COUNTRYSIDE UNITED METHODIST PRESCHOOL, INC.

Application for Enrollment

Please reserve a place at Countryside United Methodist Preschool for:

child's name_____ birth date_____

gender_____ age as of September 1:_____years _____months

address _____ phone _____

city _____ state _____zip_____ alt phone _____

email address _____

***Children entering Countryside United Methodist Preschool must be potty-trained.**
Enrollment Choice (please circle; for Extended Day indicate your choice of Wed. or Thurs. or both)
AM Classes 8:45-11:20
PM Classes 12:30-3:05

Young 3's	**3 yr. Old**	**4/5 yr. Old**	
	T/TH AM	M/W/F AM	All Day M-F
T/TH AM	M/W/F AM	M/W/F PM	M-F AM
	M/W/F PM	T/TH/F AM	Extended Day Wed .
		M-TH AM	Extended Day Thurs.

Please indicate the class schedules which are your 2nd and 3rd choices in case the 1st choice class schedule is unavailable.

List Parent's Church Affiliation or preference below:
Name of Church_____

The enrollment fee of $75 is non-refundable and is enclosed. I agree to pay all tuition expense, including first and last months' tuition in advance, and including minimum withdrawal obligations incurred relative to official withdrawal notice of one month.

Date _____ Signed_____

In which school district do you live? _____
Whom may we thank for referring you to our preschool? _____

Please complete the back-side of this form.

For Office Use Only

Class: _____
Teacher: _____

Enrollment Fee: _____

Start Date: _____
Enrollment Date: _____
Health Form:_____
History: _____
EMC: _____
Tuition Contract: _____
Photo Release: _____
Walk Permission: _____
Withdrawal Date: _____

Countryside United Methodist Preschool

New Enrollee Survey

This information is to be used to meet individual needs of the student as part of the learning process.

Name_____

The above student has or has not received services for the following conditions:

	YES	NO
Physical disabilities	_____	_____
Mental retardation	_____	_____
Developmental delays	_____	_____
Hearing Impairment	_____	_____
Speech or language delay	_____	_____
Emotional and/or Behavioral patterns	_____	_____
Learning Disability	_____	_____
Medical Disability	_____	_____
Gifted	_____	_____
Other Disability	_____	_____
Has this student been enrolled in another program and been asked to leave?	_____	_____
Has this student been enrolled in a special or exceptional educational program elsewhere?	_____	_____
Does the child require special accommodations or have physical limitations that will prohibit a normal preschool experience?	_____	_____

If yes, please describe

_____

_____

_____

If applicable, an Individualized Education Plan (IEP) must be on file before the start of school.

_____ _____

Signature of parent or guardian date

COUNTRYSIDE UNITED METHODIST PRESCHOOL, INC.

3221 Burlingame Rd. 266-6733 Topeka, KS 66611

NAME _____
First Last

NAME CALLED _____

SEX _____ BIRTHDATE _____

Parent or Responsible Party
Name _____
Address _____
Street City Zip Code
Home Phone _____ Cell Phone _____
Language spoken in home _____

Biological Parents Relationship _____
(Married, divorced, separated, etc...)
Parent's or Responsible Party's Employment
Father
Occupation _____
Full or Part-time _____
Business Name _____
Address _____
Phone _____
Mother
Occupation _____
Full or Part-time _____
Business Name _____
Address _____
Phone _____

Church Preference _____
Denomination _____

Children and Adults Living in the Home

Name	Birth Date	Relationship

Emergency Information-Local Persons Only

Name _____ Phone _____
Address _____ Relationship _____

Name _____ Phone _____
Address _____ Relationship _____

Preferred Physician
Name _____ Address _____ Phone _____
Preferred Hospital
Name _____ Address _____ Phone _____

Who will bring and pick up the child?

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Information Concerning Child
Has child had previous preschool experience? Where?

Does child have neighborhood playmates?

Does child have difficulty speaking?

Does child need help to undress and dress him/herself to use the bathroom? Describe help needed.

What words does child use to indicate need to go to the bathroom?

Are there any foods that the child should not be allowed to eat for medical reasons?

Does the child have frequent colds/allergies?

Has the child had any serious illness or hospitalizations?

Does the child have any physical disabilities or other problems of which the staff should be aware?

Does the child have any special fears?

Exceptions, special instructions or other considerations?

CCL 010
Rev. 3/2017

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

Kansas

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 #**

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**

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: _____

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.

CCL. 029
Rev.12/2008

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/bcclr/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

Name_____
Home Address_____
Street City Zip Code
Home Phone Number_____
Work Address_____
Street City Zip Code
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_____
Work Address_____
Street City Zip Code
Work Phone Number_____
Cell Phone Number_____
E-mail Address_____
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 you 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					
	1st	2nd	3rd	4th	5th	6th
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:**_____

CCL. 029a
Rev.12/2008

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)

_____ Phone number_____

Print the Name of the Individual Signing Above

_____

Address of Physician or Nurse City Zip Code