

**GOOD SHEPHERD LEARNING AND CHILDCARE CENTER
PRESCHOOL/DAYCARE ENROLLMENT AGREEMENT 2026-2027**

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 _____

Acceptance of the enrollment form and the **non-refundable enrollment fee of \$50.00** will secure your child a place in our preschool/daycare. In return, we expect that you will honor your enrollment for the term, unless you move from the city or some unusual circumstance arises.

Students must be 3 years old and potty trained to attend Good Shepherd Learning and Childcare Center

The Clearwater United Methodist Church sees the Good Shepherd Learning and Childcare Center 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 Learning and Childcare Center and to honor this enrollment as described above, and I understand that this is a Christian Program. If it becomes necessary to remove 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: _____ \$175/week for full-time 5 days/week 7:15-5:45
_____ \$50/week 5-day preschool program 8-11
_____ \$40/week 4-day preschool program 8-11
_____ \$30/week 3-day preschool program 8-11

Amount Paid: _____

DATE _____ SIGNATURE _____

GOOD SHEPHERD CHILDCARE LEARNING
AND CHILDCARE CENTER

ENROLLMENT SCHEDULE
2026-2027

_____ WILL ATTEND ON THE
FOLLOWING DAYS

_____ MONDAY

_____ TUESDAY

_____ WEDNESDAY

_____ THURSDAY

_____ FRIDAY

_____ DATE: _____
(PARENT'S SIGNATURE)

Medical Record:

Medical History Cont. - 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)						
Polio/myelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)						
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus						
Influenza (Flu)						

*Recommended <8 mo.; not required
*Recommended annually >6 mo.; not required

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

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 Hep A Hep B
 Hib PCV Varicella Other (describe): _____

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: _____

CCL.010
Rev. 07/2024

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Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing



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 Good Shepherd Preschool and CCC	License # 7227-019
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I authorize Good Shepherd 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 _____ and termination.
MM/DD/YYYY 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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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 off premises from the facility.