



6155 West Florissant Saint Louis, MO 63136  
Telephone: 314-389-1001 Fax: 314-389-9879

Director: Julie McAfee  
Assistant Director: Corrine Hamilton  
Administrative Assistant: Mychelle Chandler

**Please bring the following for Registration and Enrollment:**

- Birth Certificate
- Shot record and physical exam
- Missouri Child Care Assistance **Approval Letter** (if applicable)
- 2 most recent paystubs
- Health Insurance Card
- Food Stamp Case Number and Card
- Photo ID (Drivers license, Student ID, etc)

**If you are interested in applying for the Head Start program, additional information is needed:**

- All items listed above
- 2020 W-2 or tax return
- Proof of employment/job training/school schedule

We look forward to working with you and your family!

**Hilltop Child Development Center is a Missouri licensed, NAEYC accredited facility and a proud member of the United Way**





## CHILD'S DEVELOPMENTAL HISTORY

Date of admission: \_\_\_\_\_ Date of interview: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Does the child live with both parents? \_\_\_\_\_ If no, who does the child live with? \_\_\_\_\_

Child's Address: \_\_\_\_\_  
Street City State Zip

Child's Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Pregnancy was: Full term \_\_\_\_\_ Premature \_\_\_\_\_ If premature, how much? \_\_\_\_\_

Were there any complications with the pregnancy? YES NO

If yes, please describe: \_\_\_\_\_

Has the child ever been separated from mother, father, grandparents, etc? \_\_\_\_\_

### Household Information:

List all family in the home	Age	Relation to the child

**Medical Information:**

Child's Physician's Name: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Dentist Address: \_\_\_\_\_  
\_\_\_\_\_

Is your child currently on any medication? YES NO

If yes, please list all medications: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever had any convulsions (seizures) or very high fever?  
(Please list dates, temperatures and if accompanied by unconsciousness): \_\_\_\_\_

Is your child allergic to any medications? YES NO

If yes, please list medications: \_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized? YES NO

If yes,  
\_\_\_\_\_

Place	Physician	Date	Reason
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List any fractures or accidents: \_\_\_\_\_  
\_\_\_\_\_

Briefly describe your child: \_\_\_\_\_  
\_\_\_\_\_

**Temperament:** (Please answer yes or no)

Shy and nervous with: other children \_\_\_\_\_ adults \_\_\_\_\_

Any nervous habits (thumb sucking, nail biting, stuttering, etc.): \_\_\_\_\_

Does he/she like to play alone \_\_\_\_\_ independently \_\_\_\_\_ both \_\_\_\_\_

### Child and Feeding:

Does your child enjoy eating?

YES

NO

What are some of your child's favorite foods? \_\_\_\_\_

\_\_\_\_\_

What are some of the foods your child refuses to eat? \_\_\_\_\_

\_\_\_\_\_

Does your child have any food restrictions? \_\_\_\_\_

\_\_\_\_\_

### Child and Sleeping

What time does your child go to bed? \_\_\_\_\_ P.M What time does your child awake? \_\_\_\_\_ A.M

Does your child have nightmares?

YES

NO

Does your child sleep with a special blanket or toy?

YES

NO

Explain: \_\_\_\_\_

\_\_\_\_\_

Does your child sleep quietly?

YES

NO

Does your child wet the bed during sleeping hours?

YES

NO

Does your child sleep walk?

YES

NO

Does your child talk in his/her sleep?

YES

NO

### The Child's World

Where does your child like to go frequently outside of the home? \_\_\_\_\_

With whom? \_\_\_\_\_

Has your child been to (circle all that apply): zoo real farm shopping center

grocery store picnic outside of Missouri

## Child and Language Development

What age did your child: Sit Alone \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_ Weaned \_\_\_\_\_

Toilet train \_\_\_\_\_ Dress/Undress Self \_\_\_\_\_

Does anyone read stories to your child? \_\_\_\_\_ Child's favorite story: \_\_\_\_\_

Does your child identify needs by:      pointing                      use words                      both

How does your child react when not understood? \_\_\_\_\_

How does your child handle frustration? \_\_\_\_\_

Parent's method of discipline: \_\_\_\_\_

How effective is your method of discipline? \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please circle all that apply:

Accident Prone

Wets Pants

Lively and Noisy

Irritable

Feeds Self

Enjoys Playing with Others

Excessive Crying

Trustworthy

Stutters

Relaxed Child

Nightmares

Good Health

Sucks Thumb

Handles Anger Well

Can Share and Take Turns

Responsive

Afraid of The Dark

Depressed

Temper Tantrums

Afraid of Animals

Verbalizes Feelings

Eating Problems

Speech Problems

Unusual Fears

Eats Well

Communicates Effectively

Hyperactive

Sleeps Well

Bad Language

Toilet Trained

Withdrawn

# Hilltop Demographics

All information is confidential and individual information will not be shared with any outside entities. Answers will not affect your benefits or Head Start eligibility.

## Child's Information

**Child's Full Name:** \_\_\_\_\_ **Enrollment Date:** \_\_\_\_\_  
**Child's Birthday:** \_\_\_\_\_ **Child's Age:** \_\_\_\_\_ **Child's Gender:** M F  
**Child's Race:** Asian Black White American Indian Hawaiian/Pacific Islander Multi-Racial  
**Hispanic:** YES NO **Is this child a foster child:** YES NO

## Parent/Guardian's Information

**Name:** \_\_\_\_\_ **Gender:** M F  
**Email Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Relationship to Child:** Biological/Step Grandchild Foster Other  
**Do you have custody of the child:** YES NO  
**Birthday:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Teen Parent:** YES NO  
**Race:** Asian Black White American Indian Hawaiian/Pacific Islander Multi-Racial  
**Hispanic:** YES NO  
**Current Address:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Resident of:** St. Louis City St. Louis County Other (please name): \_\_\_\_\_  
**Household:** Single Parent Household 2-Parent Household **Are you homeless:** YES NO  
**Parent Education Level:** >HS HS GED AA BA MA CDA

## Additional Children (Non-Applicant)

**Child's Full Name:** \_\_\_\_\_ **Enrollment Date:** \_\_\_\_\_  
**Child's Birthday:** \_\_\_\_\_ **Child's Age:** \_\_\_\_\_ **Child's Gender:** M F  
**Child's Race:** Asian Black White American Indian Hawaiian/Pacific Islander Multi-Racial  
**Hispanic:** YES NO **Is this child a foster child:** YES NO

**Child's Full Name:** \_\_\_\_\_ **Enrollment Date:** \_\_\_\_\_  
**Child's Birthday:** \_\_\_\_\_ **Child's Age:** \_\_\_\_\_ **Child's Gender:** M F  
**Child's Race:** Asian Black White American Indian Hawaiian/Pacific Islander Multi-Racial  
**Hispanic:** YES NO **Is this child a foster child:** YES NO

## Health

**Child's Insurance:** Private Medicaid No Insurance

**Insurance #:** \_\_\_\_\_ **Medicaid Number:** \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_ **Doctor's Phone:** \_\_\_\_\_

**Dentist's Name:** \_\_\_\_\_ **Dentist's Phone:** \_\_\_\_\_

**Parent Insurance:** Private Medicaid No Insurance

## Income

**Employment Status:** Full Time Part Time Seasonal Retired/Disabled  
Full Time & Training Part Time & Training Training / School

**Do you receive TANF:** YES NO **Do you receive SSI:** YES NO

**Do you receive Childcare Subsidy:** YES NO

**Do you receive WIC/SNAP** (circle all that apply): WIC SNAP

**Household Income Level:** \$0-9,999 \$10,000-\$14,999 \$15,000-\$19,999  
\$20,000- \$29,999 \$30,000-\$49,999 \$50,000-above

## Education

**Does your Child have an IFSP/IEP:** YES NO

**Child's Current School District:** SLPS Jennings Riverview Hazelwood  
Ferguson/Florissant Normandy  
Other (please name): \_\_\_\_\_

### **FOR OFFICE USE ONLY:**

	Early Head Start	Head Start	Private Pay
DIAL 1:	PASS FAIL REFER	OVERALL SCORE: _____	DATE OF SCREENING: _____
DIAL 2:	PASS FAIL REFER	OVERALL SCORE: _____	DATE OF SCREENING: _____
ASQ:	PASS FAIL REFER	REFERRED TO: _____	DATE OF SCREENING: _____
HV 1:	_____	HV 2: _____	HV 3: _____
PC 1:	_____	PC 2: _____	

**SERVICES:** FIRST STEPS SCHOOL DISTRICT CHS  
BEHAVIORAL HEALTH PARENTING HOME VISITATION



## PARENT CONSENT FORM

Child's Name: \_\_\_\_\_ Child's Birthday: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Health Services:

\_\_\_\_\_ I hereby give permission for my child to receive psychological screening and diagnostic services, hearing and speech services and eye screening.

\_\_\_\_\_ I authorize Hilltop Child Development Center to have access to health records for my child \_\_\_\_\_, to obtain necessary information for the completion of the Child Care medical record.

### Press Release/Photo Release:

\_\_\_\_\_ I give permission to use photo, films and/or recordings of my child in any way deemed necessary by the Hilltop Child Development Center.

### Newsletter:

\_\_\_\_\_ I agree to receive newsletters and other mailings of interest from Lutheran Family and Children's Services.

### Field Trips:

\_\_\_\_\_ Hilltop Child Development Center has my permission to take my child on field trips, including walks around the neighborhood or bus transportation to various points of interest. I will be notified when a field trip will take place.

### Water Play:

\_\_\_\_\_ I give my child permission to participate in water play.

My signature below verifies that I have received, read and understand the Hilltop Child Development Parent Handbook.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## PARENT TUITION AGREEMENT

\_\_\_\_\_ I agree to pay the amount of \$\_\_\_\_\_ per week for childcare tuition and/or co-payment under the Division of Family Services. (Note: Hilltop charges a center fee of \$20/week for our subsidy families on top of your sliding scale to offset the cost of childcare.)

\_\_\_\_\_ I understand that the total tuition is due by Friday morning of each week and that no deductions are made for absences, sick days, holidays or inclement weather days.

\_\_\_\_\_ I agree to have all childcare fees for the current month will be paid in full by the last business day of the month. Any changes must be approved by the center Director.

\_\_\_\_\_ I understand that a two-week notice of vacation and a \$30.00 per week holding fee are required to maintain my child's slot during this time period.

\_\_\_\_\_ I further understand that termination is inevitable if conditions of this policy are not followed and that re-enrollment following termination will depend on space available and payment of outstanding fees. A new registration fee is required upon re-entry.

Weekly Tuition:

\$\_\_\_\_\_ /week

DFS Co-Pay Fee Per Day: \$ \_\_\_\_\_

Hilltop's Co-Pay Fee: \$ \_\_\_\_\_

Total Weekly Tuition: \$ \_\_\_\_\_

### OFFICE USE ONLY

WEEKLY TUITION: \$ \_\_\_\_\_

BI-WEEKLY TUITION: \$ \_\_\_\_\_

MONTHLY TUITION: \$ \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director Signature

\_\_\_\_\_  
Date

**ALL FEES MUST BE PAID BY ONLINE, CREDIT/DEBIT CARD, CHECK,  
CASHIER'S CHECK, MONEY ORDER OR CASH.**



## ARRIVAL AND PICK UP AGREEMENT

This information is vital in order to have the appropriate number of teachers in the classrooms. The following staff/child ratios shall be maintained on the premises of the center at all times:

### **State of Missouri Child Care Licensing Regulations:**

Children under 2	1 adult to 4 children (max of 8 in the room)
2 years	1 adult to 8 children (maximum of 16 children in the room)
3-4 years	1 adult to 10 children
5 years and up	1 adult to 16 children

To ensure we are keeping our ratios at all times, we ask that you provide us with your child's schedule.

My child will arrive at school at \_\_\_\_\_ A.M and will be picked up at \_\_\_\_\_ P.M. If your child's schedule needs to change, please inform office staff so that proper staffing can be planned.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



## Pick-Up and Drop-off Update Form

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_



## LATE PICK-UP POLICY

Dear Parents/Guardians,

This is a friendly reminder that our center hours are 7 A.M to 5 P.M, Monday through Friday. If you pick up your child late, a late fee is issued. **Hilltop's new late fee policy will be \$15 for the first 5 minutes and a \$1 per minute thereafter. Late fees are on a per child basis. Any family who picks up late will be dis-enrolled from our program after the third offense.** We are still required by state law to contact local law enforcement if a child is still in our program 1 hour after we close and we have not made contact with the parents or emergency contacts. Please make sure you keep all contact information current with the front desk. I want to thank you for your understanding in this matter. If you have any questions, please feel free to contact me.

Thank you for your continued support of our program,

Julie McAfee  
Hilltop Center Director

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### Late pick up policy change agreement of understanding

My signature below verifies that I have received, read and understand Hilltop Child Development Center late policy pickup agreement. I agree to abide by the policies set forth herein.

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## CCBIS Acknowledgement Form

### I have received training on the new CCBIS system. I understand:

- ✓ I am allowed a MAXIMUM of three (3) missed sign in OR sign outs per month. If I have more than three (3) missed sign in OR outs in 1 month I will be charged a \$20 fee per day for days that are not compliant.
- ✓ If I receive subsidy at any time it is my responsibility to approve any sign in/sign outs that are input by the provider every Friday. If I do not, I am responsible for payment for the days that the provider cannot bill subsidy.
- ✓ It is my responsibility to update my phone number with the provider should my number change.
- ✓ That anyone that drops off or picks up my child(ren) will need to be registered in the KinderSmart system.
- ✓ Failure to comply with any of the regulations set forth through the new CCBIS system may result termination from the program.
- ✓ Failure to sign this form will result in termination from the program, as these are new state guidelines set forth by the state of Missouri.

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Temperature Guidelines for Outdoor Play

95° and Above	Limited time, quiet activities
90°- 95°	10-15 Minutes (Depending on heat index levels)
32°- 90°	Unlimited time
20°- 32°	10-15 Minutes
10° - 20°	5 Minutes
10° and Below	<b>DO NOT GO OUTSIDE</b>

**All children will go outside. Please dress your child appropriately during winter weather (HEAVY SOCKS, COAT, BOOTS, GLOVES OR MITTENS AND HAT). Please mark all items with your child's name.**

If you feel your child's health does not permit them to go outside, your child is not healthy enough to be at the Early Childhood Education Program at this time.

Sunscreen will be administered to your child when your child is exposed to the sun. Parents must complete a medication form in order for staff to apply sunscreen to your child. Sunscreen should be 15 SPF or higher and will only be applied to exposed skin. Parents will supply sunscreen in a non-aerosol can and will clearly label the bottle of sunscreen with their child's name.

When public health authorities recommend use of insect repellent due to a high risk of insect-borne disease, only repellents containing DEET are used. Staff will only apply insect repellent no more than once per day with a signed medical form.