GOOD SHEPHERD PRESCHOOL
2021-2022 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____

CCL. 029
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

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

Name______________________
Home Address______________________
Street City Zip Code
Home Phone Number______________________
Employer______________________
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______________________
Employer______________________
Work Phone Number______________________
Cell 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______________________

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**					
	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 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:**__________

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): ☐ 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 sheets if necessary) ☐ 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

CCL 010
Rev. 5/2020

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Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
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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 #
Good Shepherd Preschool # CCC	7227-012

I authorize Good Shepherd Preschool Staff (*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 08/31/2020 and until termination
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 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: ____________

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.