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:

_____

_____

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:_____

Dear Parent or Guardian:

Our center has been approved for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses the center for the partial cost of meals. Participation in the CACFP enables us to keep our fees lower as well as serve nutritious meals to children in our program.

The parent/guardian must complete Parts 1 and 4 and one of the following options: *Part 2, Part 3A or Part 3B, to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our files and treated as confidential information.* ***Note: no white out or erasure should be used. If there is an error cross through, correct, and initial.***

Part 1 FOR CHILD ENROLLMENT:

- CHILD'S NAME: List the first and last name of all children enrolled at this center.
- DATE OF BIRTH: List each child's date of birth.
- TIMES OF CARE, DAYS OF CARE and MEALS SERVED: List the regular times of care for each child by listing their arrival time and leave time, check each day the child will be in care and check each meal type received while in care.
- ETHNICITY/RACE: Using the codes provided, enter the codes for ethnicity and race.
- FOSTER CHILD: If the child is a foster child (the legal responsibility of a foster care agency or the court), please check the box.

Part 2 FOR A HOUSEHOLD RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), TEMPORARY ASSISTANCE FOR FAMILIES (TAF), OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR):

- Complete Parts 1, 2 and 4 on the reverse side.
- Provide the name and case number for the program from which benefits are received.

Part 3A FOR A HOUSEHOLD EXCEEDING THE INCOME GUIDELINES LISTED ON THE CHART BELOW:

- Complete Parts 1, 3A and 4 on the reverse side.

TO CALCULATE ANNUAL INCOME

Weekly Income X 52 ♦ Every 2 Weeks Income X 26 ♦ Twice a Month Income X 24 ♦ Monthly Income X 12

Household Size:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	Each Add'l Family Member
Annual Income:	$22,459	$30,451	$38,443	$46,435	$54,427	$62,419	$70,411	+ $7,992

Part 3B FOR ALL OTHER HOUSEHOLDS:

- Complete Parts 1, 3B and 4 on the reverse side using the additional information below.
- HOUSEHOLD NAMES: Write the names of everyone in your household not listed in Part 1. Include yourself and all other children, your spouse, grandparents, other relatives and unrelated people in your household. Use a separate sheet of paper if you do not have enough space.
- GROSS INCOME BEFORE DEDUCTIONS: Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see list below). Next to the amount of income write how often the income was received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.
  - OTHER INCOME: strike benefits, unemployment compensation, worker's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trust/investments, royalties/annuities/rental income, and regular contributions from persons not living in the household.
  - FOSTER CHILDREN: List any personal income received by the foster child under Part 3B. Personal income is (a) money given for the child's personal use, such as clothing, school fees and allowances and (b) all other money the child gets, such as money from his/her family.
  - MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
  - SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.
- SOCIAL SECURITY NUMBER: Write the last four (4) digits of the social security number of the adult household member who signs the form. If the adult household member does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 SIGNATURE AND CONTACT INFORMATION:

- Sign and date the application. The form must be signed by the parent or guardian.
- Complete the contact information – name, address, telephone number, and employer information.

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:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

ENROLLMENT & INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS
JULY 1, 2018 THROUGH JUNE 30, 2019

Part 1. CHILD ENROLLMENT: Complete the information below for all children in care. If the child is a foster child (legal responsibility of a foster care agency or the court), please check the box.

Last Name, First Name	Date of Birth	Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/ Race*		Foster Child
		Arrival Time	Leave Time	M	T	W	T	F	S	S	B	AM	L	PM	D	EV	Ethnicity	Race	
																			❑
																			❑
																			❑
																			❑

*Ethnicity (select one): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (select one or more): W=White, B=Black or African American, I=American Indian or Alaskan Native, A=Asian, or P=Native Hawaiian or other Pacific Islander

Part 2. HOUSEHOLDS RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), TEMPORARY ASSISTANCE FOR FAMILIES (TAF), OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR): Complete Parts 1, 2 and 4.

Program Name: _____ Case No. _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on reverse side), check this box ❑

Part 3B. ALL OTHER HOUSEHOLDS – If you do not have a FAP, TAF or FDPIR case number: Complete Parts 1, 3B and 4.

GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed)
W=Weekly E2=Every 2 weeks 2M=Twice monthly M=Monthly Y=Yearly

List the Names of All Household Members not listed in Part 1	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income		Check If ZERO income
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
(Example) Jane Smith	*$200*	*W*	*$150*	*2M*	*$100*	*M*			
1									❑
2									❑
3									❑
4									❑
5									❑
6									❑

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX- XX -_____ If you do not have a Social Security Number, check this box ❑

Privacy Act Statement: 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, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Temporary Assistants for Families (TAF) or Food Distribution Program on Indian Reservation (FDPIR) case number for your child or other (FDPIR) identifier 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 if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP.

Part 4. SIGNATURE AND CONTACT INFORMATION:

I certify that all information on this form is true and that all income is reported. I understand that the facility will receive Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose their meal benefits, and I may be prosecuted.

_____ _____
Signature of Parent or Guardian Date

_____
Print Name

_____
Address

_____
City State Zip Code

_____
Daytime Telephone

_____
Employer(s)

FOR CENTER USE ONLY

_____ FAP/TAF/FDPIR HOUSEHOLD

_____ Homeless Documentation from school, emergency shelter, or agency

_____ ANNUAL INCOME: _____ HOUSEHOLD SIZE: _____

_____
Sponsor's Determining Signature Date

_____
Sponsor's Confirming Signature Date

HOUSEHOLD CATEGORY:
❒ Free
❒ Reduced Price
❒ Paid

Foster Child – Free Category
List name of foster child(ren):

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 5/01/2019 (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:_____**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

Welcome!

I am so excited about the new school year and having your child in my classroom. To help me get to know your child before the year begins, please fill out this information and return it to me by _____.

Child's Name: _____ Nicknames: _____

Hobbies/Interests: _____

What is he/she best at? _____

Siblings: _____

Pets: _____

3 words to describe your child: _____

Allergies: _____

Any special information I should know (new baby, new job, new house, etc.): _____

What is the best way to communicate with you (e-mail, notes, call, in person, etc.)? _____

Please include any additional helpful information below.

_____

_____

_____

_____