensure they are not overheated or chilled.

2, Infants' heads and face win not be covered during sleep. infants' cribs will not have blankets or bedding hanging on the sides of the crib. **We may use sleep clothing (i.e. deep sack, sleepers} that is designed to keep an infant warm without the possible hazard of covering the head or face during sleep/nap time.**

3. No blankets, loose bedding, comforters, pillows, bumper pads. or any object that can increase the risk of entrapment, suffocation or strangulation will be used in cribs, playpens or other sleeping equipment.

4. Toys and stuffed animals will be removed from the crib when the infant is sleeping. **When indicated on the Infant and Toddler Feeding and Care Plan or with written parent consent, pacifiers will be allowed in infants' cribs while they sleep. The pacifier cannot have cords or attaching mechanisms.**

5. Only an individually-assigned safety-approved crib, portable crib, or playpen with a firm mattress and tight-fitting sheet will be used for infant napping or sleeping.

6. Only one infant may occupy a crib or playpen at one time.

7. Sitting devices such as car safety seats, strollers, swings. infant carders, infant slings, and other sitting devices will not be used for sleep/nap time. Infants who fall asleep anywhere other than a crib, portable crib, or playpen must be placed in the crib or playpen for the remainder of their sleep or nap time.

8. No person shall smoke or otherwise use tobacco products in any area of the child care facility during the period of time when children cared for under the license are present.

9. Home monitors or commercial devices marketed to reduce the risk of Sudden Infant Death Syndrome (SIDS) shall not be used in place of supervision while children are napping and sleeping.

10. All parents/guardians of infants shall be informed of and given the facility's written Safe Sleep Policy at enrollment.

11. To promote healthy development, infants who are awake will be given supervised "tummy time" for exercise and for play.

I have received a copy of this safe sleep policy.

Printed Child's Name Date of Birth

Parent/Guardian Signature Date

Extraordinary Kids Preschool

Extraordinary Kids Preschool Policies

_____ Tuition is due on Friday before childcare is provided. A $25 late fee will apply for accounts not paid before Tuesday. If your account falls one week behind, you will have to withdraw your child until tuition is current. This includes state co-pays. If a collections or small claims court is needed to collect these funds, you will be responsible for any additional expenses that occur.

_____ Tuition credit is not given for absences due to illness, holidays, bad weather or behavioral instances.

_____ All children must be escorted inside the building by an adult. We will only release children to adults on the authorized release form. Parents must sign their child in and out each day.

_____ In order to keep all of our children healthy, it is our policy that your child will be fever, diarrhea, and vomit free for 24 hours before returning to the center if sent home.

_____ Each parent will need to supply a complete change of clothing, diapers if appliable, wipes, and a crib sheet and blanket to be kept at school.

_____ Toys, cell phones, and gaming systems should not be brought to the center. We provide a large variety of age-appropriate, educational toys and manipulatives.

_____ All files must be kept current to be in compliance with Missouri state laws. Please inform us of any changes in medication, phone numbers, address or contact information. Immunizations, medical forms, and DFS contract must be kept up-to-date.

_____ All medications brought into the center must be given to the director. A medical form must be completed and signed by the guardian in order for us to administer the medication to the child. The medication must be in the original bottle with your child's name on it along with instructions.

_____ Should a serious medical condition occur, we will make an immediate attempt to contact you or your emergency contact. If we are unable to reach either, will call for emergency assistance 911. Parents will assume responsibility for any resulting expenses.

_____ If your child will be arriving after 8:30 AM, you must contact the center and let us know. If your child arrives after 9:30 AM, then they will be turned away if we are not notified.

Extraordinary Kids Preschool

We ask that pickup is after 2:30 PM unless notified. Our center must be able to staff accordingly and prepare meals per children in attendance.

_____ If a child is unable to adjust or is having discipline issues after a reasonable manner of time, the director reserves the right to request a withdrawal of the child.

_____ We will follow the St. Charles Publich Schools schedule regarding bad weather.

Parent or Guardian Signature:

Date: ____/____/____

Extraordinary Kids Preschool

Extraordinary Kids Preschool Fee Agreement

My child, _____ will be attending Extraordinary Kids Preschool on the following days:

Registration Fee: $100.00

_____ Plan 1 – Daily

My established daily amount will be $_____ with a three-day minimum. This is ONLY available for infants and toddlers if space is available. Days of attendance must be the same every week, or we must have a schedule a week in advance. **A minimum of three days will be charged to your account regardless of attendance.** Tuition is due the Friday before the week of care. A late fee of $25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM. Part-time enrollment can be cancelled if space is needed for full-time childcare.

_____ Plan 2 – Weekly

My established amount will be $_____. Tuition is due Friday before the week of care. A late fee of $25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM.

_____ Plan 3 – State Assistance

State Contract Amount: $_____ Sliding Fee/day $_____ Co-pay/week $_____

Total Parent Responsibility $_____ per week

Contact Start Date: _____ End Date: _____ Approved Hours: _____ Approved Days: _____

- I understand that Plan 2 & Plan 3 are weekly rates and apply regardless of my child's attendance. No refunds will be given for missed days. Tuition is due the Friday before care. A late fee of $25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM.
- There are no refunds for missed days or Holidays. Each family will receive 5 vacation days after one year of enrollment.
- I understand that childcare services will be suspended until past due amounts are paid. All accounts must be current to continue receiving services.
- I understand that the fee is $40.00 for an NSF (non-sufficient funds) check and must be paid in full, with tuition, before continuing services.

- Late child pickup fees are due upon pickup of $1.00 per minute, per child after 6:00 PM.

Parent Signature: _____ Date: ____/____/____

Director's Signature: _____ Date: ____/____/____

Extraordinary Kids Preschool

Extraordinary Kids Preschool #4
1804 Boone's Lick Road
St. Charles, MO 63301
Phone: (636) 946-8440
DVN: 001631569

Extraordinary Kids Preschool Photo Permission Slip

Dear Parent/Guardian,

At Extraordinary Kids Preschool, we love capturing the joy and growth of our students through photographs. These images may be used to showcase our programs on our website, in promotional materials, or shared with parents via the Brightwheel app. Please indicate your preferences below regarding the use of your child's photographs.

Child's Name: _____

Parent/Guardian Name: _____

1. Permission for Website and Promotional Materials

I grant Extraordinary Kids Preschool permission to use photographs of my child on the company's website and in promotional materials (e.g., brochures, social media, advertisements).

☐ **Yes, I consent** to my child's photographs being used for website and promotional purposes.

☐ **No, I do not consent** to my child's photographs being used for website and promotional purposes.

2. Permission for Brightwheel App

I grant Extraordinary Kids Preschool permission to post photographs of my child on the Brightwheel app, including group photos shared with parents and individual photos sent to me directly.

☐ **Yes, I consent** to my child's photographs being shared on Brightwheel (group and individual).

☐ **Yes, I consent** to my child's photographs being shared on Brightwheel (individual only).

☐ **No, I do not consent** to my child's photographs being shared on Brightwheel.

Additional Notes (if any): _____

I understand that I may revoke this consent at any time by notifying Extraordinary Kids Preschool in writing. By signing below, I acknowledge my preferences for the use of my child's photographs.

Parent/Guardian Signature: _____

Date: _____

Thank you for helping us celebrate your child's experiences at Extraordinary Kids Preschool!

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

INDIVIDUAL PLAN FOR SPECIALIZED CARE

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE	DATE
X	

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.

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

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   Office of the Assistant Secretary for Civil Rights
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   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

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
CHILD AND ADULT CARE FOOD PROGRAM

INFANT AND TODDLER FEEDING AND CARE PLAN

FOR CHILD CARE FACILITY USE

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 and reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

INSTRUCTIONS (FOR 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

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about militaryrelated services in Missouri or visit www.dese.mo.gov/veterans-services.

FEEDING INFORMATION

TYPE OF FOOD	FEEDING TIME	KINDS OF FOOD	AMOUNT OF FOOD
Breastmilk			
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
Breastmilk			
Milk			
Table Food			

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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

Extraordinary Kids Preschool

Authorization For Emergency Care and Transportation

Child's Name: _____

If, at any time, due to such circumstances as an injury or sudden illness or other unforeseen emergency, medical treatment is necessary, I authorize Extraordinary Kids Preschool #___ to take whatever emergency measures they deem necessary for the protection of my child while in their care.

I understand that a natural or deliberate disaster or emergency may result in the need for my child to be transported to another location for safety.

I understand that this may involve contacting a doctor, interpreting and carrying out his or her instructions, and transporting my child to a hospital or doctor's office, including the possible use of an ambulance located at

_____

_____

Or the doctor contacted will be

_____

_____

I understand that this may be done prior to contacting me, and that any expense incurred for such treatment, including ambulance fees, is my responsibility.

Parent/Guardian Signature Date

Extraordinary Kids Preschool #___

Extraordinary Kids Preschool

INFANT SAFE SLEEP POLICY

Facility Name: Extraordinary Kids Preschool # _____ Facility DVN: _____

Date Adopted: February 6, 2023

Purpose: The purpose of the Safe Sleep Policy is to maintain a safe sleep environment that reduces the risk of sudden infant death syndrome (SIDS) and sudden unexpected infant deaths (SUIDS) in children less than one year of age. Missouri law (S 210.223.1, RSMo,) requires all licensed child care facilities that provide care for children less than one year of age to implement and maintain a written safe sleep policy in accordance with the most recent safe sleep recommendations of the American Academy of Pediatrics (AAP). Missouri child care licensing rules require licensed child care facilities to provide parent(s) and/or guardians(s) who have infants in care be provided a copy of the facility's safe sleep policy.

Sudden infant death syndrome is the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and a review of the clinical history.

Sudden unexpected infant death is the sudden and unexpected death of an infant less than one year of age in which the manner and cause of death are not immediately obvious prior to investigation. Causes of sudden unexpected infant death include, but are not limited to, metabolic disorders, hypothermia or hyperthermia neglect or homicide, poisoning, and accidental suffocation.

Child care providers can maintain safer sleep environments for infants that help lower the chances of SIDS. Our goal is to take proactive steps to reduce the risk of SIDS in child care and to work with parents to keep infants safer while they sleep. To do so, this facility will practice the following safe sleep policy:

Safe Sleep Practices

1. Infants, less than one (1) year age, will always be placed on their backs to sleep. When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements, 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. Caregivers will put the infant to sleep as specified in the written instructions.

2. When infants can easily turn from their stomachs to their backs and from their backs to their stomachs, they shall be initially placed on their backs, but shall be allowed to adopt whatever positions they prefer for sleep. The American Academy of Pediatrics recommends that infants are placed on their back to sleep, but when infants can easily turn over from their back to their stomach, they may adopt whatever position they prefer for sleep. We will follow this recommendation by the American Academy of Pediatrics.

3. Sleeping infants shall have a supervised nap/sleep period. The caregiver shall be positioned where he or she can hear and see the infant, The caregiver shall physically check on the infant frequently during napping or sleeping and shall remain in close proximity to the infant in order to hear and see them if they have difficulty during napping/sleeping or when they awaken.

4, Equipment such as a sound machine, that may interfere with the caregiver's ability to see or hear a child who may be distressed, is prohibited.

5. Steps will be taken to keep infants from overheating by regulating the room temperature, avoiding excess bedding, and not over-dressing or over-wrapping the infant. Infants should be dressed appropriately for the environment, with no more than one (1) layer more than an adult would wear to be comfortable in that

environment. Caregivers will conduct physical checks of the infant to ensure the infant is not overheated or distressed.

6. The lighting in the room must allow the caregiver/teacher to see each infant's face. to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier (if used).

7. An caregivers will receive in-person or online training on infant safe steep based on AAP safe sleep recommendations. This training must be completed within 30 days of employment or volunteering and will be completed every three years.

Safe Sleep Environment

1. Room temperature will be kept at no less than 68'F and no more than 85'F when measured two feet from the floor. Infants are supervised to ensure they are not overheated or chilled.

2, Infants' heads and face win not be covered during sleep. infants' cribs will not have blankets or bedding hanging on the sides of the crib. **We may use sleep clothing (i.e. deep sack, sleepers} that is designed to keep an infant warm without the possible hazard of covering the head or face during sleep/nap time.**

3. No blankets, loose bedding, comforters, pillows, bumper pads. or any object that can increase the risk of entrapment, suffocation or strangulation will be used in cribs, playpens or other sleeping equipment.

4. Toys and stuffed animals will be removed from the crib when the infant is sleeping. **When indicated on the Infant and Toddler Feeding and Care Plan or with written parent consent, pacifiers will be allowed in infants' cribs while they sleep. The pacifier cannot have cords or attaching mechanisms.**

5. Only an individually-assigned safety-approved crib, portable crib, or playpen with a firm mattress and tight-fitting sheet will be used for infant napping or sleeping.

6. Only one infant may occupy a crib or playpen at one time.

7. Sitting devices such as car safety seats, strollers, swings. infant carders, infant slings, and other sitting devices will not be used for sleep/nap time. Infants who fall asleep anywhere other than a crib, portable crib, or playpen must be placed in the crib or playpen for the remainder of their sleep or nap time.

8. No person shall smoke or otherwise use tobacco products in any area of the child care facility during the period of time when children cared for under the license are present.

9. Home monitors or commercial devices marketed to reduce the risk of Sudden Infant Death Syndrome (SIDS) shall not be used in place of supervision while children are napping and sleeping.

10. All parents/guardians of infants shall be informed of and given the facility's written Safe Sleep Policy at enrollment.

11. To promote healthy development, infants who are awake will be given supervised "tummy time" for exercise and for play.

I have received a copy of this safe sleep policy.

Printed Child's Name Date of Birth

Parent/Guardian Signature Date

Extraordinary Kids Preschool

Extraordinary Kids Preschool Policies

_____ Tuition is due on Friday before childcare is provided. A $25 late fee will apply for accounts not paid before Tuesday. If your account falls one week behind, you will have to withdraw your child until tuition is current. This includes state co-pays. If a collections or small claims court is needed to collect these funds, you will be responsible for any additional expenses that occur.

_____ Tuition credit is not given for absences due to illness, holidays, bad weather or behavioral instances.

_____ All children must be escorted inside the building by an adult. We will only release children to adults on the authorized release form. Parents must sign their child in and out each day.

_____ In order to keep all of our children healthy, it is our policy that your child will be fever, diarrhea, and vomit free for 24 hours before returning to the center if sent home.

_____ Each parent will need to supply a complete change of clothing, diapers if appliable, wipes, and a crib sheet and blanket to be kept at school.

_____ Toys, cell phones, and gaming systems should not be brought to the center. We provide a large variety of age-appropriate, educational toys and manipulatives.

_____ All files must be kept current to be in compliance with Missouri state laws. Please inform us of any changes in medication, phone numbers, address or contact information. Immunizations, medical forms, and DFS contract must be kept up-to-date.

_____ All medications brought into the center must be given to the director. A medical form must be completed and signed by the guardian in order for us to administer the medication to the child. The medication must be in the original bottle with your child's name on it along with instructions.

_____ Should a serious medical condition occur, we will make an immediate attempt to contact you or your emergency contact. If we are unable to reach either, will call for emergency assistance 911. Parents will assume responsibility for any resulting expenses.

_____ If your child will be arriving after 8:30 AM, you must contact the center and let us know. If your child arrives after 9:30 AM, then they will be turned away if we are not notified.

Extraordinary Kids Preschool

We ask that pickup is after 2:30 PM unless notified. Our center must be able to staff accordingly and prepare meals per children in attendance.

_____ If a child is unable to adjust or is having discipline issues after a reasonable manner of time, the director reserves the right to request a withdrawal of the child.

_____ We will follow the St. Charles Publich Schools schedule regarding bad weather.

Parent or Guardian Signature:

Date: ____/____/____

Extraordinary Kids Preschool

Extraordinary Kids Preschool Fee Agreement

My child, _____ will be attending Extraordinary Kids Preschool on the following days:

Registration Fee: $100.00

_____ Plan 1 – Daily

My established daily amount will be $_____ with a three-day minimum. This is ONLY available for infants and toddlers if space is available. Days of attendance must be the same every week, or we must have a schedule a week in advance. **A minimum of three days will be charged to your account regardless of attendance.** Tuition is due the Friday before the week of care. A late fee of $25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM. Part-time enrollment can be cancelled if space is needed for full-time childcare.

_____ Plan 2 – Weekly

My established amount will be $_____. Tuition is due Friday before the week of care. A late fee of $25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM.

_____ Plan 3 – State Assistance

State Contract Amount: $_____ Sliding Fee/day $_____ Co-pay/week $_____

Total Parent Responsibility $_____ per week

Contact Start Date: _____ End Date: _____ Approved Hours: _____ Approved Days: _____

- I understand that Plan 2 & Plan 3 are weekly rates and apply regardless of my child's attendance. No refunds will be given for missed days. Tuition is due the Friday before care. A late fee of $25.00 will be charged to your account for ANY outstanding balances NOT received by Tuesday (service week) at 10:00 AM.
- There are no refunds for missed days or Holidays. Each family will receive 5 vacation days after one year of enrollment.
- I understand that childcare services will be suspended until past due amounts are paid. All accounts must be current to continue receiving services.
- I understand that the fee is $40.00 for an NSF (non-sufficient funds) check and must be paid in full, with tuition, before continuing services.

- Late child pickup fees are due upon pickup of $1.00 per minute, per child after 6:00 PM.

Parent Signature: _____ Date: ____/____/____

Director's Signature: _____ Date: ____/____/____

Extraordinary Kids Preschool

Extraordinary Kids Preschool #4
1804 Boone's Lick Road
St. Charles, MO 63301
Phone: (636) 946-8440
DVN: 001631569

Extraordinary Kids Preschool Photo Permission Slip

Dear Parent/Guardian,

At Extraordinary Kids Preschool, we love capturing the joy and growth of our students through photographs. These images may be used to showcase our programs on our website, in promotional materials, or shared with parents via the Brightwheel app. Please indicate your preferences below regarding the use of your child's photographs.

Child's Name: _____

Parent/Guardian Name: _____

1. Permission for Website and Promotional Materials

I grant Extraordinary Kids Preschool permission to use photographs of my child on the company's website and in promotional materials (e.g., brochures, social media, advertisements).

☐ **Yes, I consent** to my child's photographs being used for website and promotional purposes.

☐ **No, I do not consent** to my child's photographs being used for website and promotional purposes.

2. Permission for Brightwheel App

I grant Extraordinary Kids Preschool permission to post photographs of my child on the Brightwheel app, including group photos shared with parents and individual photos sent to me directly.

☐ **Yes, I consent** to my child's photographs being shared on Brightwheel (group and individual).

☐ **Yes, I consent** to my child's photographs being shared on Brightwheel (individual only).

☐ **No, I do not consent** to my child's photographs being shared on Brightwheel.

Additional Notes (if any): _____

I understand that I may revoke this consent at any time by notifying Extraordinary Kids Preschool in writing. By signing below, I acknowledge my preferences for the use of my child's photographs.

Parent/Guardian Signature: _____

Date: _____

Thank you for helping us celebrate your child's experiences at Extraordinary Kids Preschool!

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

INDIVIDUAL PLAN FOR SPECIALIZED CARE

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE	DATE
X	