

**KID'S CORNER AFTER SCHOOL PROGRAM
ENROLLMENT AGREEMENT**

FULL NAME OF CHILD _____ Grade _____

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 Kid's Corner. 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 Kid's Corner 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 Kid's Corner and to honor this enrollment as described above, and I understand that this is a Christian after school program. 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.

\$135.00 - Full Time Monthly (1/2 payments in Aug and May)

\$12.00 - Daily Part-Time

\$7.00- Daily Part-Time only 1 hour

Fees are due on the 1st day and the 15th day of each month:

Payment of fees will be expected even if days are missed.

Amount Paid: _____

DATE _____ SIGNATURE _____

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) _____

Print the Name of the Individual Signing Above _____

Phone number _____

Address of Physician or Nurse _____

City _____

Zip Code _____

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/bccr/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

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Work Address _____
Street City Zip Code

Work Address _____
Street City Zip Code

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 _____

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 your 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: _____

History of Immunizations

For all children in child care facilities and family day care homes, 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/Y

SECTION I.

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
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Parent/Physician Signature		Date of Illness:	
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
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 laws requiring immunizations [K.S.A. 65-508(d) and K.S.A. 65-519(c)].

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:

DTP Pertussis Only Tetanus Polio MMR Rubella Only Hep A Hep B
 Hib PCV7 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: _____



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 #
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I hereby authorize _____ (Name of individual/staff member) and/or _____ (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
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Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	Date Signed
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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 _____ MM/DD/YYYY	by _____ 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.