2025-2026

St. Mark's Mother's Day Out

A flexible program enabling you to have a little time to yourself.
While your child is playing with other children they are growing in social, emotional, and motor skills.

Hours available: 9:30-12:30 on Tuesdays, Wednesdays, and Thursdays
We are closed if Independence Schools close for weather-related reasons.

Limited Numbers: Check availability online and signup to secure a spot for the days you want.
➡ Sign-ups are available on our website www.mysmallwonderpreschool.com or at www.stmarksparish.com

What to Bring: (in a labeled diaper bag or backpack)
for children being potty-trained - at least 2-3 diapers/pull-ups, baby wipes, change of clothes
for children potty-trained – 1 change of clothes

What to Wear: Children will be enjoying time creating art projects and playing outdoors if weather permits.
Please dress them in comfortable, washable clothing suitable for play.

Staying for Lunch? If staying between 12:00 and 12:30, please pack a lunch in a separate, labeled bag containing ready-to-eat cold lunch, drink/cup, and utensils.

Rates:

_____Hourly rate: $6.oo/hour, payable at the end of each day or weekly.
Payments should be made at the time you pick up your child. You can pay online by credit card, cash, or personal check. If paying by check, make it out to St. Mark Catholic Church.

EACH AND EVERY ITEM MUST BE CLEARLY MARKED WITH YOUR CHILD'S NAME. This includes diaper bags, lunch bags, cups, coats, change of clothes, bottles, diaper wipe containers, etc.

Child's Name_____Date of Birth_____Age_____

2nd Child's Name_____Date of Birth_____Age_____

Child/Children live with: ____Both parents _____ Mom ____Dad _____Other

Mom/Guardian's Name_____Cell/Home Phone_____

Dad/Guardian's Name_____Cell/Home Phone_____

Email_____

Address_____
City, State & Zip

_____
Person (besides parent) to contact in case of an emergency

_____
Child's Physician Phone Hospital Preference

➡

Person(s) authorized to pick up your child includes:_____

_____

Is there **ANYONE WHO IS NOT AUTHORIZED** to pick up your child?_____

Does your child have any known allergies or health concerns of which we should be aware?

_____

Is your child taking prescription medication? If so, what kind and for what purpose?

_____

Anything else you wish us to know about your child?

_____

(____I do) (____ I do not) give St. Mark Small Wonder and Mother's Day Out my consent for my child to be photographed during school activities. This includes but is not limited to, pictures on the parent portal, Brightwheel app, and publication in St. Mark's bulletin.

ALL CHILDREN ARE ACCEPTED ON A TRIAL BASIS.

I have read and understand the above, provided all information to the best of my ability, and hereby request that my child be permitted to participate in the Mother's Day Out program at St. Mark's. I understand that in case of an emergency, every effort will be made to contact me. However, if I cannot be reached, I give permission for my child, _____ to be taken to the aforementioned doctor and/or hospital for any emergency medical treatment. I further understand that I will be responsible for any costs incurred therein. I hereby release and save harmless St. Mark's Parish and all employees and volunteers from any liability for any injuries.

Date:_____ _____

Parent's Signature

_____(initial) I hereby grant permission for my student to be included in photographs, videos and other recordings made in connection with St. Mark's Mother's Day Out for a period of three calendar years. I have read, understand and agree to the above statement.

SAVE PRINT RESET

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE
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.)

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

All students are required to have immunization information on file. Please attach a copy of the immunization record or use this form.

Thank you!

MISSOURI IMMUNIZATION RECORD

OFFICIAL DOCUMENT

Retain this document as proof of immunizations. According to Missouri law, your child must meet the State of Missouri immunization requirements to be enrolled in school or child care.

NAME

DATE OF BIRTH | DCN (Department Client Number)

NAME OF PARENTS OR LEGAL GUARDIAN

ADDRESS

ALWAYS KEEP A RECORD

The immunization record plays a vital role in protecting the health of the individual throughout life, for health care providers, school, day care, employers.

Missouri Department of Health and Senior Services • P.O. Box 570
Jefferson City, MO 65102-0570

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER
Services provided on a nondiscriminatory basis.
If you desire a copy of this publication in an alternate form because of a disability, contact the Department of Health and Senior Services' immunization program at 800-699-2313. Hearing-impaired citizens may contact the department by phone through Missouri Relay, 800-735-2966.

ALLERGIES / COMMENTS / VACCINE REACTIONS

VACCINE	DATE GIVEN MO/DAY/YR	PHYSICIAN/CLINIC
PNEUMOCOCCAL POLYSACCHARIDE (23 valent)		
INFLUENZA (annual) List mo/day/yr of each vaccine		

TUBERCULIN SKIN TEST

DATE GIVEN MO/DAY/YR	DATE READ MO/DAY/YR	PHYSICIAN/NURSE SIGNATURE	RESULTS
			mm
			mm
			mm

LEAD SCREENING

LEVEL	DATE	LEVEL	DATE	LEVEL	DATE

IMMP-1 (2-07)

VACCINE		DATE GIVEN MO/DAY/YR	PHYSICIAN/CLINIC
DTaP, DTP, or DT Diphtheria, Tetanus, Pertussis (Whooping Cough) specify if DT	1 2 3 4 5		
POLIO Specify IPV or OPV	1 2 3 4		
HAEMOPHILUS INFLUENZAE type b (Hib)	1 2 3 4		
HBIG			
HEPATITIS B circle type	1 2 3 4	adult / ped adult / ped adult / ped adult / ped	
PNEUMOCOCCAL CONJUGATE	1 2 3 4		
MMR	1 2		
VARICELLA (Chickenpox)	1 2		
HEPATITIS A			
Tdap/Td Tetanus, Pertussis, Diphtheria Adult (every 10 yrs)			
Meningococcal			
Rotavirus	1 2 3		
HPV Human Papillomavirus	1 2 3		
OTHER			