Central Community Preschool Access Codes Authorization

Please provide the names of all 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.	
6.	
7.	

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: _____

CCL.010
Rev. 07/2024

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

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. 28-4-582(e)(2).

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

I authorize any Central Community Preschool staff 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 09/01/2024 (MM/DD/YYYY) and 08/31/2025 (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**

- -

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 off premised from the facility.

CCL. 029
Rev. 07/2024

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/Childcare Licensing

Kansas Department of Health and Environment

Medical Record

Medical History

In accordance with K.A.R. 28-4-117, a completed medical record shall be on file for all children in care under 10 years of age and all children living in the home under 16 years of age. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment.
The Medical Record is 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/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

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_____

Hospital Preference (for emergencies)_____

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:_____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Medical Record:

Medical History Cont. - 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.; not required						
Influenza (Flu) **Recommended annually >6 mo.; 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 ____Hep A ____Hep B ____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. 06/2024

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/Childcare Licensing

Kansas Department of Health and Environment

Medical Record:
Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

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 Family Child 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.

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 pages if necessary)
☐ None

Signature of Licensed Physician or Nurse approved for Child Health Assessment	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

Authorization for Automatic Bank Draft 2024-2025

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:

Tuesday, September 3, 2024
Tuesday, October 1, 2024
Friday, November 1, 2024
Monday, December 2, 2024
Thursday, January 2, 2025
Monday, February 3, 2025
Monday, March 3, 2025
Tuesday, April 1, 2025
Thursday, May 1, 2025

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 2024-2025 school year.

Name _____ Date_____

Signature _____

Central Community Preschool Financial Agreement

There is a one-time **$100.00** 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: _____

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 _____

APPLICATION FOR ENROLLMENT/AUTHORIZED PICK-UP LIST

Child's Name _____ Birthdate _____/_____/_____

Address _____

City_____ State _____ Zip_____

Primary Contact _____ 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 _____

Relationship to Child: Mother Father

Living with Child? Yes___ if no, indicate custody:

Custodial Joint Visitation None

Cell phone _____

Address _____

Employer _____

Work Phone _____

Email _____

2. Name_____

Relationship to Child: Mother Father

Living with Child? Yes___ if no, indicate custody:

Custodial Joint Visitation None

Cell phone _____

Address _____

Employer _____

Work Phone _____

Email _____

Additional Emergency/Authorized Pick-Up Contacts:

Name	**Phone Number**	**Relationship to Child**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature _____ **Date** _____

EMERGENCY CONTACT CARD 2024-2025

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 2024-2025

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 2024-2025

Child's Name: _____

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

***Anyone on this list must be on the access code form**

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

Revised 12/22

EMERGENCY CONTACT CARD 2024-2025

Child's Name: _____

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

***Anyone on this list must be on the access code form**

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

Revised 12/22

Photo and Video Release

2024-2025

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

Parent(s) Name(s): _____

*Please check below for the **PUBLIC WEBSITE PAGES**:*

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

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

*Please check below for the **PRIVATE CLASSROOM FACEBOOK PAGES**:*

_____ I give permission to Central Community Preschool to take photographs or video of my child, which may be used on the private classroom Facebook page and for the Christmas and Spring Program Concerts.

_____ I DO NOT give permission to Central Community Preschool to take photographs or video of my child, which may be used on the private classroom Facebook page and for the Christmas and Spring Program Concerts.

Parent/Guardian Signature _____ Date _____

central community preschool

2024-2025

CHILD'S NAME: _____ BIRTHDAY:_____ AGE ON 9/3/24: _____

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 ☐ School District:_____

central community preschool

2024-2025

CHILD'S NAME: _____ BIRTHDAY:_____ AGE ON 9/3/24: _____

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 ☐ School District:_____