ASBURY CHURCH
CHILD DEVELOPMENT CENTER & PRESCHOOL
2801 W. 15th Street · Wichita, KS 67208 · 316-942-4490 · www.asburychurch.org
Shandy Kurth, Director · shandy.kurth@asburychurch.org

PRE-ENROLLMENT APPLICATION

Child's Name: _____Birth date: _____

Parent's Name: _____Phone:_____

Email Address:_____ Start Date: _____

Class Enrolled For:

☐ Preschool/Pre-K

M/W Am M/W/F Am M-F Am

☐ Child Development Center

☐ Infant ☐ 109 (12mo to 2 ½) ☐ 108 (2 ½ to 3 ½)

☐ 110 (3 ½ to 4 ½) ☐ 118 (4 ½ to 5 ½)

Days:_____ Registration Paid ☐

Times:_____ First Week Paid ☐

Monthly Payment: _____

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Childs Name:_____ Birthdate: _____ Start Date:_____

Sex: M/F

Primary Home Address: _____
Street City Zip Code

Child Lives with: Both parents Mother Father Other:_____

1st Contact in case of Emergency:

Name:_____Relationship:_____

Best way to Reach: _____

Employer: _____ Work Phone Number: _____

Email Address: _____

2nd Contact in case of Emergency:

Name:_____Relationship:_____

Best way to Reach: _____

Employer: _____ Work Phone Number: _____

Email Address: _____

Authorized persons to pick up:

_____

Name Address Phone Relationship

_____

Name Address Phone Relationship

_____

Name Address Phone Relationship

Food Allergies:_____

Medical Conditions:

_____

_____

_____

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

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 #**
Asbury Child Development Center	0018955-014

I hereby authorize Shandy Kurth (Name of individual/staff member) and/or Asbury Church 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 10/01/2019 (MM/DD/YYYY) and Termination (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. Witness Signature Required	**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

NOTARY NOT REQUIRED

_____
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: See Immunizations

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. 3/2018

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

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 Asbury CDC 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)_____

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:

_____

Does your child have any of the following conditions (yes or no)? <u>If yes, provide information on Authorization for Emergency Medical Care form CCL. 010</u>.

_____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_____

Have there been major changes at home that might affect your child in care? ___ No ___Yes, as follows:

_____

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(d)].

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:_____ Required **Date:**_____

Required for All Enrollments

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.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	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.

CCL. 029a
Rev. 3/2017

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

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.

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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.

ASBURY CHILD DEVELOPMENT CENTER

2801 w 15th street N. Wichita, Ks. 67203
Hours of Operation: Monday – Friday 7am to 6pm

Parent Contract

This is acknowledgment that I have read and agree to follow the policies and procedures set forth by Asbury Child Development Center outlined in the parent handbook including Asbury's behavior policy and understand that these policies are enforced for the best interest of the children in our care and to adhere to state regulations. I acknowledge that termination of this contract requires a two week's notice.

I agree to pay _____/mo in two payments and am aware that payments are due no later than the 3rd of each month, and full payment for the month must be completed no later than the 15th of each month. I am aware that registration fees are paid annually. I am also aware that late payment will incur a $10 penalty charge.
(Rates attached in Policy Handbook.)

Child's Name: _____ Days/Hours Attending: _____

Parent's Printed Name:_____

Parent's Signature: _____ Date:_____

Parent's Printed Name: _____

Parent's Signature: _____ Date:_____

Director's Printed Name: _____

Director's Signature: _____ Date:_____

Permission Slip

I _____ give my child _____ permission to do the following while in the care of Asbury Child Development Center:

☐ Watch PG rated movies

☐ Use sunscreen provided by the Center

☐ Use bug spray provided by the Center

☐ Use rooms in the Church that are not on the Center license for special events such as the Atrium, Fireside Room, Sanctuary etc.

If permission is not give for one of the items above, please state your reason:

_____

_____

_____

Parent Signature: _____ Date: _____

Throughtout the year, we love to capture fun events your child is partaking in here at Asbury. At times, these pictures are posted in various places such as the church publications, Facebook or Instagram. Pictures will only be used on Asbury pages without the child's name. Please sign below to indicate your consent for your child's picture to be used in this way. God Bless.

Please sign below to consent for us to share you child's photo in this manner during school activities.

CHILD'S NAME: _____

PARENT SIGNATURE: _____ Date: _____