Maplewood Richmond Heights Early Childhood Center

2801 Oakland Avenue, Maplewood, MO 63143 | (314) 644-4405 | FAX (314) 781-1896 | www.mrhsd.org

Dr. Cyndi Hebenstreit, Principal

Checklist for New Students

<u>Forms inside the preschool packet:</u>

- Student Enrollment forms
- Missouri Dept. – Child Enrollment Form
- Letter on Check Policy/Tuition Agreement
- Health/Medication Information Form/Contact Information

The following Medical forms must have doctor's signature, the forms are enclosed in packet.

- Physical/Up-to-date Immunization Record/Evidence of Blood Lead Testing

ALL MEDICAL information is due before school starts (If not received, your child may be excluded)

<u>Please include:</u>

- Birth Certificate
- Occupancy Permit with Child's name on it
- Driver's License/State ID
- IEP or 504 Plan (if applicable)
- Staff not living in district will need Board approval
- $40.00 Registration Fee – payable to MRH ECC

<u>Free and Reduced Lunch Forms change annually and will be available after July. The forms will be sent in the summer mailing.</u>

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2017/2018 Preschool Tuition Agreement

Child's Name ________________________________

Address ________________________________

Phone Number ________________________________

I understand and agree to adhere to payment guidelines set forth by MRH School District. The different payment tiers are as follows: Full price/Reduced lunch status/Free lunch status.
Please check the program that applies: *

- **5 full day program** – 9 payments of $703/360/352
  - **State Assistance** (Sliding scale fee determined by case worker is your daily rate)
  - **Head Start** – 9 payments of $171 or TBA
- **3 full day program** – 9 payments of $403/206/202
- **2 full day program** – 9 payments $300/153/150
- **5 half day (AM) program** – 9 payments of $352/176
- **3 half day (AM) program** – 9 payments of $195/98
- **2 half day (AM) program** – 9 payments of $130/65

- ***POSSIBLE TUITION INCREASE PENDING BOARD APPROVAL****

I also understand that a **$5.00 late fee** will be charged for each payment that is received after the **10th of each month.** If any payment is NOT received by the **15th of the month,** I understand that my child will be dropped from our Preschool Program and put on a wait list. All delinquent tuition issues will be forwarded to our Director of Finance and sent to the Collection Agency.

Parent / Guardian Signature ________________________________

Parent / Guardian (Print) ________________________________

Date: ________________

Fill out the reverse side

The mission of the Maplewood Richmond Heights School District is to inspire and prepare students as leaders, scholars, stewards, and citizens for a diverse and changing world.

school as studio

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MRH Early Learning Programs Tuition Schedule*

Number of Days	5 Full Day	3 Full Day	2 Full Day	5 Half Day	3 Half Day	2 Half Day First Friends
Days	Mon-Fri	Mon/Wed/Fri	Tues/Thurs	Mon-Fri	Mon/Wed/Fri	Tues/Thurs
Hours	8am-3pm	8am-3pm	8am-3pm	8am-11am	8am-11am	8am-11am
Monthly Payment	$703	$403	$300	$352	$195	$130
Yearly Payment	$6,327	$3,626	$2,700	$3,164	$1,755	$1,170
Reduced Status Monthly	$360	$206	$153	N/A	N/A	N/A
Reduced Status Yearly	$3,240	$1,854	$1,377	N/A	N/A	N/A
Free Status Monthly	$352	$202	$150	$176	$98	$65
Free Status Yearly	$3,168	$1,818	$1,350	$1,584	$882	$585

Requirements: You must live in the MRH School District. Child **MUST** be potty trained and 3 years old. The 2 half day(First Friends) session your Child must be 2 years old and this is the **ONLY** session that does not require child to be potty trained.

Procedures for MRH Preschool Reduced Fees

- Complete and return the Federal Free and Reduced Lunch Form available in the ECC office. (Yearly revised rates will be available in July)
- After submission of the form, notification from the MRH Food Service will be sent to your home, indicating your eligibility.
- Families qualifying for the Federal Free and Reduced Lunch Program will receive a reduction in tuition fees.

Guidelines for State Assistance/Head Start

MRH Early Childhood Center is an approved preschool provider for the Division of Family Services.

- Families must meet specific DFS criteria and apply in person at the Page Ave office.
- DVN #001-328-101
- State Assistance is **ONLY** available for 5 Full Days

Head Start Subsidy

- MRH ECC is an approved Head Start partner and offers preschool services for MRH Head Start eligible families. Please contact ECC-Head Start Case Manager to discuss program eligibility.
- Head Start is **ONLY five full days**

$40.00 Registration fee is due at time of enrollment

Possible Tuition increase pending Board approval.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION / BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	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)		

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

CACFP REQUIREMENT

RELATED CHILD

☐ YES ☐ NO — HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐ FULL TIME OR ☐ PART TIME		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MONDAY	☐	AM PM	AM PM	
TUESDAY	☐	AM PM	AM PM	
WEDNESDAY	☐	AM PM	AM PM	
THURSDAY	☐	AM PM	AM PM	
FRIDAY	☐	AM PM	AM PM	
SATURDAY	☐	AM PM	AM PM	
SUNDAY	☐	AM PM	AM PM	

CACFP REQUIREMENT	CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY			
	☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE			
	CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY			
	☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☐ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
	☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☐ COLUMBUS DAY (OCTOBER)
	☐ VETERANS DAY (NOVEMBER)	☐ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ CHRISTMAS DAY (DECEMBER)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

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

DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC	
NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL	
NAME	TELEPHONE NUMBER

ACKNOWLEDGEMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND 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 ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS

PARENT'S/GUARDIAN'S SIGNATURE ▸	DATE

CACFP REQUIREMENT			
	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

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

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.)

Ht. Wt. B/p

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

Evidence of Blood Lead Testing

Child's name: ____________________

Child's Date of Birth: ________

Receipt of Test

Received a Venous / Capillary blood lead test on ______ (date).
(circle one)

Test was administered by: ____________________ (signature of medical provider)

Medical provider address: ____________________________

____
city, state zip

Refusal of Test

I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the age of six years. I do object to my child being blood tested in order to determine if he/she is lead poisoned.

Reason for Refusal ____

Signed ____________________ Relation to child: __________ Date: __________
(parent or guardian)

Parent/Guardian Address: ____________________________

____
city state zip

Provide patient with two copies: One for record
One for child-care provider

One copy should be retained in chart,