Amanda Arnold Child Care Program

Registration Form

This acknowledges that ______________________________, grade:________, is enrolled in the Amanda Arnold Child Care Program (**use the child's legal name**) for program year **2019-2020**.

Please note that all fees listed below are subject to change if enrollment in the program decreases or 2018-2019 school days changes. There is a $25.00 enrollment fee due at enrollment for new members.

Monthly Enrollment Options (please check the session to be attended):

Morning Only (AM)

______$105.00/month (5 days a week)

______$85.00/month (3 days a week) ______,______,______

Afternoon Only (PM)

______$140.00/month (5 days a week)

______$115.00/month (3 days a week) ______,______,______

Morning and Afternoon (AM/PM)

______$175.00/month (5 days a week)

______$145.00/month (3 days a week) ______,______,______

Billing: How do you wish to pay? Monthly_____ Twice a month_____

Medical Allergies- ___________________

Medication- ___________________

Does it need to be given during child care? ____________________

Photography Release- Amanda Arnold Child Care Program has permission to take and use photographs of my child for program purposes.

Yes- Child's name:____

Parent/Guardian (signature):_____________________________________

No- Child's name:____

Parent/Guardian (signature):_____________________________________

Office use only: Health forms______ Enrollment Fee (if applicable) ______ Medication Forms (if applicable) ______

Amanda Arnold Child Care Program

Please read all guidelines thoroughly for the safety of your child/ren in our program.

Disenrollment

I understand that a two-week written notice is necessary when a child withdraws from the program. Tuition already paid will not be refunded if written notice is not given or there is less than a two-week notice. Any tuition paid beyond the written two-week notice will be refunded. Unpaid fess will be turned in to the Budget and Accounting department for collections.

Authorized Pick- Up Persons

To ensure each child's safety, s/he will leave Amanda Arnold Child Care Program only with people designated by the parents as authorized pick-up persons. The director and staff must be notified in writing if anyone not so designated is to be picking up your child.

Tuition

Monthly payments will be due by the 5th and the 5th and 15th if paying twice a month. A late fee of $10.00 will be assessed the next day (the 6th and 16th if paying twice a month). A fee of $30.00 plus bank fee will incurred by USD 383 if there is a returned check.

Absences and Tuition

Parents are expected to pay for child care for all regularly scheduled school days, including those when a child is absent. If you are taking extended leave (vacations, sabbaticals etc.) tuition is due as normal to save your child's spot in the program.

After School Activities

No child will be allowed to attend any after school activity (school related or otherwise) unless the parents have filled out a completed Activity Release Form with the Child Care Program.

Please notify us if your child/ren will not be attending childcare on a particular day, we spend a lot of time looking for children at the end of the day that may have gone home sick or left for other reasons. Please email or telephone us if your child/ren will not attend care.

We discourage parents from asking children to sign themselves out to walk home at the end of the day, However, if the parents elect to do this, a permission form must be completed. Amanda Arnold Child Care is not responsible for your child after s/he leaves our supervision. All children who sign themselves out must leave the school building immediately. A new form must be signed each time a child sign themselves out.

Please sign your child/ren out each time at pick-up. Your child/ren's safety is our first priority.

Parent/Guardian (Print):____ Date:________________

Parent/Guardian (signature):____

Amanda Arnold Child Care Program

Below you will see the list of No School days that we will be offering care. If you are in need of care, please fill out the form below, with payment, to Laura Dockery. Spots are very limited.

Please place a check mark next to the days that you are needing care.

Child's Name:_______________________________________

No School days $20/day/child

__________ 9/21/2018

__________ 10/8/2018

__________ 10/19/2018

__________ 10/25/2018

__________ 2/8/2019

__________ 2/14/2019

__________ 2/18/2019

__________3/8/2019

__________4/1/2019

__________ 4/19/2019

__________**Total Amount Due**

***Please make checks payable to AACCP**

***No School days- breakfast and a snack will be provided. Lunch will not, please bring a sack lunch.**

CCL.027
Rev. 8/2013

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-296-0803
Website: www.kdheks.gov/kidsnet

Authorization for Dispensing Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label. A record of administration must be kept.

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or**

____
First and Last Name of Child or Youth

____
Name of Medication (only one medication per authorization) Prescription OR Non Prescription

____
Reason for Medication

____
Dose Time to be Given **Start Date** **Stop Date****

____
Name of Licensed Physician or Nurse Practitioner prescribing the medication Phone # of Physician

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

____
Parent's Signature Date Signed

instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Administering Medication ___________________________________ Initialing as ____________

*Signature of Person Administering Medication ___________________________________ Initialing as ____________

*Signature of Person Administering Medication ___________________________________ Initialing as ____________

*Signature of Person Administering Medication___________________________________ Initialing as ____________

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's or youth's appearance and/or condition.

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Rev. 1/2014

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 296-0803
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	**Frequent sore throats/ colds**	**Ear Infections or Aches**	**Heart or Lung Conditions**
Skin Problems	**Asthma**	**Headaches**	**Diabetes**
Vision	**Speech/Communication**	**Hearing**	**Emotion/Behavior**
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	**If yes to both of these questions, you do NOT need to complete the immunization history below.** **If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.**

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	**Relationship to the Child/Youth**	**Date Completed**

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	**What is that person's relationship to the child/youth?**

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	**Date Signed**

CCL 010
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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) 296 -0803
Website: www.kdheks.gov/kidsnet

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 #**
Amanda Arnold Child Care Program	0015952

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 until no longer enrolled____.
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.

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Rev. 8/2013

Kansas Department of Health and Environment
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Topeka, KS 66612-1274
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Website: www.kdheks.gov/kidsnet

Authorization for Dispensing Medications to Children or Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label.

Medication #1

____
First and Last Name of Child or Youth

____
Name of Medication

____
Reason for Medication

____
Dose Time to be Given Stop Date

____
Name of Licensed Physician/Nurse Practitioner prescribing the medication

(_________)______________________________
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

____
Parent's Signature Date

Medication #2

____
First and Last Name of Child or Youth

____
Name of Medication

____
Reason for Medication

____
Dose Time to be Given Stop Date

____
Name of Licensed Physician/Nurse Practitioner prescribing the medication

(_________)______________________________
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

____
Parent's Signature Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Administering Medication ____ Initialing as___________

*Signature of Person Administering Medication ____ Initialing as __________

*Signature of Person Administering Medication ____ Initialing as __________

*Signature of Person Administering Medication ____ Initialing as __________

Note Form

Date	Comments about the incident or other related incidents, including remarks about the child's or youth's appearance.