Agape Montessori School

Student Registration Form

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

Parent Information

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

Additional Family Information

Siblings & Ages	

Emergency Information

Preferred Hospital	

Emergency Contacts (other than parent/guardian)

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

Medications

Please list any medications administrated to your child on a regular basis; as well as the dosage.	

Allergies/Dietary Needs

Please list any allergies or special dietary needs your child may have.	

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. 8/2013

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) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
Website: www.kdheks.gov/kidsnet

Kansas
Department of Health and Environment

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 #**
Agape Montessori School	0070103

I hereby authorize Deborah Pulliam (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 _____ (MM/DD/YYYY) and _____ (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.	**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 _____ (MM/DD/YYYY) by _____ (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.

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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

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_____
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:**_____

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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/KB** **%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

Agape Montessori School

"Where Love & Learning Come Together"

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

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Topeka, KS 66612-1274
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Kansas Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
Agape Montessori School			0070103
Street Address of the Facility	**City**	**Zip Code**	**County**
16550 W. 129th St.	Olathe	66062	Johnson

X______________________________ may go to the following locations off the premises with adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Devonshire Village	127th & Mur-Len	Olathe		X
Signature of Parent or Guardian X			**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**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

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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_____

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Pulliam Properties, LLC

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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.

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Kansas
Department of Health and Environment

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 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.**

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

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.