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: ________________

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

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).

<table>
<tr><th rowspan="2">Vaccine</th><th colspan="6">Record the Month. Day and Year that each Dose of Vaccine was Received</th></tr>
<tr><th>1st</th><th>2nd</th><th>3rd</th><th>4th</th><th>5th</th><th>6th</th></tr>
<tr><td>Diphtheria, Tetanus, Pertussis (DTaP)</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Poliomyelitis (IPV/OPV)</td><td></td><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>Measles, Mumps, Rubella (MMR)</td><td></td><td></td><td colspan="4"></td></tr>
<tr><td>Hepatitis B (HepB)</td><td></td><td></td><td></td><td colspan="3"></td></tr>
<tr><td>Varicella (VAR)</td><td></td><td></td><td colspan="2">Hx of Disease:
Physician Signature</td><td colspan="2">Date of Illness:</td></tr>
<tr><td>Hemophilus Influenzae Type B (Hib)</td><td></td><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>Pneumococcal Conjugate (PCV)</td><td></td><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>Hepatitis A (HepA)</td><td></td><td></td><td colspan="4"></td></tr>
<tr><td>Rotavirus **Recommended <8 mo of age; not required</td><td></td><td></td><td></td><td colspan="3"></td></tr>
<tr><td>Influenza(Flu) ** Recommended annually >6 mo of age; not required</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

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:**________________

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

2801 W. 15th Street · Wichita, KS 67208 · 316-942-4490 · www.asburychurch.org
Shandy Kurth, Director · shandy.kurth@asburychurch.org

Childs Name:___________________________ Birthdate: ________________ Start Date:_____________

Sex: M/F   Primary Home Address: ____
Street   City   Zip Code

Child Lives with: Both parents   Mother   Father   Other:_________________

<u>1st Contact in case of Emergency:</u>

Name:_________________________________Relationship:___________________________

Best way to Reach: ___________________________

Employer: ________________________ Work Phone Number: ___________________

Email Address: _______________________________

<u>2nd Contact in case of Emergency:</u>

Name:_________________________________Relationship:___________________________

Best way to Reach: ___________________________

Employer: ________________________ Work Phone Number: ___________________

Email Address: _______________________________

<u>Authorized persons to pick up:</u> Addresses are required!!

____
Name   Address   Phone   Relationship

____
Name   Address   Phone   Relationship

____
Name   Address   Phone   Relationship

Food Allergies:____

Medical Conditions:

____
____

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**
____________________________		
____________________________		
____________________________	______________________________	________

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 fire side room, sanctuary etc.

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

Parent Signature: _______________________ 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 1st 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 per week that payment is late. I am aware my weekly payment terms will be calculated as 4.3 weeks each month for billing purposes.
(Rates attached in Policy Handbook.)

DCF PARENTS:
Monthly DCF Payment:_______________ Monthly Out of Pocket: ____________
Provider ID: E471386

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:________

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.

2801 W. 15th Street · Wichita, KS 67208 · 316-942-4490 · www.asburychurch.org
Shandy Kurth, Director · shandy.kurth@asburychurch.org

CDC SUPPLY LIST

1 1/2inch binder

2 packs Page dividers

Plastic two pocket folder

Laminating sheets

Elmer's Glue Bottle

Box of Tissues

Package of wipes

Lysol

Clorox Wipes

Washable Markers

2 pairs of clothes

Play-Doh or Shaving Cream

Tooth Brush and Tooth Paste

2 Crib sheets

1 small blanket

1 small pillow

PICK 2

Sequins, Beads

Powdered Starch, Q-tips

Googly Eyes, Glitter Glue

Golf Pencils, Sticky Tac

Only Binder, dividers, folder and bedding need labeled. All other items go in a community bin.

Infant Offer Form

As a participant in a USDA Child Nutrition Program, our childcare facility/provider offers meals to children of all ages, including infants. Infant feeding is based on current Academy of Pediatrics nutrition guidelines. Infant foods are served appropriate for the age and developmental readiness of your infant. To better meet your personal preferences and infant's needs, you may choose as many options as you like from the list below and update as your infants' feeding needs progress. A new infant offer form is not required when changes are made; however, whenever changes are made please initial and date the changes.

Infant Name: ____________________________________ Date of Birth: _________________

☐ I will provide breastmilk for my infant.
- ☐ Center/Provider provided formula may be used to supplement feedings, if necessary.

☐ I would like to breastfeed on site, if this option is available.

☐ I accept the ___________________________________ Iron Fortified Infant formula.
name of formula offered by center/provider

☐ I will provide formula for my infant. Name of formula (must be iron-fortified and manufactured in the USA): __________________________

☐ I will submit a Meal Modification Request Form for non-reimbursable formula.
Name of formula: ______________________________

☐ I accept the following center/provider provided solid foods (appropriately textured) to be served to my infant as s/he is developmentally ready for them, and after I have discussed it with the caregiver.
- ☐ Iron Fortified Infant Cereal
- ☐ Grains
- ☐ Vegetables
- ☐ Fruits
- ☐ Infant Meats/Meat Alternates

☐ I decline all infant food offered by the center/provider and will provide solid foods for my infant.
- ☐ Iron Fortified Infant Cereal
- ☐ Grains
- ☐ Vegetables
- ☐ Fruits
- ☐ Infant Meats/Meat Alternates

Parent Signature: ________________________________ Date: _______________________

This institution is an equal opportunity provider.

ASBURY CHILD DEVELOPMENT CENTER – SAFE SLEEP CONTRACT

Asbury Child Development Center Adheres to state regulation for safe sleep in infants.

Needed only for Infants

Childs Name:____________________________________ Date started in care: _______________________

The polices we follow are as follows:

Each staff member who cares for children and each volunteer who cares for children shall follow the safe sleep policies and practices of the child care center.

(2) Each staff member who cares for infants and each volunteer who cares for infants shall ensure that all of the following requirements are met:

(A) Each infant shall nap or sleep in a crib or a playpen.

(B) An infant shall not nap or sleep in the same crib or playpen as that occupied by another infant or child at the same time.

(C) If an infant falls asleep on a surface other than a crib or playpen, the infant shall be moved to a crib or playpen.

(D) Each infant shall be placed on the infant's back to nap or sleep.

(E) When an infant is able to turn over independently, the infant shall be placed on the infant's back but then shall be allowed to remain in a position preferred by the infant. Wedges or infant positioners shall not be used.

(F) Each infant shall sleep in a crib or a playpen that is free of any soft items, which may include pillows, quilts, heavy blankets, bumpers, and toys.

(G) If a lightweight blanket is used, the blanket shall be tucked along the sides and foot of the mattress. The blanket shall not be placed higher than the infant's chest. The head of the infant shall remain uncovered. Any infant may nap or sleep in sleep clothing, including sleepers and sleep sacks, in place of a lightweight blanket.

(i) When children are awake, they shall not be left unattended in cribs or other confinement for more than 30 minutes.

Parents Signature of Acknowledgment of our Policies:

____

Administration Signature as a promise of adhering to these policies:

____

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	0018955-015

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 1/01/2020 (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.