

**GOOD SHEPHERD PRESCHOOL
2020-2021 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 _____

EMAIL ADDRESS _____

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 \$50.00** will assure your child a place in our preschool. 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 Preschool 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 Preschool. I agree to honor this enrollment as described above, and I understand that this is a Christian Preschool. 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: _____ \$80 for a 2 day program 3-year-old: (T-Th am ONLY)
_____ \$100 for a 3 day program: (MWF am)
_____ \$100 3 day program (MTTh afternoon)
_____ \$130 for Transitional 4 Pre-K: (MTTF afternoon ONLY)

Amount Paid: _____

Only circle shirt size if needed: YXS YS YM YL

Additional shirts are \$10. Please let us know if you want an adult-sized shirt or an extra youth shirt.

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 _____ 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) _____

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)? If yes, provide information on Authorization for Emergency Medical Care form CCL 010.

- | | | |
|-------------------------|-----------------------------------|-----------------|
| _____ 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					
	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(d)].

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: _____



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. <u>Good Shepherd Preschool And CCC</u>	License # <u>7227-012</u>
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I hereby authorize Good Shepherd Preschool Staff (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 08/19/2020 and until termination
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 if required by the local hospital or clinic.	Date Signed
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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.