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**:_____

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. 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

Kansas
Department of Health and Environment

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 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 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).

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(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:**_____

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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/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

CCL 010
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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 #**
Agape Montessori School	0070103

I authorize ______Rebecca De La Fuente or other staff member________________________ (*caregiver/staff*) 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____ (*child's first and last name)* while child or youth is in the facility's custody between ______________________ and ________present________.
MM/DD/YYYY MM/DD/YYYY

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: ___________________________________
MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

____

____

____

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 ______________________ by____.
MM/DD/YYYY Name of Person

(Seal, if any.)

____
Signature of notarial officer

____
Title (and Rank)

My appointment expires: ______________________________

- -

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.

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

CCL. 034
Rev. 3/2020

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

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 Street	Olathe	66062	Johnson

________________________________ 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 & MurLen	Olathe		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**	

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

Agape Montessori School

"Where Love & Learning Come Together"

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_____

Revised 7/07/10
Pulliam Properties, LLC

CCL.026
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
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1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

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

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/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

(_____)_____
Phone Number of Physician, PA, or APRN

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

(_____)_____
Phone Number of Physician, PA or APRN

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

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

CCL.027
Rev. 5/2020

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

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/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 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.

First and Last Name of Child/Youth _____ Date of Birth _____

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, PA or APRN prescribing the medication _____ Phone # of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

Parent's Signature _____ Date Signed _____

****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.**

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

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