

**GOOD SHEPHERD PRESCHOOL
2022-2023 ENROLLMENT AGREEMENT**

FULL NAME OF CHILD _____

NAME CHILD IS CALLED _____ BIRTHDATE _____

FULL NAME OF FATHER _____

FULL NAME OF MOTHER _____

MAILING ADDRESS _____

HOME PHONE _____ Street/Box _____ City _____ Zip _____

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)

**** Class availability will be based on enrollment in the program

Amount Paid: _____

Only circle shirt size if needed: YXS YS YM YL

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 _____
First Last

Date of Birth _____ Gender _____
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 _____

Employer _____

Employer _____

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 _____

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					
	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: _____

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): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> None	

Length/Height: _____ IN/CM %ILE _____	Weight: _____ LB/KG %ILE _____
Physical Examination	<input checked="" type="checkbox"/> 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) <input type="checkbox"/> 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 _____



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-D15
I authorize <u>Good Shepherd / Kids' Corner Staff</u>	(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 00/01/2022 and 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
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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: _____

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.