

Agape Montessori School

Parent Agreement Form

Open: Monday – Friday, 7:00am – 6:00pm

This contract is made for the care of _____.

(Child's name)

Child's D.O.B.: _____

Child's Age at Start Date: _____

Payments shall be due Monday of each week. This contract may be terminated by either the parent(s)/guardian(s) by giving a written notice of 2 weeks in advance of the ending date. The provider may immediately terminate the contract without giving any notice if the parent(s)/guardian(s) do not make payments when due.

The payment shall be \$ _____ per week for the following program:

Program Type: ☐ Morning (8:30am – 11:30am) ☐ Extended (7:30am – 12:30pm)

☐ School Day (8:30am – 3:30pm) ☐ Full Day (7:00am – 6:00pm)

Program Days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Enrollment Type: ☐ Year-Round ☐ School Year Only ☐ Summer Only ☐ Teacher's Child

Location: ☒ **Blackbob:** 14299 S. Darnell St. Olathe, KS 66062 (913-764-3456)

☐ **Mur-Len:** 16550 W. 129th St. Olathe, KS 66062 (913-768-0812)

Registration Fee: _____ ☐ CC Ref # _____ ☐ Check # _____ ☐ Cash

Activities Fee: _____ ☐ CC Ref # _____ ☐ Check # _____ ☐ Cash

Prepaid Tuition: _____ ☐ CC Ref # _____ ☐ Check # _____ ☐ Cash

Parent's Name: _____

Parent's Phone Number: _____

Parent's Email Address: _____

Start Date: _____

How did you hear about us?: _____

The signature of the parent(s)/guardian(s) to this contract also indicates that they agree to abide by the written policies as laid out in Agape Montessori School's Parent Handbook. Changes to these written policies may be made, and a copy of the new handbook will be provided to the parent(s)/guardian(s).

Parent's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Medical Record Medical History

In accordance with K.A.R. 28-4-117, a completed medical record shall be on file for all children in care under 10 years of age and all children living in the home under 16 years of age. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment.

The Medical Record is transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care _____ Name of Child Care Facility Agape Montessori School

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/Cell Phone Number _____

Work Phone Number _____

E-mail Address _____

Best way to contact _____

Parent/Guardian Information

Name _____

Home Address _____
Street City Zip Code

Home/Cell Phone Number _____

Work 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 _____

Address _____

Phone Number _____

Name _____

Address _____

Phone Number _____

Child's Physician _____ Phone Number _____

Hospital Preference (for emergencies) _____

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:** _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

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Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Medical Record:

Medical History Cont. - 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					
	1 st	2 nd	3 rd	4 th	5 th	6 th
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.; not required						
Influenza (Flu)						
**Recommended annually >6 mo.; 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 ____Hep A ____Hep B ____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: _____

Length/Height: <u> </u> IN/CM %ILE <u> </u>		Weight: <u> </u> LB/KG %ILE <u> </u>	
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 pages if necessary)			
☐ None			
Signature of Licensed Physician or Nurse approved for Child Health Assessment			Date
Print the Name of the Individual Signing Above			Phone Number
Address		City	Zip Code

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 off premises from the facility.

Permission Form for Children to go Off-Premises

Name of the Facility (exactly as stated on the license) Agape Montessori School			License # 0065848	
Street Address of the Facility 14299 S Darnell St	City Olathe	Zip Code 66062	County Johnson	

_____ may go to the following locations off the premises with adult supervision:

First and Last Name of Child or Youth

Place Islamic Center of Kansas	Street Address 14750 W 143rd St	City Olathe	By Vehicle	Walk/Bike X
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	



Sunscreen/Neosporin Consent Form

I hereby give Agape Montessori School Staff my permission to apply the provided sunscreen on my child, _____ (child's name) as needed.

Parent Signature

Date

I hereby give Agape Montessori School Staff my permission to apply Neosporin on my child, _____ (child's name) as needed.

Parent Signature

Date

Food Informational Sheet

Child's Name _____

__Drinks Bottles:

Please describe drinking schedule including type of milk, amount served (in ounces), as well as how often, or at what times he/she drinks:

How do you serve the bottle (temperate)? _____

__Eats Baby Food: Your child must try new foods at home at least twice before bringing to school.

Please describe eating schedule including types of food (fruit, vegetable, cereal, oatmeal), amount served (in table spoons), as well as how often, or at what times he/she eats:

__Eats Table Food: We typically serve **Milk** (Whole under 2 years, 2% over 2 years) with lunch and **Juice** with snacks. Please indicate what you would prefer your child drink at these meal times:

Lunch: Whole Milk____ 2% Milk____

AM Snack: Milk____ Juice____ Water____

PM Snack: Milk____ Juice____ Water____

Can he/she drink without a lid? Yes____ No____

Food Allergies: _____

Additional Information: _____

(If at any time this information should change, please fill out a new informational sheet)

Parent's Signature _____

Date _____

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child or youth designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1		
First and Last Name of Child/Youth	Date of Birth	
Name of Medication		
Reason for Medication		
Dose	Time to be Given	Stop Date
Name of Licensed Physician/PA/APRN prescribing the medication		
I allow the above medication to be given to my child/youth by the designated person.		
Parent's Signature		Date

Medication #2		
First and Last Name of Child/Youth	Date of Birth	
Name of Medication		
Reason for Medication		
Dose	Time to be Given	Stop Date
Name of Licensed Physician/PA/APRN prescribing the medication		
I allow the above medication to be given to my child/youth by the designated person.		
Parent's Signature		Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE.
Designated Person to note any comments or remarks about the child's/youth's appearance below on this form.
*Each designated person administering medication is to sign below on this form and identify initials used.

[illegible]

[illegible]