About Crestview Learning Center

- We offer Families Parent Nights which provide opportunities for families to spend time together.
- We serve nutritionally balance meals following CACFP guidelines. Breakfast at 8:15am, Lunch at 11:15am, and Snack is served at 2:30pm.
- Our Teachers are well trained and continue education beyond the required hours
- The Curriculums we offer are:
    - For Toddlers: Creative Curriculum and Animal Trackers
    - For Preschool: Handwriting without Tears, Second Step, Kinder Process
    - For Pre-K: Handwriting without Tears, Second Step and Kinder Process
- Our operating hours are 7:00am-6:00pm, M-F, with the exception of some holidays and 3 Staff Education Days
- The tuition rates are: (Subject to change)

Age Group	**Classroom**	**Rate / Wk**
6 wks to 12 mos	Infants	$220.00
12 mos to 1.5 yrs	Toddlers 1	$200.00
1.5 yrs to 2.5 yrs	Toddlers 2	$190.00
2.5 yrs to 4 yrs	Preschool	$180.00
4 yrs to school age	Pre-K	$170.00

Instructions for Completing the Enrollment Process:

1. Please fill out each page, completely. Any missing information will delay your start date
2. Return your completed Enrollment Packet to the Main Office located at:
   3601 SW 29th Street, Suite 209
   Topeka, KS 66614
   PLEASE NOTE: The Main Office is CLOSED on Fridays, returning a packet anytime between Wednesday and Friday will NOT guarantee a start date of the following Monday
3. Once your completed packet is returned and your information is entered into the system, you will receive a welcome email stating the next available start date
   a. If that date is when you would like to start, you will need to clarify via email
   b. Once you have confirmed your start date, you will receive a bill for the month
   c. You will need to set up a payment option at that time, as the enrollment fee and 1st week's tuition is due prior to your child starting
4. You will need to schedule a time before your child starts to go over everything with your Center Director (usually just show up about 10 minutes early on your child's first day)
5. Your Center Director's email will be included in the welcome email
6. Once you have started at the Center, your Center Director will set you up with a fingerprint for clocking your child in and out. She will also explain KidReports and the house rules to you.
7. Please read the Parent Handbook as soon as you can, located on our website at: https://learnplaygrow.org/parents

Crestview Enrollment Information

Child's Information:

Last | First | MI

Sex | Birth Date | Social Security Number

Parent or Responsible Party: Relationship to Child: _____

Last | First | MI

Social Security Number | Birth Date | Cell Phone #

Employer | Work Phone #

Position | E-mail Address

Secondary Parent or Responsible Party: Relationship to Child: _____

Last | First | MI

Social Security Number | Birth Date | Cell Phone #

Employer | Work Phone #

Position | E-mail Address

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, relationship and telephone number.

Name	Address, Zip	Relationship	Phone #
Name	Address, Zip	Relationship	Phone #
Name	Address, Zip	Relationship	Phone #
Name	Address, Zip	Relationship	Phone #
Name	Address, Zip	Relationship	Phone #
Name	Address, Zip	Relationship	Phone #
Name	Address, Zip	Relationship	Phone #

I hereby certify the information I have provided TDC Learning Centers, Inc. is true and correct to the best of my knowledge.

Signature Date

I have reviewed the Parent Handbook _____ Initial Here
And can refer to it anytime at: www.learnplaygrow.org

Revised September 2019

In accordance with Federal law, the childcare provider does not discriminate on the basis of sex, race, color, religion, national origin or disability with respect to enrollment of children or employment of staff. With respect to disability, both the child and adult must be capable of functioning meaningfully within the center and without harming themselves or others.

CCL 010
Rev. 5/2020

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

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 #**
TDC's Crestview Learning Center	0000134

I authorize TDC Learning Centers, Inc 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 01/01/2021 (MM/DD/YYYY) and 12/31/2021 (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**

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: ________________________

- -

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. 5/2020

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

Kansas
Department of Health and Environment

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_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____
Home Address_____
Street City Zip Code
Home Phone Number_____
Employer_____
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_____
Employer_____
Work Phone Number_____
Cell Phone Number_____
E-mail Address_____
Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____
Address _____ Address _____
Phone Number _____ 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					
	1st	2nd	3rd	4th	5th	6th
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(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 ____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:**_____

CCL. 029a
Rev. 05/2020

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): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: _____IN/CM %ILE_____		**Weight: _____LB/KG %ILE_____**
Physical Examination	✓ **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) ☐ 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

CCL. 034
Rev. 3/2020

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: 785-559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
TDC's Crestview Learning Center			000134
Street Address of the Facility	**City**	**Zip Code**	**County**
2245 SW Eveningside	Topeka	66614	Shawnee

_____may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Crestview Church	2245 SW Eveningside	Topeka		Walk
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

TDC Learning Centers Inc. Photo Release Form

I, _____(name of parent or guardian), hereby give permission for my child, _____(name of child)
to be photographed by TDC Learning Centers, Inc. and give TDC Learning Centers, Inc. permission to use the photographs for the following reasons:
(Check each box that you give your consent for)

- ☐ Our Website-www.learnplaygrow.org
- ☐ Other printable marketing materials
  (ie: brochures, display boards, etc.)
- ☐ Facebook Group
  Your Facebook name for invites _____

I also give my permission for my child to participate in the making of a video experience of TDC Learning Centers, Inc. that will be used for marketing purposes.

- ☐ YES
- ☐ NO

_____ _____
Authorized Parental Signature Date

_____
Authorized Parental Name Printed

_____ _____
Center Director's Signature Date

Created June 2010- Updated February 2016

NAME: _____

Getting to Know You!

1. What is the primary language spoken in your home?

   _____

2. Do you require any translator services?

   _____

3. Do you have any customs or family traditions you would like to see incorporated in our program?

   _____

   _____

   _____

4. Do you, or anyone in your family, have any hobbies, interests, or talents?

   _____

   _____

   _____

5. Would you be willing to volunteer some time to share any customs, traditions, hobbies, interests or talents with the Center?

   _____

6. Would you be interested in becoming a Parent Committee Member?

   _____

7. Is there anything else you'd like to share about your child(ren) or family?

   _____

   _____

   _____

   _____

   _____

   _____

Center:
Classroom:

Child Care Aware® of Eastern Kansas
1100 SW Wanamaker, Suite 201, Topeka, KS 66604
Phone (785) 357-5171 Fax: (785) 357-1813
east.ks.childcareaware.org

CONSENT FORM

I give permission for __TDC Learning Centers_____ to exchange demographic information about my family and development information about my child with Child Care Aware® of Eastern Kansas to support my child's learning.

Family's Special Instruction: *(If applicable, indicate below any specific information that you do not want exchanged.)*

_____

Parent/Guardian Name (Printed):_____ Parent DOB:_____Phone:_____

_____
Authorizing Signature Relationship to Child Date

_____
Address City State Zip Code

Child's Name: _____Birth Date: _____

_____
Witness Signature Position Date

Child Care Aware® of Eastern Kansas and its partners shall respect the privacy of families served and hold in confidence all information obtained in the course of professional services. Each agency will employ a code of ethics to assure a professional attitude, which upholds confidentiality toward children and their families and any sensitive situations arising with the collaboration.

If you have any questions please contact us using the information provided above.

I understand that written records will not be released without my written consent. This consent expires upon your written request or your child leaving the program. All copies of the form are valid.

For office use only:

TP_____ PE_____ DD_____ F/R L _____ ESL _____ Primary Language_____

FC/KC_____ O _____ Notes _____

___myIGDIs ___myIGDIs/P3 ___N/A

ChildCare Aware® OF EASTERN KANSAS

the questions on this page refer to the

parent or guardian

(primary caregiver)

Parent/Guardian Demographic Information

Parent/Guardian First Name: _____

Parent/Guardian Last Name: _____

Parent/Guardian Date of Birth: __ __ /__ __ /__ __ __ __

Street Address: _____

_____

City: _____

State: _____ **Zip Code:** _____

Phone: (_____)_____-_____

Parent/Guardian Gender/Sex: ❒ Male ❒ Female

Parent/Guardian Ethnicity (select one):
❒Hispanic/Latino/Spanish origin
❒Non-Hispanic/Non-Latino/Not Spanish origin

Parent/Guardian Race (select all that apply):
❒African American or Black
❒Native American or Alaska Native
❒Asian
❒Native Hawaiian or other Pacific Islander
❒White
❒Other _____

Relationship to Child: _____

Is the person filling out this form the primary caregiver of the child?
❒Yes ❒No

If the person filling out this form is ***not*** the child's primary caregiver, what is your relationship to the child's primary caregiver? _____

Parent/Guardian Education (select one):
❒Currently enrolled in high school
❒Of high school age, but not enrolled
❒Less than HS diploma
❒GED
❒HS diploma
❒Some college/training
❒Technical training certification/Associate degree
❒Bachelor degree or higher

Parent/Guardian Employment Status (select one):
❒Employed full-time
❒Employed part-time
❒Not employed

Parent/Guardian Marital Status (select one):
❒Never married
❒Married
❒Divorced
❒Widowed

Parent/Guardian Insurance Status:
❒Medicaid/State Medical Insurance Program
❒No Insurance Coverage
❒Tri-care (military insurance)
❒Private or other

Do you (Parent/Guardian) speak a language other than English at home?
❒Yes ❒No

Parent/Guardian Primary Language (select one):
❒English ❒Arabic ❒Chinese ❒French
❒Italian ❒Japanese ❒Korean ❒Polish
❒Russian ❒Spanish ❒Tagalog ❒Tribal Language
❒Vietnamese ❒Other

Military Status:
❒Current Armed Forces Member
❒Former Armed Forces Member
❒None

Housing Arrangement (select one):
❒Stable housing ❒Homeless/shelter ❒Temporary housing

_____ Total # of people in household (include everyone)

_____ # of children in household

Household Income Sources (select all that apply):
❒Wages ❒Social Security ❒Worker's Comp
❒Alimony ❒Agricultural ❒Unemployment
❒Supplemental Security Insurance (SSI) ❒Other
❒Temporary Assistance to Needy Families (TANF)

Total Yearly Household Income:
❒Less than $10,000 ❒10,000-19,999 ❒20,000-29,999
❒30,000-39,999 ❒40,000-49,999 ❒50,000-59,999
❒60,000-69,999 ❒70,000-79,999 ❒ 80,000-89,999
❒90,000-99,999 ❒Greater than $100,000

Continued on back ⇨

ChildCare Aware® OF EASTERN KANSAS

the questions on this page refer to the

child in care

Child Demographic Information

Child First Name: _____

Child Last Name: _____

Child Date of Birth: __ __/__ __/__ __ __ __

Street Address: _____

_____

City: _____

State: _____ **Zip Code:** _____

Phone: (_____)_____-_____

Number of Weeks Premature: _____ (0=not premature)

Child's Relationship to Primary Caregiver:

❒ Son ❒ Daughter ❒ Niece ❒ Nephew
❒ Sibling ❒ Foster Child ❒ Grandchild ❒ Other

Does the child have an IEP or IFSP?

❒IEP ❒IFSP ❒None

Child's Gender/Sex: ❒ Male ❒ Female

Child Ethnicity (select one):

❒Hispanic/Latino/Spanish origin
❒Non-Hispanic/Non-Latino/Not Spanish origin

Child Race (select all that apply):

❒African American or Black
❒Native American or Alaska Native
❒Asian
❒Native Hawaiian or other Pacific Islander
❒White
❒Other _____

Does the child speak a language other than English at home?

❒Yes ❒No

Child Primary Language (select one):

❒English ❒Arabic ❒Chinese ❒French
❒Italian ❒Japanese ❒Korean ❒Polish
❒Russian ❒Spanish ❒Tagalog ❒Tribal Language
❒Vietnamese ❒Other

Child Insurance Status:

❒Medicaid/State Medical Insurance Program
❒No Insurance Coverage
❒Tri-care (military insurance)
❒Private or other

Is the child participating in Part B Assistance for Education of All Children with Disabilities (IEP from school district)?

❒Yes ❒No

Is the child participating in Part C Early Intervention services (IFSP from TARC)?

❒Yes ❒No

Thank you for taking the time to fill out this form. Please return it to your child's care provider as soon as possible.

WICHITA STATE UNIVERSITY
CENTER FOR COMMUNITY SUPPORT AND RESEARCH

OFFICE LOCATION |
358 N. Main, Wichita, KS 67202
PHONE | 316.978.3843
TOLL FREE IN KS | 800.445.0116
FAX | 316.978.3593
WEBSITE |ccsr.wichita.edu
TWITTER | twitter.com/wsuccsr

Purpose of the Evaluation: Wichita State University's Center for Community Support and Research (CCSR) is working with the Kansas Children's Cabinet and Trust Fund (KCCTF). The goal is to find out how children and families are doing in programs being paid for by the Early Childhood Block Grant (ECBG) in the 22 ECBG sites. The research will look at children ages 0-5 years old and their development. The research will help funders decide what helps to make children ready for school.

Participant Selection: You have been asked to help with this research because you are a parent who has a child in a program paid for by the ECBG.

Explanation of Procedures: Your child or your family may be asked information. These tools include:

The Ages and Stages Questionnaire- 3 (ASQ-3) is a developmental screening done by parents or caregivers. It is for children ages 2-60 months old. The ASQ-3 takes 10-15 minutes and is done twice per year.

The Ages and Stages Questionnaire: Social-Emotional – 2 (ASQ: SE-2) is a social-emotional screening done by parents. It is for children ages 1-72 months old. It takes 10-15 minutes and is done twice per year.

Discomfort/Risks: The tools ask questions about you or your child. Completing these tools and/or the information you learn from them may make you feel uncomfortable. You can skip over questions you don't want to answer or quit at any time.

Benefits: You will be helping with the research on the 22 ECBG sites. The reason for this project is to show how well programs are helping children and their families all over Kansas. It is important to show that the programs improve children's readiness for school over time. This can only be done by getting information from children and families in these programs across different points in time.

Confidentiality: Information from your forms will be entered into an electronic database. The electronic database is safe, secure and password protected. You will be asked to put your name and your child's name on the forms. This information will allow for the assignment of a unique number. Once this is assigned the information from the forms will be stored with the number and not the names. This is to protect your confidentiality. The names and numbers assigned will be stored separately from your information for any of the forms. Your information will not be shared with anyone other than the program you are working with and the Kansas Children's Cabinet and their

agent.

Refusal/Withdrawal: You do not have to do any of the forms if you don't want to. Your decision whether or not to help with this research will NOT affect your future relations with Wichita State University, Wichita State University's Center for Community Support and Research, the program(s) your child is in, or the Kansas Children's Cabinet and Trust Fund or their agents. You are free to skip any question or quit at any time. You have the same rights with all the forms.

Contact: If you have any questions about the research, you can contact Dr. Lynn Schrepferman of CCSR by phone at 316-978-6772 or by email: lynn.schrepferman@wichita.edu. If you have questions pertaining to your rights as a research participant, you can contact the Office of Research and Technology Transfer at Wichita State University, Wichita, KS 67260-0007, telephone 316-978-3285.

Being apart of the Kansas ECBG Evaluation depends on you signing this consent form for you and your child. By signing this you show that you have read this form and you have decided to participate.

You will be given a copy of this consent form to keep.

_____	_____
Name of Participant (Parent/Caregiver)	Date
_____	_____
Signature of Participant (Parent/Caregiver)	Date
_____	_____
Name of Child	Date
_____	_____
Witness Signature	Date

Child Abuse and Neglect Reporting Policy

All employees of TDC Learning Center, Inc. are State Mandated Reporters and are required to report any suspicion or knowledge of child abuse and/or neglect.

Procedures and Practices, including responsible person(s):
All observations or suspicions of child abuse or neglect will be immediately reported to the Child/Adult Abuse Kansas Protection Report Center: 1-800-922-5330, no matter where the abuse might have occurred. Staff should notify their Center Director that a report has been made. Center Directors are responsible to ensure that the Executive Director is notified immediately when a report has been made.

All staff involved in the reported incident will follow the direction of SRS regarding completion of written reports. If the parent or legal guardian of the child is suspected of abuse, staff will follow the guidance of Child Protective Services regarding notification of the child's parent or legal guardian. Reporters of suspected child abuse will not be discharged for making a report, unless it is proven that a false report was knowingly made.

Signs of suspected child abuse or neglect will be recorded on the Suspected Abuse/ Neglect Report Form, which will be kept in a confidential file located in the Center file, Central Office file and in the child's confidential file.

Staff who are accused of child abuse may be suspended or given leave (with or without) pay, pending investigation of the accusation. Such staff may also be removed from the classroom and given a job that does not require interaction with children. However, no accusation or affirmation of guilt will be made until the SRS investigation is complete. Caregivers found guilty of child abuse will be immediately dismissed.

When this policy applies: Whenever any staff member has reason to suspect that any child on the premises of this child care facility may have been abused or neglected by anyone.

Communication plan for staff and parents:
Staff and volunteers will receive a written copy of this policy in their Orientation Packets before beginning work and will be required to sign that they have read and understood the policy. All parents will receive a written copy of this policy in their enrollment packet upon their child's enrollment.

TDC learning Centers, Inc.

Child Custody/Visitation

TDC Learning Centers, Inc. does not intend to become an arbitrator of custody conflicts. We reserve the right to deny services to individuals who are unable to adequately resolve custodial conflicts without disrupting child care services. Please complete the appropriate section and sign below.

Child's Name:_____

_____CHILD RESIDES WITH BOTH PARENTS OR LEGAL GUARDIAN
(No further information is required. Please sign below.)

_____JOINT CUSTODY (Complete this section and sign below.)

Primary residential parent name Address Phone

Non-Residential parent name Address Phone

If your child's non-residential parent will be visiting the child care center, we require that you keep the center staff apprized of your arrangements.

_____EXCLUSIVE (SOLE) CUSTODY (Complete this section and sign below.)

Custodial parent name Address Phone

Non-Custodial parent name Address Phone

Please indicate the terms of non-custodial parent's visitation below:

_____**Specified Visitation**: Does this include visiting the child at the child care center? Yes___ NO___

_____**General Visitation**: Do you give permission for the above non-custodial parent to visit the child at the child care center? Yes___ NO___

_____**Severed Visitation**: No Visitation

If you desire that your child not be visited at the child care center by the non-custodial parent and the terms of the visitation do not specify that this parent may visit the child at the center, we will not allow the non-custodial parent visitation privileges. Custodial parents are responsible for communicating their child care visitation preference to the non-custodial parent.

If for any reason the custodial parent fails to provide the correct visitation policy, and the non-custodial parent visits at the center, bringing a copy of a certified court order specifically allowing for child care center visitation, we will respect the court order and allow visitation.

_____ _____

Parent Signature **Date**

TDC Learning Centers, Inc.
Parent/Provider Agreement

Welcome to TDC Learning Centers!

We hope you and your child will enjoy the child care and early education we provide. We continually work to improve our centers and our service to you. Your tuition fees help pay for the services your child uses, so it is very important you know the TDC payment policies. TDC is a nonprofit organization. The Board of Directors reserves the right to change fees or tuition as needed. We work hard to keep the costs of child care as low as possible.

This contract is made between **TDC Learning Centers, Inc.** and _____ (Parent/Guardian name) for the care of _____ (Child/ren Name) at a licensed facility of the provider

Tuition rates are attached and are subject to change per the Board of Directors. Operating hours are 7am -6pm, Monday – Friday with the exception of 8 holidays and 2 staff education days.

- An enrollment fee of $50.00 per child, or $75 max per family and one week of tuition in advance is due at the time of enrollment. The registration fee and 1st week of tuition are Non-Refundable. After the first year of attendance, a $15 annual enrollment fee will be charged each September.
- **Payment for child care is due the first work day of the week (or month) before the child attends.** If payment is going to be delayed for **any** reason, the Center Director should be informed immediately.
- A family who has not made payment for that week by Wednesday morning will lose child care service from TDC from that day forward until payment has been received.
- Payments received Wednesday or after are subject to delinquent fees.
- Families receiving DCF benefits will be required to run their Vision Card every month according to the above policy. Tuition fees not covered by DCF are subject to the above requirements.
- Families who lose child care for delinquent payment can re-enroll when the bill is paid in full, depending upon space available. The space will NOT be reserved.
- **A re-enrolling family, previously delinquent in paying for child care, is not eligible for subsidized care from TDC.**
- A monthly summary of your account will be provided.
- If you choose to withdraw your child from the program, a minimum written notice of 2 weeks (10 working days) is required. Any parent failing to do so will be charged the normal tuition rate for two weeks. Withdrawal forms are available at the centers.
- If a check, ACH payment, debit or credit card payment is returned for insufficient funds, cash or money order must be delivered immediately to replace the returned amount, plus the return fee. **A fee of $30.00 will be charged for each returned check or payment.** In the event of two returned checks or payments, only cash or money orders will be accepted for future services.
- Late Pick-Up Fee: For each child picked up after center closing hours, a delinquent fee will be charged as follows: First 5 minutes is $15. Each additional minute: $1 per minute. The Procare clock will be used to determine fees.

I understand these policies and by my signature below agree to abide by them and assume full responsibility of payment. I understand that these policies are also in the Parent Handbook that I received.

_____ _____
Parent Signature Date

_____ _____
Provider Signature Date

3601 SW 29th St., Suite 209 * Topeka, KS * 66614 * (785)272-5051 * Fax (785)272-1906

TuitionExpress.com Information for Parents

Automatic Payment Processing

Safe – Convenient – Easy

We are excited to offer you the convenience of Tuition Express – an automated payment processing system that is intergraded into the ProCare Child Care Management System that allows you to pay your tuition and fees four ways:

- **Online Payments, when you choose**
- **POS/Credit Card Swipe, when you choose**
- **Recurring credit card payments, every Monday**
- **Recurring bank-to-bank transactions, every Monday**

Tuition Express is a Payment Card Industry Service Provider and it is the premier payment processing solution in the childcare/early education industry. It will allow parents the ability to check their balance online, receive Email Payment Notifications, and the ability to print reports regarding their account.

Since 2003, Tuition Express has safely and conveniently processed billions in tuition and fee payments. Your account information is safe. Write checks no more. And easily make your tuition payment on time, every time. Saving your childcare provider time and money, since they no longer need to go to the bank or hunt down parents regarding past due payments and fees.

Is it free?

Yes. All services are free to parents and guardians whose child care provider uses Tuition Express®.

How to sign up…

Email the main office at tdc@learnplaygrow.org to get a 4 digit registration code. Then you will receive an email with instructions and a link to start using Tuition Express at your convenience. Or complete the following form.

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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Child's Name: _____ DOB: _____

Kansas State Child Care Licensing
Exclusion Policy for Sick Children

Conditions for Exclusion that Require 24 hours without Symptoms to Return to Care

- Fever (temperature above 100 degrees or higher taken auxiliary (armpit)) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea).
- Diarrhea, that is, increased number of stools, increased stool water, and/or decreased form that is not contained by the diaper until diarrhea stops; blood or mucus in the stools not explained by dietary change, medication, or hard stools.
- Vomiting illness (two or more episodes of vomiting in the previous 24 hours) until vomiting resolves or until health care provider determines the illness to be non-communicable, and the child is not in danger of dehydration.
- Known contagious diseases while still in the communicable stage (chicken pox, streptococcal pharyngitis, rubella, pertussis, mumps, measles, hepatitis A).

Conditions for Exclusion that Require Doctor's Written Approval to Return to Care

- An acute change in behavior including lethargy/lack of responsiveness, irritability, persistent crying difficulty breathing, uncontrolled coughing, noticeable (spreading) rash, or other signs or symptoms of illness until medical evaluation indicates inclusion in the facility.
- Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness.
- Fainting or seizures (other than pre-existing conditions)
- Mouth sores with drooling, unless a health care provider or health official determines the condition is noninfectious.
- Rash with fever or behavior change, until a health care provider determines that these symptoms do not indicate a communicable disease.
- Purulent conjunctivitis (defined as pink or red conjunctiva with white or yellow eye discharge), until 24 hours after treatment has been initiated.
- Untreated scabies, head lice, or other infestation. Any severe itching that might indicate an infestation.
- Untreated Tuberculosis, until a health care provider or health official states that the child can attend child care.

I have read and understand the above TDC Learning Center, Inc's Illness and Exclusion Policy.
I will abide by its guidelines.

Parent/Guardian Signature:_____ Date:_____

Building for the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to participants receiving day care. Each day more than 2.6 million participants receive a CACFP meal at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (two of the four groups):
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities

Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Day Care Homes:** Licensed private homes.
- **After School Care Programs:** Centers in low-income areas provide snacks to school aged children and youth.
- **Homeless Shelters:** Emergency shelters provide food services to homeless children.
- **Adult Day Care Centers:** Licensed public or private nonprofit adult day care centers and some for-profit centers.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following participants:

- children age 12 and under,
- migrant children age 15 and younger,
- youths through age 18 in after school care programs in needy areas,
- adults age 60 or older, and
- functionally impaired adults age 18 or older.

Contact Information

If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center:

State Agency:
Child Nutrition & Wellness
Kansas State Department of Education
900 SW Jackson Street, Suite 251
Topeka, KS 66612
785-296-2276

USDA is an equal opportunity provider and employer.

USDA

Child and Adult Care Food Program
ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— **Any household member receiving benefits can establish eligibility for all children in the household.**	**Case Number or Identification Number**

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Tell us how much and how often. If no income, write "0". Use net income if self-employed.														
	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	**Today's Date**	**Print Name of Adult Signing**
X_____	_____	**Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN

Address	**City/State/Zip Code**	**Daytime Phone**

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW
Washington, D.C. 20250-9410

FAX: 202-690-7442

EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced Price ☐ Paid

Household Size: _____

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Determining Official **Today's Date**

X_____ _____
Signature of Confirming Official **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.

Annual TDC Closed Days

All TDC Centers and the Main Office will be closed on the following:

New Year's Day (Friday, January 1, 2021)

Memorial Day

Independence Day (Observed 7/5/2021)

Labor Day

Thanksgiving Day and Day After

Christmas Eve

Christmas Day (Observed 12/27/2021)

New Year's Day (Observed 12/31/2021)

In addition, ALL Centers will be closed for Staff Education Days on:

Friday, February 19th
Monday, February 22nd
Friday, August 27th

TDC's Inclement Weather Policy is intended to accommodate the needs of both families and employees. TDC Learning Centers will follow USD 501, unless USD 501 closes due to temperature. Independent choices may be reached by the Executive Director.

Parents and staff members should not contact Center Directors or Main Office regarding decisions that may or may not be made. All announcements pertaining to winter weather will be made by 5:30am on the day affected and notices will be posted on KSNT, WIBW, Facebook, Twitter, learnplaygrow.org, eblast, group text and KidReports. We apologize for any inconvenience. However, the safety of our staff and families is our main priority.

Dillons FOOD STORES®

Community Rewards

Did you know that just by registering and shopping for your everyday groceries at Dillons, you can help raise funds for TDC Learning Centers?? This means that if you register your Plus card and select TDC, every time you shop, we earn much needed dollars for our programs!! Helping us raise money has never been easier! If you have already enrolled in Community Rewards and are supporting TDC, we thank you! You do not need to re-enroll this year. However, if you have not, please read on and consider supporting us when you shop!!

A customer must have 3 things to register and begin supporting TDC Learning Centers, Inc.:

1. A Plus card, which is available at any store by asking an associate
2. A valid email address, which can be obtained from any free online service and can be anonymous
3. A personalized account at Dillon's website, which again can be anonymous

To enroll in the Community Rewards Program:

1. Members must visit the website at www.Dillons.com/communityrewards
2. Sign in OR Create an account (see below on creating an online account at the website)
3. Click on "*Enroll Now"*
4. Enter the 5-digit NPO and search **(our NPO is WU620)**
5. Select the TDC Learning Centers, Inc. and click on "Enroll"

To create an online account at the website:

1. Visit the website at www.Dillons.com/communityrewards
2. Click on "*Register*" at the top of the page
3. Enter your email address, password, zip code (select preferred store) and check the box if you desire to receive email from Dillons
4. Click on the "*Create Account*" at the bottom of the page
5. You will receive an email confirmation to your inbox, to activate your account, click on the link in the body of the email and enter your sign-in information to confirm.

THANK YOU FOR SUPPORTING TDC LEARNING CENTERS, INC.

Getting Started

1. Sign in to smile.amazon.com on your desktop or mobile phone browser.
2. From your desktop, go to **Your Account** from the navigation at the top of any page, and then select the option to **Change your Charity** listed under **Shopping programs and rentals**.
3. Or, from your mobile browser, select **Change your Charity** from the options at the bottom of the page.
4. Select TDC Learning Centers Inc.

For more information about the AmazonSmile program, go to http://smile.amazon.com/about.