



WAITLIST NOW OPEN FOR OUR NEW EARLY LEARNING CENTER

Add Your Child's Name Today!

We're now accepting names for our Early Learning Center waitlist. Priority enrollment will be given to YMCA members (child must be a current member).

HOW TO JOIN THE WAITLIST

To be placed on the list, families must:

- Complete the full enrollment packet and gather copies of all current immunizations.
- Submit it **in person** or by **email** to smccullough@opymca.org.

Each application will be stamped with the date, time, and staff initials to ensure the waitlist is managed fairly and in order. Secure your spot early!



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY



SAVE YOUR CHILD'S SPOT

Early Learning Center Wait List Open Now!

Join our wait list for our Early Learning Center coming in 2026! We will only place children with complete packets on the wait list. Please answer the questions in the box to the right so we can better prepare for opening.

1. Do you plan on using MO State Subsidy to help pay for childcare?
☐ Yes ☐ No
2. How many children are you placing on the wait list? _____
3. What hours are you needing for childcare?
Ex: 6am-2pm _____

Visit opymca.org for more information.

For more information, contact Samie McCullough at smccullough@opymca.org



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](http://www.dese.mo.gov/veterans-services) 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)		

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**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.)

☐
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: <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

☐ New Year's Day
☐ Martin Luther King, Jr.'s Birthday
☐ Lincoln's Birthday
☐ Washington's Birthday

☐ Easter
☐ Truman Day
☐ Memorial Day
☐ Juneteenth
☐ Independence Day

☐ Labor Day
☐ Columbus Day
☐ Veterans Day
☐ Thanksgiving Day
☐ Christmas Day

CACFP REQUIREMENT

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

**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 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
MEDICATION AUTHORIZATION

SAVE

PRINT

RESET

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

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MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE
PERMISSION FOR CHILD TO LEAVE FACILITY

SAVE

PRINT

RESET

NAME OF CHILD	
ACTIVITY	
LOCATION	
METHOD OF TRANSPORTATION (WALK, BUS, CAR, ETC.)	
TRANSPORTED BY (PERSON RESPONSIBLE FOR SUPERVISION)	
TIME OF LEAVING	TIME OF EXPECTED RETURN
DATE OF ACTIVITY	PERMISSION GRANTED EFFECTIVE
	FROM: TO:
SIGNATURE (PARENT(S), GUARDIAN OR DESIGNEE)	DATE

MO500-3343 (8-21)



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE
PERMISSION FOR CHILD TO LEAVE FACILITY

NAME OF CHILD	
ACTIVITY	
LOCATION	
METHOD OF TRANSPORTATION (WALK, BUS, CAR, ETC.)	
TRANSPORTED BY (PERSON RESPONSIBLE FOR SUPERVISION)	
TIME OF LEAVING	TIME OF EXPECTED RETURN
DATE OF ACTIVITY	PERMISSION GRANTED EFFECTIVE
	FROM: TO:
SIGNATURE (PARENT(S), GUARDIAN OR DESIGNEE)	DATE

MO500-3343 (8-21)



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

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

CENTER'S INFORMATION

NAME OF CHILD CARE CENTER		PHONE NUMBER
CENTER CONTACT PERSON'S NAME	CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)	

CHILD'S INFORMATION

CHILD'S FULL NAME		DATE OF BIRTH
PARENT OR GUARDIAN NAME	STREET ADDRESS	
CITY	STATE	ZIP CODE DAYTIME PHONE NUMBER

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

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE:	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:
MON	AM PM	AM PM	
TUES	AM PM	AM PM	
WED	AM PM	AM PM	
THURS	AM PM	AM PM	
FRI	AM PM	AM PM	
SAT	AM PM	AM PM	
SUN	AM PM	AM PM	

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

<input type="checkbox"/> FULL DAY CARE	<input type="checkbox"/> BEFORE SCHOOL CARE	<input type="checkbox"/> EVENING CARE
<input type="checkbox"/> HALF DAY - MORNING	<input type="checkbox"/> AFTER SCHOOL CARE	<input type="checkbox"/> OVERNIGHT CARE
<input type="checkbox"/> HALF DAY - AFTERNOON	<input type="checkbox"/> BEFORE AND AFTER SCHOOL CARE	

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

<input type="checkbox"/> BREAKFAST	<input type="checkbox"/> LUNCH	<input type="checkbox"/> SUPPER
<input type="checkbox"/> MORNING SNACK	<input type="checkbox"/> AFTERNOON SNACK	<input type="checkbox"/> EVENING SNACK

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

<input type="checkbox"/> NEW YEARS DAY	<input type="checkbox"/> TRUMAN DAY	<input type="checkbox"/> COLUMBUS DAY
<input type="checkbox"/> MARTIN LUTHER KING'S BIRTHDAY	<input type="checkbox"/> MEMORIAL DAY	<input type="checkbox"/> VETERAN'S DAY
<input type="checkbox"/> LINCOLN'S BIRTHDAY	<input type="checkbox"/> JUNETEENTH	<input type="checkbox"/> THANKSGIVING DAY
<input type="checkbox"/> WASHINGTON'S BIRTHDAY	<input type="checkbox"/> INDEPENDENCE DAY	<input type="checkbox"/> CHRISTMAS DAY
<input type="checkbox"/> EASTER	<input type="checkbox"/> LABOR DAY	

SIGNATURE OF PARENT OR GUARDIAN

DATE

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIALED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM

FIRST ANNUAL UPDATE	PARENT SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT SIGNATURE	DATE

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2. fax:
(833) 256-1665 or (202) 690-7442; or
3. email:
Program.Intake@usda.gov

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