



2023-2024

CHILD'S NAME: _____ BIRTHDAY: _____ AGE ON 9/5/23: _____

PARENT NAME: _____ PHONE: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

SPECIAL INFO: _____

ENROLLMENT DATE: _____ START DATE (Fall/Spring): _____

SESSION PREFERENCE (Days & Times): _____

TEACHER PREFERENCE: _____

Reg. Fee

Contact List



Photo and Video Release

2023-2024

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

Parent(s) Name(s): _____

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/Guardian Signature _____ Date _____



EMERGENCY CONTACT CARD 2023-2024

Child's Name: _____

Dad's Name: _____ Mom's Name: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Child: _____

****PLEASE FILL OUT BOTH SIDES OF THIS FORM**

Revised 12/22

EMERGENCY CONTACT CARD 2023-2024

Child's Name: _____

Contact Name	Phone Number	Relationship to Child
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Anyone on this list must have a security code.**

****PLEASE FILL OUT BOTH SIDES OF THIS FORM**

Revised 12/22

APPLICATION FOR ENROLLMENT/AUTHORIZED PICK-UP LIST



Child's Name _____ Birthdate ____/____/____

Address _____

City _____ State _____ Zip _____

Primary Phone _____ Start 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 _____

2. Name _____

Relationship to Child: Mother Father

Relationship to Child: Mother Father

Living with Child? Yes___ if no, indicate custody:

Living with Child? Yes___ if no, indicate custody:

Custodial Joint Visitation None

Custodial Joint Visitation None

Cell phone _____

Cell phone _____

Additional Phone _____

Additional Phone _____

Address _____

Address _____

Employer _____

Employer _____

Work Phone _____

Work Phone _____

Email _____

Email _____

Additional Emergency/Authorized Pick-Up Contacts:

Name	Phone Number	Relationship to Child
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
-------	-------	-------

_____	_____	_____
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Parent/Guardian Signature _____ Date _____



Central Community Preschool Financial Agreement

There is a one-time **\$75.00** enrollment fee due upon enrollment to secure your child's spot. Enrollment fees are non-refundable and will not be applied towards tuition. Tuition is as follows (please check one):

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

- 2 sessions a week: \$130.00 per month**
- 3 sessions a week: \$160.00 per month**
- 5 sessions a week: \$250.00 per month**

Payments are due on the first week day of each month, September-May. If arrangements are not made to take care of your outstanding balance, your child may not return to school.

Tuition payments must be made through auto draft unless other arrangements have been made with the office. All payments received are applied to previous balances.

There will be a \$15.00 charge on all returned auto drafts and the amount must be paid with **cash** or **cashier's check**.

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: _____

Parent/Guardian Signature: _____ Date: _____

Preschool Session (Day/Time): _____

CCP Program Director Signature: _____

Authorization for Automatic Bank Draft 2023-2024

Company Name: Central Community Preschool/Central Community Church

I (we) hereby authorize **Central Community Preschool/Central Community Church** to initiate debit entries to my (our) **Select One:**

() Checking Account

() Savings Account

Indicated below at the depository financial institution named below, hereinafter called **FINANCIAL INSTITUTION**, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. If payment is rejected due to non-sufficient funds, cashier's check or cash payment is required for that month and a \$15.00 administrative fee will be applied.

**Financial Institution Name _____

Routing Number: _____ Account Number: _____

****Attach a voided check to this form**

Frequency:

9 Auto withdrawals:

Friday, September 1, 2023

Monday, October 2, 2023

Wednesday, November 1, 2023

Friday, December 1, 2023

Monday, January 1, 2024

Thursday, February 1, 2024

Friday, March 1, 2024

Monday, April 1, 2024

Wednesday, May 1, 2024

Child's Name: _____

Class Session: _____

Central Community Preschool Payment Amount: \$_____

This authorization is to remain in full force and effect until **Central Community Preschool/Central Community Church** has received written notification of its termination in such time and manner as to allow **CCP/CCC** and **Financial Institution** a reasonable opportunity to act on it, or until the last day of CCP's 2023-2024 school year.

Name _____ Date _____

Signature _____



**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 _____
First Last

Date of Birth _____ Gender _____
MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Employer _____

Employer _____

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell Phone Number _____

E-mail Address _____

E-mail Address _____

Best way to contact _____

Best way to contact _____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____
Address _____
Phone Number _____

Name _____
Address _____
Phone Number _____

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: _____

Any known allergies or medical conditions of child:

Any major changes at home that might affect your child in care:

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					
	1 st	2 nd	3 rd	4 th	5 th	6 th
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:** _____

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): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> 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) <input type="checkbox"/> 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



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. Central Community Preschool	License # 0000430-014
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I authorize any Central Community Preschool staff member and/or Mariah Baughman(caregiver/staff) 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

(child's first and last name) while child or youth is in the facility's custody between

September 1, 2023 and August 31, 2024.

MM/DD/YYYY

MM/DD/YYYY

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: _____

MM/DD/YYYY

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

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 <u>Kansas</u> 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: _____

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 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 (other than parents) 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? _____

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?

Parent/Guardian Signature _____ Date _____



Central Community Preschool Access Codes Authorization

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:	
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:** _____