

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

| | | |
|------------------|------------------|-----------------------------|
| <u>Young 3's</u> | <u>3 yr. Old</u> | <u>4/5 yr. Old</u> |
| MWF AM | MWF AM | MWF AM All Day M-F |
| | MWF PM | MWF PM |
| | M-F AM | M- Th AM Extended Day Wed . |
| | | M- F 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: _____ | Start Date: _____ |
| Teacher: _____ | Enrollment Date: _____ |
| | Health Form: _____ |
| Enrollment Fee: _____ | 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?



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>Countryside United Methodist Preschool</u> | License # <u>0020517</u> |
|---|-----------------------------|

I hereby authorize Meredith E. (Eddie) Kidd II (Name of individual/staff member) and/or
d CUMPS Staff (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 08/01/2019 and 06/30/2020
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.

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 _____
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 _____

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) _____

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 your 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 | | | | | |
|---|---|-----------------|--|-----------------|------------------|-----------------|
| | 1 st | 2 nd | 3 rd | 4 th | 5 th | 6 th |
| 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: _____

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) _____

Print the Name of the Individual Signing Above _____

Phone number _____

Address of Physician or Nurse _____

City _____

Zip Code _____