central community preschool

2020-2021

NAME: _____ BIRTHDAY:_____

PARENT NAME: _____ PHONE: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

SPECIAL INFO: _____

ENROLLMENT DATE: _____ START DATE: _____

CLASS PREFERENCE: _____

☐ Reg. Fee ☐ Contact List ☐ Handbook ☐ Enrollment packet

APPLICATION FOR ENROLLMENT/AUTHORIZED PICK-UP LIST 2020-2021

Child's Name _____ Birthdate _____/_____/_____

Address _____

City_____ State _____ Zip_____

Primary Phone _____ Start Date_____ End Date _____

My child may be released to any of the person(s) mentioned below unless court ordered documentation provided to Central Community Preschool states otherwise. I authorize Central Community Preschool to contact any of the below mentioned person(s) in the order listed when possible, on my child's behalf, if needed.

Parents/Guardians:

1. Name _____

Relationship to Child: Mother Father

Living with Child? Yes___ if no, indicate custody:

Custodial Joint Visitation None

Cell phone _____

Additional Phone _____

Address _____

Employer _____

Business Phone _____

Email _____

2. Name_____

Relationship to Child: Mother Father

Living with Child? Yes___ if no, indicate custody:

Custodial Joint Visitation None

Cell phone _____

Additional Phone _____

Address _____

Employer _____

Business Phone _____

Email _____

Additional Emergency/Authorized Pick-Up Contacts:

3. Name _____ Relationship to Child _____

Address _____ Phone_____

4. Name _____Relationship to Child _____

Address _____ Phone _____

Parent's Signature _____ Date _____

CCL. 029
Rev. 5/2019

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care_____ Name of Child Care Facility_____

Child's Name_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Work Address_____
Street City Zip Code

Work Phone Number_____

Cell Phone Number_____

E-mail Address _____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Work Address_____
Street City Zip Code

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

Best way to contact_____

Names and ages of children in family_____

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary._____

_____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows:

_____

Does your child have any of the following conditions (yes or no)? <u>If yes, provide information on Authorization for Emergency Medical Care form CCL. 010</u>.

_____Allergies _____Frequent sore throats/colds _____Ear Aches
_____Asthma _____Speech, Visual, Hearing _____Diabetes
_____Epilepsy/Seizures _____Other_____

If yes answered to any above, please provide additional information_____

Have there been major changes at home that might affect your child in care? ___ No ___Yes, as follows:

_____

Please provide additional information or special instructions that will help the person caring for your child.

_____

Parent/Guardian Signature:_____ **Date:**_____

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:_____ **Date of Birth:**_____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
**Influenza(Flu) ** ** Recommended annually >6 mo of age; not required						

Section II.
Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

_____DTaP/DT _____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA _____HepB ____Hib
_____PCV ____Varicella ____Other

Physician's Signature (required): _____ **Date:**_____

☐ **(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.**

Section III.

Parent/Guardian Signature:_____ **Date:**_____

CCL. 029a
Rev. 3/2017

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: _____IN/CM %ILE_____		**Weight: _____LB/KG %ILE_____**
Physical Examination	**✓ If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) ☐ None	
Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

CCL 010
Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4582(e)(2).

Name of facility exactly as stated on the license.	**License #**
Central Community Preschool	0000430-011

I hereby authorize any Central Community Preschool staff member (Name of individual/staff member) and/or Jessica Fisher (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____(First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of September 1, 2020 and May 31, 2021
. MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ by_____.
MM/DD/YYYY Name of Person

(Seal, if any.)

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

-

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

Is child covered by health insurance? ☐ Yes ☐ No If yes,

complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number_____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.

Central Community Preschool Financial Agreement

There is a one-time **$50.00** registration fee due upon enrollment to secure your child's spot. Child must attend on the first day of school (or on the agreed start date, if starting mid-year), or the registration fee and the place in the program will be forfeited. Registration fees are non-refundable and will not be applied towards tuition. Tuition is as follows (please circle one):

Morning Sessions: 8:45-11:45 am
Afternoon Sessions: 12:30-3:30 pm

2 sessions a week: $105.00 per month
3 sessions a week: $130.00 per month
5 sessions a week: $200.00 per month

Payments are due on the first of each month, September-May. If payment is not received by the 10th day of each month, there will be a **$15.00** late fee applied to your balance. If the balance is not paid, your child may not return to school.

Payments must be made by cash or check.
All payments received are applied to previous balances.

There will be a $25.00 charge on all returned checks and the amount of the check will be added to the account balance.

Withdrawal Policy

If you plan to withdraw your child from Central Community Preschool, we must have a written notice two weeks prior to your child's last day. **If we receive no notice, you will be charged for two weeks.** All balances must be paid in full by the child's last day. Any unpaid balances will be sent to collections.

By signing below, I acknowledge that I have read and understand this agreement and agree to pay as stated above.

Child's Name: _____ Child's Start Date: _____

Parent/Guardian Signature: _____ Date: _____

Preschool Session (Day/Time): _____

CCP Program Director Signature: _____

Central Community Preschool Access Codes Authorization 2020-2021

Please provide the names of up to five people (listed on your child's current enrollment paperwork) most likely to drop-off and/or pick up your child. **This includes parents.** Next to the individual's name, please list the last four digits of **their** Social Security number. Individuals listed will use this four digit code to gain access into CCP through the E1 entrance.

Child's Name:	**Child's Teacher:**
Name of Authorized Drop-Off and Pick-Up Person (Including Parents) ALL INDIVIDUALS LISTED MUST CURRENTLY BE LISTED ON YOUR CHILD'S CURRENT ENROLLMENT PAPERWORK.	**Last Four Digits of Social Security Number**
1.	
2.	
3.	
4.	
5.	

I understand that I am responsible to contact the CCP office in order to disable and/or make changes to any authorized individual's access code.

Parent/Guardian Signature: _____ Date: _____

Central Community Preschool Personal and Developmental History

Child's Name: _____ Birthdate: _____/_____/_____

FAMILY INFORMATION

Does the child live with both parents full time? Yes ____ No____

If no, please indicate primary custodial parent: _____ _____and please indicate custodial arrangement

Joint Custody Sole Custody Visitation Supervise Visitation None *If none, court papers must be provided

Please indicate Parent/Guardian's current marital status:

Mother: Single Married Widowed Divorced Father: Single Married Widowed Divorced

Please list family members and anyone else that shares a home with your child.

Name _____Age_____ Relationship to child _____ Full Time or Part Time _____

Name _____Age_____ Relationship to child _____ Full Time or Part Time _____

Name _____Age_____ Relationship to child _____ Full Time or Part Time _____

Name _____Age_____ Relationship to child _____ Full Time or Part Time _____

EDUCATIONAL BACKGROUND

Has your child previously attended a child care center, preschool, or in-home daycare? Yes _____ No_____

If yes, where? _____

SPIRITUAL BACKGROUND

Do you attend church? Yes_____ No_____ If so, where do you attend? _____

ALLERGIES

Does your child have any allergies? No _____ Yes_____ (If yes, documentation must be provided). Please describe:

_____

TOILETING HABITS

We are licensed to care for children that are fully potty-trained. Children may not wear diapers or pull-ups while in attendance. All children attending CCP must be able to indicate that they need to use the restroom and be relied upon to know what to do once they are in the restroom with little guidance.

Is your child able to do this? Yes _____ No _____

What word is used for urination? _____ Bowel movement? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

Does your child have a lot of experience playing with other children? Yes _____ No_____

How does your child interact with other children?

_____

What methods of discipline are used with your child?

_____

What makes your child sad or upset and what does your child dislike?

_____

Please indicate your child's fears and/or anxieties here:

_____

Tell us what your child loves:

_____

Please describe your child's demeanor/personality:

_____

In what particular ways would you like us to help your child?

_____

Is there anything else that you'd like to share about your child, or your family, to help us be more aware of his/her needs?

_____

ADDITIONAL NOTES (OPTIONAL):

Parent Signature _____ Date _____

central community preschool

Photo and Video Release

2020-2021

Child's Name: _____ Child's Teacher: _____

Parent(s) Names: _____

Please check below:

_____ I give permission to Central Community Preschool to take photographs or video of my child, which may be used on the preschool website, Facebook or Instagram pages.*

_____ I DO NOT give permission to Central Community Preschool to take photographs or video of my child, which may be used on the preschool website, Facebook, or Instagram pages.

***Children will not be mentioned by name**

Parent or Guardian Signature _____ Date _____

Checklist for Parent Files

Parents, have you completed the following forms?

Tan Forms

1. **Medical Record**

- All lines must be filled in, even if the information is the same or a repeat.
- Hospital preference must be listed.
- Dentist must be listed, even if you just pick one.
- Allergies: must write yes or no on each line
- Please sign and date at the bottom.

2. **History of Immunizations**

- Immunizations can be attached to this form.
- Please fill out other information and sign and date.
- Immunizations may be faxed to (316) 942-3291, attention: Jessica Fisher

3. **Health Assessment**

- Fill in Name and Date at top.
- Form must have physician or nurse signature or stamp with signature.

White Authorization for Emergency Medical Care

- Witness dates **MUST** match.
- Witness may be spouse, family member or family friend.
- Witness may not be a CCP staff member.
- Must have policy number or card number in bottom section
- Fill in the date of your child's last tetanus shot (refer to immunization record)

Green Financial Agreement

- Start date is child's first day of school.
- Please circle session you are enrolled in.

Emergency Card: This one is two-sided!

Please return all forms in the file folder to the front office or your child's teacher. Thank you so much for your time and attention in filling out these enrollment forms. They help us serve your family better!