GOOD SHEPHERD PRE-SCHOOL
ENROLLMENT AGREEMENT

FULL NAME OF CHILD____

NAME CHILD IS CALLED____________________BIRTHDATE____________

FULL NAME OF FATHER____

FULL NAME OF MOTHER____

MAILING ADDRESS____
Street/Box City Zip

HOME PHONE____________________

FATHER-PLACE OF EMPLOYMENT_____________________________
BUSINESS PHONE_________________

MOTHER-PLACE OF EMPLOYMENT_____________________________
BUSINESS PHONE_________________

EMERGENCY NAMES & PHONE NUMBERS

PHYSICIAN____

AT LEAST TWO FRIENDS OR RELATIVES___________________________

____

____

NAMES & PHONE NUMBERS OF PERSONS TO WHOM WE MAY RELEASE YOUR CHILD

NAME___________________________PHONE____________________

NAME___________________________PHONE____________________

NAME___________________________PHONE____________________

Acceptance of the enrollment form and the Non-refundable Enrollment Fee of $25.00 will assure your child a place in our pre-school. In return, we expect that you will honor your enrollment for the term, unless you move from the city or some unusual circumstance makes a mutual agreement to dissolve the contract the most advantageous arrangement for the child.

The Clearwater United Methodist Church sees the Good Shepherd Pre-School as a ministry to children and families in the community. Therefore, Christian principles will be used in dealing with the children, and Christian values will be taught.

I agree to abide by the policies of Good Shepherd Pre-School. I agree to honor this enrollment as described above, and I understand that this is a Christian Pre-School. In case I do need to move my child from the program, I will give an advance notice of two weeks, or pay for that time.

Monthly fee, due on the 1st day of each month: $75.00 for a 4 year old
$55.00 for a 3 year old

Amount Paid: ______________

I prefer: _______Mornings _______Afternoons _______No Preference

DATE____________SIGNATURE______________________________

CCL. 029
Rev.12/2008

Kansas Department of Health and Environment
Child Care Licensing and Registration Program
1000 SW Jackson, Suite 200, Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax: (785) 296-0803
Website: www.kdheks.gov/bcclr/index.html

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES AND FAMILY DAY CARE HOMES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in registered family day care homes or 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 or family day care home.

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)____

1. 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:

____

2. Does you child have any of the following conditions? Please answer yes or no.
______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______________________________

3. Have there been major changes at home that might affect your child in care? ___ No___Yes, as follows:

____

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

____

Signature of Parent/Guardian____**Date:**______________

CCL 010
Rev. 9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Day Care Unit: Phone: 785-296-1270 Fax: 785-296-0803
Foster Care Unit: Phone 785-368-7015 Fax: 785-296-7025
Website: www.kdhe.state.ks.us/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) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate.	**License or Certificate #**

I hereby authorize Gretchen Bond, Gayla Rinehart (Name of individual/staff member) and/or Lisa Berntsen (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 ____________ and ____________.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	**Date Signed**

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

Notarization of Parent's or Guardian's signature only 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: ____________________

Complete information regarding health care insurance, if applicable.

Health Insurance Policy Name:______________________ Policy Number ____________

Medical Assistance Program ______________________ Card Number____________

Military Medical Care I.D. Number ______________________

If known, date of last Tetanus inoculation: ____________________

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

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.

Recommended Immunizations for Ages 0-5 years

Age	Vaccines
At Birth	HepB
2 months	HepB (1-2mos) + DTaP + PCV + Hib + Polio + Rota
4 months	DTaP + PCV + Hib + Polio + Rota
6 months	HepB (6-18mos*) + DTaP + PCV + Hib + Polio + Rota (Influenza) Annually^
12 months	MMR + PCV + Hib + Varicella + HepA (12-15mos*) DTaP 6 mos after 3rd dose
18 months	HepA 6mos after dose 1
5 years	DTaP + MMR + Polio + Varicella

Vaccine Descriptions:

HepB: protects against hepatitis B

DTaP: a combined vaccine that protects against diphtheria, tetanus, and pertussis (whooping cough)

Hib: protects against *Haemophilus influenzae* Type b (is not the "flu" vaccine)

PCV: protects against pneumococcal disease

Polio: protects against polio, also known as IPV

Rota: protects against infections caused by rotavirus

Influenza: protects against influenza (flu)

MMR: protects against measles, mumps, and rubella (German measles)

Varicella: protects against varicella, also known as chickenpox

HepA: protects against hepatitis A

*This is the age range in which this vaccine should be given.

^Influenza is a seasonal vaccine. All children between the ages of 6 months and 18 years should receive vaccination during the influenza season **each year**. If this is the first time for flu vaccine, a child should receive two doses, separated by at least 4 weeks. If a child only received one dose in the first season, they should receive two doses the next season

Note: If your child misses a dose of the needed vaccines, you don't need to start over. Just make an appointment quickly to go back to your doctor for the next shot. The doctor will help you keep your children up-to-date on their vaccinations so they are fully protected against many diseases.

For more information call: (785) 296-1270 KDHE CCLR or (785) 296-5591 KDHE Immunization Program

Or visit:http://www.kdheks.gov/bcclr/index.html or http://www.kdheks.gov/immunize/index.html

Kansas Department of Health and Environment— Child Care Licensing and Registration Program & Immunization Program

Kansas Department of Health & Environment

Adapted from the Centers for Disease Control Recommended Immunizations for Babies Schedule

CCL. 029a
Rev.12/2008

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 Child Health Assessment is optional for children in Registered Family Day Care Homes. 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. Any Health Assessment Form should be attached to the KDHE Medical Record Form.

Child's Name_______________________________ Date of Birth_______________________________

Past Health History (Developmental – Illness – Hospitalization)_______________________________

Allergies_______________________________

Current Medications_______________________________

Nutritional Status_______________________________

Physical Examination

Height__________ Weight__________

Head_______________________________ Abdomen_______________________________

EENT_______________________________ GU_______________________________

Teeth_______________________________ GYN_______________________________

Heart_______________________________ Skeletal_______________________________

Lungs_______________________________ Neurological_______________________________

Screening Tests (Dates Done and Results)

Vision_______________________________ TBC. Test_______________________________

Hearing_______________________________ Sickle Cell_______________________________

Speech_______________________________ HGB._______________________________

DDST_______________________________ U.A._______________________________

Lead_______________________________ Other_______________________________

Diagnosis:

Recommendation:

Do you see this child for regular health supervision: Yes ______ No ______

____ ____________________

Signature of Licensed Physician or Nurse Approved for Child Health Assessments Date (MM/DD/YYYY)

____ Phone number____________

Print the Name of the Individual Signing Above

____

Address of Physician or Nurse City Zip Code