



107 Church Street
Marble Hill, Missouri 63764
Phone: 573-618-0057
Email: cbaker@beehive-academy.com



Dear Parents and Caregivers,

Thank you for choosing Beehive Academy! We are thrilled to have the opportunity to partner with you in providing a safe, nurturing, and family- centered environment for your child. It's an honor to be entrusted with your child's care and education, and we are committed to making their learning experience enriching and enjoyable.

At Beehive Academy, our mission is to deliver high-quality early education that supports your child's development at every stage. We achieve this through personalized, evidence-based teaching strategies that are tailored to meet your child's unique needs. Our programs incorporate a blend of child-directed play and structured activities that foster creativity, curiosity, and a lifelong love for learning, all while nurturing your child's emotional and social growth.

Our team of dedicated educators is passionate about providing an enriching environment where each child can thrive. We believe that learning should be an exciting journey, and we work closely with you as a partner in your child's development. By collaborating with families, we can create a truly supportive learning experience that aligns with your child's developmental goals.

At Beehive Academy, we deeply value your feedback and encourage open communication to ensure that we are meeting the needs of your child and family. Together, we can provide the very best learning environment where your child will grow, explore, and build the foundation for future success.

Thank you once again for placing your trust in us. We look forward to being a part of your child's educational journey!

Chelsea Baker

Director of Beehive Academy



Infant Daily Schedule

****We follow each child's individual needs in regards to feeding and sleeping.**

**** Additional diaper routine as needed**

**** Bottles offered as needed based on last bottle taken before arrival**

6:00-8:00: Free play/Diaper change as needed (Group Play/Centers)

8:00-8:30: Breakfast with solids

8:30-9:00: Circle Time- Curriculum

9:00-9:45: Diaper Routine

10:00-10:30: Outside (Gross Motor)

10:30-11:00: Sensory, arts, craft- Curriculum (Fine Motor)

11:00-11:30: Lunch

11:30-12:00: Diaper Routine

12:00-2:00: Story Time- Curriculum / Nap

2:00-2:30: Snack & Diaper Routine

2:30-3:00: Outside

3:00 - 3:30 : Music- Curriculum

3:30-4:00: Snack & Diaper routine

4:00-5:00: Child directed play

5:00-5:30: Diaper Routine

5:30-6:00: Clean up and prepare for pickup



Preschool Daily Schedule

6:30am-8:00am	Bathroom and Hand Washing/Stations
8:00am-8:30am	Breakfast
8:30am-9:00am	Circle Time- Curriculum
9:00am-9:45am	Recess & Gross Motor
9:45 am-10:00 am	Bathroom and Handwashing
10:00am-10:30am	Sensory Play
10:30am-11:00am	Recess
11:00 am-11:30 am	Lunch
11:30am-12:00pm	Bathroom and Handwashing
12:00 pm-12:15 pm	Making your Own Cot
12:15 pm-2:00 pm	Nap Time
2:00pm-2:30pm	Bathroom and Handwashing
2:30pm-3:00pm	Snack
3:00 pm-3:30 pm	Music
3:30pm-4:00pm	Arts & Crafts
4:00pm-4:30pm	Recess
4:30pm-5:00pm	Bathroom and Handwashing
5:00 pm- 6:00 pm	Naturalistic learning opportunity

*Recess/Play can be outside weather permitting



Policies

Our agreement between parents and Beehive Academy Preschool

State Licensing

Beehive Academy Preschool is licensed by the state of Missouri. As a result, we must follow regulations set forth by the state that help us meet and maintain our Missouri license. We thank you in advance for your support in complying with these regulations.

Enrollment Procedures

A one-time non-refundable \$25 enrollment fee is required to register and hold your child's spot either on the waiting list or on the classroom enrollment. You will be required to turn in all of the following information on or before your child's first day:

1. Completed enrollment form
2. Updated Immunization record
3. Medical form, signed by a physician

Unless notified of being waitlisted, your child is enrolled when all forms and the enrollment fee mentioned above are completed and turned into the preschool. Once your child is enrolled standard tuition rates are effectively due on Tuesday of each week.

School Hours and Attendance

Beehive Academy Preschool is open Monday through Friday from 6:30am to 6:00pm. We require all children to be picked up before 6:00 pm. If your child is not picked up by 6:00pm, you will be charged \$10 per each 15 minutes the child remains at Beehive Academy Preschool.

Please notify the director, in writing, two weeks in advance when requesting a schedule change. No schedule changes shall be made without the written approval from the director.

Beehive Academy is closed in observance of the following holidays: New Year's Day, Good Friday, Memorial Day, Fourth of July, Labor Day, Thanksgiving, open until noon on Christmas Eve and closed all of Christmas Day. A full week's tuition must be paid during these weeks.

Vacation and Withdrawal

If your child is enrolled for full time care and has been enrolled for 6 (six) months, they are eligible for a 1 (one) week vacation per 12 (twelve) month period. A 2 (two) week notice must be given prior to taking your vacation week. We request a two-week notice if your child withdraws from our program. Tuition is due until the end of that 2 (two) weeks.



Feeding

Parents of bottle-fed babies will need to provide 4 labelled bottles, nipples, and lids. After feedings, contents remaining in any bottle must be discarded within two hours. Formula or water will be placed in a bottle for feedings; however, juice can only be served in a sippy cup. Bottles are not heated in the microwave, as this will produce “hot spots”. Instead, they are warmed using a bottle warmer.

If providing breast milk, all breast milk must be dated and have your child’s name on it. Fresh breast milk will be stored for one day in our refrigerator. Milk that is present at the end of the day must be taken home or we will have to discard it. No bottles will be served with cereal or any other food product in them. The only items served from a bottle includes breast milk and formula. This is a licensing standard.

If providing breast milk, you can bring it daily or you can bring in one-gallon Ziplock bag of frozen breastmilk (labeled) to keep in our freezer. We will remove the appropriate amount of breastmilk daily and ask for you to replenish when necessary.

If using purees or other baby foods you will be responsible for providing these items. These are to be labeled with the date brought to the facility and child’s name. We will bring the appropriate amount into the classroom for the day and ask you to replenish when necessary. The center will provide table food for your child once appropriate. All utensils and dishes used for meals will be provided by the center.

Sleeping

Sleeping Infants nap according to their own needs, we will not place them on a nap schedule as this is prohibited by state rules. If infants fall asleep while they are being rocked, lightly bounced, or taken for a walk in a stroller, they will be put in their cribs to continue their sleep. When your child turns one, they can sleep on a cot with parent permission. This will assist in the transition from the Infant room to the Toddler room when that time comes.

Safe Sleeping Practices

Infants will be placed on their backs to sleep in a crib. The infants at our center are provided with a firm, tight-fitting mattress in a crib that meets current safety standards. Pillows, quilts, bumpers, comforters, sheepskins, stuffed toys, or other fluffy products in the crib are prohibited by the state licensing agency. Your child will have a designated crib. Only one child will be permitted in a crib at any given time. A sheet will be

provided for your infant and toddler. Parents are welcome to bring in a swaddle or wearable blanket for your child if under 12 months of age or a blanket for his/her child to use at nap times after age one.

Diapering

Your child will be changed at regular intervals throughout the day (no longer than 2 hours between) and as needed. Feel free to bring a labeled bottle of diaper cream with you if you would like it to be applied to your child's rash. We will not be applying baby powder on the infants. The use of powder has been linked to childhood asthma and other respiratory problems.

Children in the Infant and Toddler room will not be potty trained.

Child's Personal Belongings

For attendance at Beehive Academy Preschool, the child will need the following:

- 4 Labeled extra changes of clothes
 - Socks, coats, hats, jackets, sweaters, etc
- Baby food/purees (labeled)
- Diapers
- Wipes
- Labeled diaper ointment
- 4 labeled bottles to be kept at our center
 - These will be washed and sanitized appropriately after each use
- Labeled breastmilk/sealed formula
- Labeled sleepsack if desired
- Labeled pacifiers if desired

Please refrain from bringing any personal belongings from home to the center unless requested by the teacher for a classroom activity.

Beehive Academy Preschool reserves the right to update the Policy Agreement at any time. If changes were to occur, all parents and caregivers will be given written notice.



Tuition Rate Sheet

Tuition Rate Sheet Effective January 2025

Preschool Tuition	
Full Time	\$165.00/week
Family	10% off \$165.00 = 148.50 per child

Infant Tuition	
Full Time	\$200.00/week
Family (applies to full-time only)	10% off \$200.00 = \$180.00 per child

School Aged	
Full Time (Summer)	\$165.00/week
Before/After School Full time (5 days per week)	\$80.00/week
Before OR After School Only	\$20.00/day

INFANT SAFE SLEEP POLICY

Facility Name: Beehive Academy Preschool

DVN:003071947

Date Adopted: January 1, 2025

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 (§ 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. 2 Rev (4/16)
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. All caregivers will receive in-person or online training on infant safe sleep 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 will 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. sleep 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 carriers, 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.

Parent/Caregiver Contract

Please read the following before initialing and signing.

Date of contract: _____

The conditions of this agreement provide protection for you as well as Beehive Academy Preschool. For the center to be financially stable and to provide your child with the services they deserve, this contract must be included in the enrollment package.

As a parent/caregiver with a child enrolled at Beehive Academy Preschool, I agree to:

_____1: Pay a one-time non-refundable registration fee of \$25 per child at the time of enrollment

_____2: Tuition is due on Tuesday of each week, with no deductions for absence, including holidays. If your tuition is one week late, there will be a \$20 late fee applied to that week and your child will not be able to attend until your bill is paid in full.

_____2a:\$165/week for full time enrollment

_____2b:\$200/week for full time enrollment

_____2c:State pay-Foster child or Assistance Paperwork on file

_3: In the event of a physical emergency, Beehive Academy Preschool has permission to administer medical attention as it sees fit. The medical expenses are the responsibility of the parents or guardians.

_____4: I agree to carry out the responsibilities under this Contract between Beehive Academy Preschool and Parents/Caregivers. I understand that these policies may be changed and that I will receive written notice in the event of a modification.

_____5: If the Director feels that you have not followed the Contract between Beehive Academy and Parents/Caregivers, or that your child poses a threat to themselves or others in the center, a meeting between the Director, Owners and Parents/Caregivers will be scheduled. If a resolution cannot be resolved, a one week notice will be given, after which the child must be withdrawn and this Contract is terminated.

Parent's Signature: _____ Child's Name: _____



MISSOURI DEPARTMENT OF
ELEMENTARY AND SECONDARY
EDUCATION

MISSOURI DEPARTMENT OF HEALTH AND SENIOR
SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION
ASSISTANCE

OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		
IDENTIFYING INFORMATION		
PARENT/GUARDIAN NAME	TELEPHONE NUMBER	
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS <input type="checkbox"/>		
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 <input type="checkbox"/>		
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)

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.)	<input type="checkbox"/> American Indian or Alaskan native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> White
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CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

Will child attend: <input type="checkbox"/> Full time <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Tuesday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Wednesday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Thursday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Friday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Saturday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Sunday	<input type="checkbox"/>	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> 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

<input type="checkbox"/> New Year's Day <input type="checkbox"/> Martin Luther King, Jr.'s Birthday <input type="checkbox"/> Lincoln's Birthday <input type="checkbox"/> Washington's Birthday	<input type="checkbox"/> Easter <input type="checkbox"/> Truman Day <input type="checkbox"/> Memorial Day <input type="checkbox"/> Juneteenth <input type="checkbox"/> Independence Day	<input type="checkbox"/> Labor Day <input type="checkbox"/> Columbus Day <input type="checkbox"/> Veterans Day <input type="checkbox"/> Thanksgiving Day <input type="checkbox"/> Christmas Day
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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 <input type="checkbox"/> do <input type="checkbox"/> 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 <input type="checkbox"/> do <input type="checkbox"/> 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

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FIRST ANNUAL UPDATE

PARENT/GUARDIAN SIGNATURE

DATE

SECOND ANNUAL UPDATE

PARENT/GUARDIAN SIGNATURE

DATE

THIRD ANNUAL UPDATE

PARENT/GUARDIAN SIGNATURE

DATE



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
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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
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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
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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
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
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Emergency Contact Form

Parents/Caregivers:

Missouri State licensing regulations require licensed child care facilities to gather and maintain information for easy accessibility incase of an emergency situation. Please help us follow these regulations by filling out all of the information below. Beehive Academy will use this information to contact you should an emergency arise.

Name of Child: _____ Parent/Caregiver: _____

Special Care (e.g. Allergies, etc)

Phone Numbers of Dad: _____ Mom: _____

Work Numbers of Dad: _____ Mom: _____

1st Alternative Emergency Contact & Number: _____

2nd Alternative Emergency Contact & Number: _____

In the event of a crisis, it will be necessary for all children to be signed out by the person picking up the child. ONLY the persons listed below will be allied to take your child from Beehive Academy Preschool. Please make sure to list everyone you can think of that you would allow to pick up your child in such an emergency.

_____	_____
_____	_____
_____	_____

If, at any time, due to such circumstances as an injury or sudden illness or other unforeseen emergency, if medical treatment is necessary, I authorize Beehive Academy Preschool to take whatever emergency measures the 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 instruction and transporting my child to a hospital or doctor's office, including possible use of an ambulance.

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

Parent/Caregiver Signature: _____ **Date:** _____

OVER-THE COUNTER (OTC) MEDICATION PERMISSION FORM

Name of Child: _____ Date: _____

This form authorizes Beehive Academy Preschool to administer: (check all that apply)

- ☐ Sunscreen _____
- ☐ Insect repellent _____
- ☐ Diaper cream _____

The following conditions apply:

1. If you bring a brand of OTC medication different than what is listed above, a new form must be completed and on file
2. This form must be updated annually
3. One form must be completed for each enrolled child
4. Manufacturer's guidelines for application will be followed

Parent/Caregiver Signature: _____ Date: _____

1st annual update due:	Parent/Caregiver signature:	Date:
2nd annual update due:	Parent/Caregiver signature:	Date:
3rd annual update due:	Parent/Caregiver signature:	Date:
4th annual update due:	Parent/Caregiver signature:	Date:
5th annual update due:	Parent/Caregiver signature:	Date:



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

MEDICATION AUTHORIZATION

MEDICATION REQUIREMENT

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

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

(PROPER NAME OF MEDICATION)

CHILD’S FULL NAME

DATE MEDICATION TAKEN FROM

UNTIL

DOSAGE

TIME(S) OF DAY

POSSIBLE SIDE EFFECTS

SIGNATURE OF PARENT(S) OR GUARDIAN

DATE

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

FORM TO BE RETAINED IN CHILD’S RECORD



Social Media Release Form

Beehive Academy Preschool utilizes social media sites as a way to promote the activities of our school and as a vehicle to keep parents/guardians/family and prospective families aware of the workings of our school day and school activities. I understand that even if I deny permission, my child may be in the background of some photos that will be utilized.

Child's Name _____

- ☐ I give my permission for photos/images of my child to be used by Beehive Academy Preschool for social media purposes.

Parent/Guardian--date

- ☐ I do not want my child's photos/images to be used by Beehive Academy Preschool

Parent/Guardian—date



RESET

CHILD'S NAME	BIRTHDATE
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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.

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.)

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's part of a bound notebook or folder.

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE
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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

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@desse.mo.gov.

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.

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

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TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE):	YEAR	MONTH	2 X A MONTH	EVERY 2 WEEKS	WEEKLY	SNAP (Food Stamp)	TEMPORARY ASSISTANCE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE
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Family Questionnaire

Child's name: _____

Your name: _____

I. Family of Origin

Your age _____

Number of children _____

Names and ages of children _____

How do you define the culture that most influences your parenting?

What language(s) do you speak at home?

II. Being a Parent

Please share your experience about when you first became a parent.

How old were you?

How did it change things?

What was the response of others to your pregnancy?

III. Parenting Approach

Please share how your child plays.

Who does your child typically play with?

What kinds of things does he/she like to play with?

How do you decide what to give him/her to play with?

Please share how your day typically flows.

How would you describe the morning routine at your house? After school? Mealtime? What about bedtime?

Morning:

After school:

Mealtime:

Bedtime:

Do you feel that you are raising your children differently from the way their friends are being raised or differently from your neighbors? If yes, what are the differences?

III. Parenting Approach (continued)

Who is the decision maker in your family? How are important things communicated?

Who provides comfort in your family?

What kinds of things do you do to celebrate important moments in your child's life?

Most parents consider discipline an important part of bringing up children. Can you tell us about a time when you disciplined your child?

Do you work outside the home?

Who do you turn to for advice or help when you are stressed or worried about your child?

What are the biggest challenges you see your child facing in the coming years?

IV. Learning Goals for Your Child: Being, Becoming, Belonging

What would you like others to say about your child that would make you proud?

What do you understand to be your child's strengths?

What do you observe to be your child's challenges?

What do you hope your child will gain from being at preschool?

What concerns do you have about your child being at preschool?

Is there anything else you would like to share about your child or family?

I look forward to an exciting year of learning with your child and getting to know you.

Please feel free to contact me at _____.