THE CHILDREN'S TABLE REGISTRATION

3609 SW State Route 7, Blue Springs, MO 64014

12-MONTH PROGRAMS

FULL TIME CARE **NURSERY THROUGH PRE-KINDERGARTEN**

FULL TIME ONLY

6:30 AM – 5:30 PM

NAME OF CHILD (B) or (G) BIRTHDATE

____

____

____

SCHOOL AGE PROGRAMS

BEFORE & AFTER SCHOOL

Circle days attending – FULL TIME or SELECT DAYS M T W TH F

Attends School at: Cordill-Mason Elementary / Mason Elementary

6:30 AM – 5:30 PM

NAME OF CHILD

____

____

BEFORE SCHOOL ONLY

Circle days attending – FULL TIME or SELECT DAYS M T W TH F

Attends School at: Cordill-Mason Elementary / Mason Elementary

6:30 AM – Departure

NAME OF CHILD

____

____

AFTER SCHOOL ONLY

Circle days attending – FULL TIME OR SELECT DAYS M T W TH F

Attends School at: Cordill-Mason Elementary / Mason Elementary

Arrival from school – 5:30 PM

NAME OF CHILD

____

____

ENROLLMENT FEES – All information must be filled in and enrollment fees MUST accompany us to insure a place for your child.

Enrollment Fees $100.00 per child $150.00 per family

Are you a member of The Table Church? Yes No

FATHER'S NAME ________________	MOTHER'S NAME ______________________
ADDRESS: ______________________	ADDRESS: ____________________________
CITY ________ STATE_______ ZIP___	CITY_________ STATE_______ ZIP_________
HOME PHONE _______ CELL________	HOME PHONE_____________ CELL________
WORK #_________________________	WORK # ____________________________
E-MAIL ADDRESS ________________	E-MAIL ADDRESS______________________

OFFICE USE ONLY

$100.00 per child $150.00 per family ______CASH ______ CHECK #___________

DATE RECEIVED ___________ TIME RECEIVED ___________

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

CHILD CARE ENROLLMENT FORM

SAVE PRINT RESET

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 and Child and Adult Care Food Program

INFANT AND TODDLER FEEDING AND CARE PLAN

THIS SECTION TO BE COMPLETED BY CHILD CARE FACILITY:

The formula provided by this child care facility is: ________________________________.

(Check a box) ☐ **Yes** ☐ **No** This child care facility **is participating** in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when the child is developmentally ready for them.

Instructions to Parents – Please complete for child who is less than 24 months of age. *Update information as needed. Use a new form or initial/date changes on this form.*

CHILD'S NAME	DATE OF BIRTH	DATE ENROLLED

Feeding Information

Type of Food	Feeding Time	Kinds of Food	Amount of Food
Breast Milk			
Formula			
Infant Food			
Table Food			

Who is preparing (mixing) the formula? Check all that apply: ☐ Parent ☐ Caregiver

Does your child have any problems with feedings, such as choking or spitting up?

☐ Yes Explain: ________________________________

☐ No

Does your child use a pacifier? ☐ Yes ☐ No

Note: Pacifiers, if used, cannot be hung around an infant's neck. Pacifier mechanisms or pacifiers that attach to infant clothing cannot be used with sleeping infants.

Infant Feeding Preference (under 12 months)

Mark your preference (check all that apply).

☐ I will provide breast milk for my infant.

☐ I will nurse my infant at the center at these times: ________________________

The facility's formula may be used to supplement feedings if necessary: ☐ Yes ☐ No

If breast milk is unavailable for a feeding, the facility should: ________________________

☐ I request that the formula provided by the child care facility be served to my infant.

☐ I will provide infant formula for my infant. Name of formula: ________________________

☐ I request that the child care facility provide solid foods for my infant as s/he is ready for them, and after I have discussed it with child care facility staff. **OR**

☐ I will provide solid foods for my infant.

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Toddler Feeding Preference (12 through 23 months)

Check all that apply: ☐ Spoon ☐ Cup ☐ Feeds Self ☐ Feeding Table or Chair

Type of Food	Feeding Time	Kinds of Food	Amount of Food
Breast Milk			
Milk			
Table Food			

Arrangements for Sleep – Licensing rules require that infants be placed on their back to sleep.

Time(s) Child Usually Naps	Length of Nap

Additional Instructions Related to Sleeping:

Note: When, in the opinion of the infant's licensed health care provider, an infant requires alternative sleep positions or special sleeping arrangements that differ from those required by rule, the provider must have on file at the facility written instructions, signed by the infant's licensed health care provider, detailing the alternative sleep positions or special sleeping arrangements for such infant. The caregiver(s) must put the infant to sleep in accordance with such written instructions.

☐ My child is 12 months or older, and I give my permission for my child to sleep on a cot.

Signature of Parent/Legal Guardian	Date

Diapering Instructions

List any lotions and/or ointments, etc. that you have provided and give permission for caregivers to use on your child. ______________________________

For ☐ Wet ☐ Bowel Movement ☐ Rash ☐ Other

☐ I do not want caregivers to use any lotions, powders, ointments or similar items on my child.

I will furnish the following baby supplies for my child; clearly labeled with my child's name:

Special Instructions for Care (e.g., restrictions, allergies, etc.):

Signature of Parent/Legal Guardian	Date

OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

RELIGIOUS ORGANIZATION CHILD CARE FACILITY NOTICE OF PARENTAL RESPONSIBILITY

LEGAL NAME OF FACILITY	DVN
The Children's Table	002663372

PHYSICAL ADDRESS (STREET, CITY, STATE, ZIP CODE)
3609 SW St Rt 7 Blue Springs, MO 64014

FACILITY TELEPHONE NUMBER	FACILITY E-MAIL ADDRESS
816-427-7062	info@thetablebluesprings.com

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	3717 S Witney Avenue, INdependence MO 64055	816-350-5450	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	08-03-22
Fire Marshal's Office (Fire Safety Inspection)	1709 Industrial Drive, Jefferson City, MO 64102	660-543-5048	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	05-22-22
Local Health Office or DHSS (Sanitation Inspection)	1709 Industrial Drive Jefferson City, MO 64102	573-751-2930	PENDING ☐ APPROVED ☒ NOT APPROVED ☐	06-17-22

STANDARD STAFF/CHILD RATIOS ESTABLISHED BY THIS FACILITY			STAFF/CHILD RATIOS FOR LICENSED CENTERS		
AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN	AGE RANGE	NUMBER OF STAFF	NUMBER OF CHILDREN
Under 2 years of age	1 staff member for every	5	Under 2 years of age	1 staff member for every	4
2 to 4 years of age	1 staff member for every	15	2 years of age	1 staff member for every	8
5 years of age and older	1 staff member for every	20	3 and 4 years of age	1 staff member for every	10
TOTAL NUMBER OF CHILDREN ENROLLED BY THIS FACILITY: 90			5 years of age and older	1 staff member for every	16

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:
Our purpose is to help each child retain control of their emotions and actions, NOT to stop them from expressing fëelings and needs. Our goal is to equip children with the tools to make appropriate choices. Thtough positive reinforcement, redirection and modeling, we will guide them in this process. When a child displays unacceptable behavior, the teacher will choose an appropriate discipline such as time away from others to think about the behavior. Physical punishment is NEVER used, nor are the children subjected to frighening, humiliating, embarrassing or emotionally harmful situations or remarks. The child needs, above all, are love, patience, understanding and respect.

THE EDUCATION PHILOSOPHY AND POLICIES OF THIS FACILITY ARE:
The Children's Table will provide a warm, loving, Christian enviroment for each child. We provide a place where a child can continue to develop a positive self-image through quality education programs while still enjoying the laughter and fun of childhood. All areas of a child's development are important. The Children's Table is committed to providing developmentally appropriate activities for all ages.

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.

	DATE
PARENT(S)	
PRINCIPAL OPERATING OFFICER/FACILITY DIRECTOR: Hannah Bennett	8/23/23
INDIVIDUAL RESPONSIBLE FOR THE RELIGIOUS ORGANIZATION – PASTOR, MINISTER, PRIEST, ETC.	8-23-23

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.

SUNSCREEN AUTHORIZATION

(A) ALL SUNSCREEN shall be given to a child with written permission of a parent.

(B) The SUNSCREEN shall be in the original container and **labeled with the child's name** and instructions for administration, including the times.

(C) SUNSCREEN should be applied before child comes to school and we will reapply after lunch.

(D) **NO Aerosol Sunscreen**

IF YOUR CHILD NEEDS SUNSCREEN, PLEASE SIGN HERE.

DATE: ______________________________

CHILD'S NAME: ______________________________

CLASS: ______________________________

NAME OF SUNSCREEN: ______________________________

TIME OF SUNSCREEN APPLICATION: Please circle time sunscreen is to be applied:

After lunch   After School

PARENT SIGNATURE:

____

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

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more) AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY) XXX-XX-	DATE / /
PRINTED NAME OF ADULT	ADDRESS	PHONE NUMBER ( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐ MONTH ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐ SNAP (Food Stamp) ☐ TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

The Children's Table Blue Springs

Financial Policies

Tuition Fees

1. We accept online payments only. There is a .35 cent fee if you use a checking/routing #. If you use a credit card the fees vary. No cash or checks.
2. Weekly invoices will be emailed.
3. Weekly tuition fees are billed each Thursday and due the following Monday. You can pay ahead if you wish. Each Monday morning your account must be at a $0 balance or show a credit.
4. Weekly rates do NOT change unless vacation is used.
5. Any account showing a balance by **Tuesday at 6:30am** will be considered past due and charged a **$15 late fee**.
6. **Any account showing a balance on Wednesday at 6:30am will not be able to be in attendance until the account is paid in full.**
7. Because of commitments by the school, refunds of tuition will not be made.
8. If you choose to pay monthly, then full payment is needed prior to the month you are paying.
    a. Example: Payment for the month of September will be due in full on the first Monday in September.
    b. Late fees will follow the same schedule as above.
9. Enrollment fees are due annually. The due date for 2023-2024 enrollment fee is due August 28, 2023.

Tuition Credit

1. No credit on tuition is given on days The Children's Table is closed due to holidays, weather conditions, staff development days, pandemics, national and state emergencies, and building emergencies.
2. The Children's Table is closed on these HOLIDAYS in 2023/2024 : April 7th, May 29th, July 4th, September 4th, November 23rd, November 24th, December 25th, December 26th, January 1st, and January 2nd. Payment is due for ALL days.
3. On Teacher In-Service days, we will be closing early at **12:00pm**. The days are: **July 07, 2023, October 27, 2023, January 12, 2024, April 26, 2024**. Payment is not discounted for teacher training.
4. Our annual Back to School Open House will be held on **Monday, August 28, 2023. We will close early at 5:00pm that evening. Open House will begin at 6:30pm.**
5. No credit on tuition is given when a child is absent from school.

Past Due Accounts

Accounts with past due balances equaling more than two week's tuition will result in their children being dropped from the program in which they are enrolled until payment of the past due amount is received. Spots will not be guaranteed.

Late Pick-up Fee

A $10 fee will be assessed for pick-ups between 5:31pm and 5:35pm. A $25 fee will be assessed for pick-ups 5:36 pm and after. This will be assessed 3 times. After the 3rd late pick-up, a meeting will be held with the Director to discuss continuation of care.

Vacation: (September 1, 2022 – August 31, 2023 and September 1, 2023 – August 31, 2024)

1. Each full time preschool child (Infant to Pre K) will receive 10 vacation days. Children must attend full-time for the full 52 weeks to be eligible for vacation.
2. A child must be enrolled and in attendance for six months before vacation can be taken. Vacation must be taken September 1 – August 31 of current school year for full time preschool children.
3. No credit is given for unused vacation days and vacation days do NOT carry over to the next year.
4. Families are not allowed to use two subsequent weeks of vacation, regardless if the weeks are in separate months.
5. ***SUMMER CAMP CHILDREN** - A child enrolled in the Before & After School program the previous nine months to summer camp will have up to 5 days vacation credit to use over the summer.
6. To use a vacation day(s), email Director Savannah Bennett (savannahb@thetablebluesprings.com) with the days you will be using. These days will be added to the system and reflected on the next week's invoice.

Rates

Rates are effective June 26, 2023. If a child moves into another room, the weekly rate does not change.

Full Time Care (weekly)

Birthdate on or after 8/1/21 $305
Birthdate between 8/1/20 - 7/31/21 $265
Birthdate between 8/1/19 - 7/31/20 $245
Birthdate on or before 7/31/19 $230

*We do offer a sibling discount. It is 10% off the oldest child's weekly tuition. During Summer Camp, we do not offer a sibling discount if the oldest child is in the Summer Camp program.

School-Age Program (weekly)

***Prices are from the first day of school till the last day of school. Summer Camp prices are different.**

Before AND After School K-5 $67.50*
Before OR After School K-5 $57.50*
Full Day Care $18 in addition to weekly rate**
Full Day Care for child not enrolled for Before/After School Care $32

*Weekly rate doesn't change.
**Full Day includes School Closings and Holidays during the school year.

Summer Camp 2024 - Rates TBD

X________________________________ ______________

Parent Signature Date

EMERGENCY CONTACT SHEET

Name____

Email____

Classroom ____

Working Times and Days ______________________________

In case of emergency, please contact:

Name______________________________ *Telephone Numbers*
Cell __________
Work__________
Home __________

Relationship ________________________

Name______________________________ *Telephone Numbers*
Cell__________
Work__________
Home__________

Relationship ________________________

My Doctor is: ______________________________ Phone__________

I am allergic to: ____

My specific instructions in the case of an emergency
are____
____

*My Family: Spouse/Partner Name*______________________________

Children: Name *Age* *Attends School At*

____
____
____
____

____

Date Signature

SAVE

PRINT

RESET

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

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.)

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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 CHILDREN'S TABLE MINISTRIES ILLNESS & ACCIDENT GUIDELINES

Immediate treatment shall be administered to a child who sustains a minor injury (scratches, scrapes, insect bites, etc.). It will be documented on a minor injury form located in the classroom. Parents will be notified when the child is picked up.

If a major injury to a child occurs, the staff will immediately call for professional help or 911. Parent designated emergency contacts or the child's doctor will be notified immediately. IF THE EMERGENCY IS SUCH THAT IMMEDIATE ATTENTION IS NECESSARY, THE STAFF HAS WRITTEN PERISSION FROM THE PARENT OR GUARDIAN TO TAKE THE CHILD TO THE HOSPITAL.

Parents are required to sign a Medical Form included each year with the enrollment packet. An up-to-date copy of immunizations and a physician's signature is required for UNDER school-age children.

Any child showing signs of illness will be isolated from the other children until she/he leaves school.

Medication will be given ONLY upon the written order of a physician and the written permission of the parent. Medication must be in the original container and bear the child's name. Documentation will be given to staff giving medication.

ILLNESS

Parents must arrange back-up care in case their child becomes ill. We cannot admit children to the classroom or allow them to remain at school with the following symptoms:

- Listlessness, sleepiness, loss of appetite, and/or general discomfort.
- Skin rash or skin disorder that is contagious.
- Inflamed or swollen throat glands.
- Persistent cough.
- Diarrhea within the past 24 hours.
- Vomiting within the past 24 hours.
- Fever during the past 24-48 hours depending on illness or other symptoms.
- Yellow or greenish mucous running from the nose with weeping or pinkish eyes (excluding allergies).
- Inflamed or weeping eyes, discharging ear or earache, thrush, chills.
- Other disease symptoms are in the informed judgement of director or designate.

I understand and agree that my child ______________________________

May not be accepted for care when ill.

Parent Signature__________________________ **Date**________________

Authorization to Pick Up a Child Form The Children's Table

Name of child(ren)____

I hereby inform The Children's Table Blue Springs that the people listed below are authorized to pick up the above-named child(ren).

1. Name ______________________________
   Relationship ______________________________
   Phone Number ______________________________

2. Name ______________________________
   Relationship ______________________________
   Phone Number ______________________________

3. Name ______________________________
   Relationship ______________________________
   Phone Number ______________________________

4. Name ______________________________
   Relationship ______________________________
   Phone Number ______________________________

Parent Signature ____________________

Printed Name ____________________

Date ____________________

THE CHILDREN'S TABLE MINISTRIES
MEDICATION COMMUNICATION

All medication shall be given to a child only with the dated, written permission of a parent, stating the length of time the medication may be given. Prescription and nonprescription medication shall be in the original container and labeled with the child's name, instructions for administration, including the times, and amounts for dosages, and the physician's name. Sample medication provided by a physician may be used.

I authorize child care personnel to administer the following medication to my child:

CHILD'S NAME	DATE TO BEGIN MEDICATION	DATE TO STOP MEDICATION

DOSAGE	TIME OF MEDICATION

POSSIBLE SIDE EFFECTS

PARENT OR GUARDIAN SIGNATURE	DATE

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

FORM TO BE RETAINED IN CHILD'S RECORD

BRIGHT WHEEL

We will be using the app BrightWheel. It is a parent/teacher communication tool. WE post announcements (i.e. school closings, upcoming events, etc.), we can also post pictures of your children to show different things they are doing in school. It is also a great way for parents and teachers to send private messages to each other.

I give The Children's Table permission to post pictures of my child ____________, on the app BrightWheel.

______________________________ ________________________

Signature of Parent Date