

Agape Montessori School

"Where Love & Learning Come Together"

Student Registration Form

Child's Full Name		D.O.B		Age		Phone	
Street Address		City		State		Zip	

Parent Information

Father/Guardian's Name		Occupation	
Work Phone		Cell. Phone	
Email Address			
Preferred Method of Contact			
Mother/Guardian's Name		Occupation	
Work Phone		Cell. Phone	
Email Address			
Preferred Method of Contact			

Additional Family Information

Siblings & Ages	
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Emergency Information

Preferred Hospital	
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Emergency Contacts

Contact #1		Phone #		Relationship	
Contact #2		Phone #		Relationship	

Allergies/Dietary Needs

Please list any allergies or special dietary needs your child may have.	
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The following people may pick up my child from Agape Montessori School

Name		Relationship	
Name		Relationship	
Name		Relationship	
Name		Relationship	
Name		Relationship	

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. <u>Agape Montessori School</u>	License # <u>0065848</u>
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I hereby authorize Shea Dawson (Name of individual/staff member) and/or
other Agape 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 _____ and _____
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
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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: _____

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: _____

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.



**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

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Work Address _____
Street City Zip Code

Work Address _____
Street City Zip Code

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell Phone Number _____

E-mail Address _____

E-mail Address _____

Best way to contact _____

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)? If yes, provide information on Authorization for Emergency Medical Care form CCL 010.

_____ 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					
	1 st	2 nd	3 rd	4 th	5 th	6 th
Diphtheria, Tetanus, Pertussis (DTaP)						
Polio/myelitis (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.

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: _____

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): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> None	

Length/Height: _____ IN/CM %ILE _____	Weight: _____ LB/KB %ILE _____
Physical Examination	If Normal <input checked="" type="checkbox"/> 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) <input type="checkbox"/> 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

Agape

Montessori School

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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

Agape Montessori School

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IMAGE RELEASE CONSENT FORM

As part of our education program we take photographs of children in action as they participate in the classrooms, field trips, parties, etc. Please indicate below in what ways we may use images of your child. In any use of these images, names and other personal information will **NOT** be identified, unless first discussed with the parent.

- ☐ Images of my child(ren) may be used for art projects.
- ☐ Images of my child(ren) may be displayed around the facility.
- ☐ Images of my child(ren) may be collected in my child's portfolio.
- ☐ Images of my child(ren) may be used as part of Agape Montessori School pamphlets, brochures, curriculum, and informational booklets .
- ☐ Images of my child(ren) may be used on the Agape Montessori School Website.
- ☐ Please **do not** use ANY images of my child(ren) in ANY way.

I have read the above description and give my consent for the use of the images as indicated above.

Child(ren)'s name(s): (please print)

Parent/Guardian Signature

Parent/Guardian Name (please print)

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 _____



Authorization for Dispensing Medications to Children or Youth Short-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. Non-prescription medications can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label.

Medication #1		
First and Last Name of Child or Youth		
Name of Medication		
Reason for Medication		
Dose	Time to be Given	Stop Date
Name of Licensed Physician/Nurse Practitioner prescribing the medication ()		
Phone number of Health Care Provider		
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.		
Parent's Signature		Date

Medication #2		
First and Last Name of Child or Youth		
Name of Medication		
Reason for Medication		
Dose	Time to be Given	Stop Date
Name of Licensed Physician/Nurse Practitioner prescribing the medication ()		
Phone number of Health Care Provider		
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.		
Parent's Signature		Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

CCL.027
Rev. 8/2013

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: 785-296-0803
Website: www.kdheks.gov/kidsnet



Authorization for Dispensing Medications to Children and Youth Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label. A record of administration must be kept.

**Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or

First and Last Name of Child or Youth			
Name of Medication (only one medication per authorization)			Prescription OR Non Prescription
Reason for Medication			
Dose	Time to be Given	Start Date	Stop Date**
Name of Licensed Physician or Nurse Practitioner prescribing the medication		Phone # of Physician	
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.			
Parent's Signature			Date Signed

Instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.