LITTLE BUGS DAYCARE ENROLLMENT APPLICATION

Name Of Child:	Birthdate:	Enrollment Date:

PARENT/GUARDIAN INFORMATION

Please check the box (☐) to indicate the primary residence of the child listed above.

☐ PARENT/GUARDIAN # 1		☐ PARENT/GUARDIAN # 2	
Name:		Name:	
Relationship:		Relationship:	
Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:	
Home Address:		Home Address:	
Employer Name:		Employer Name:	
Employer Phone:		Employer Phone:	
Employer Address:		Employer Address:	
E-Mail Address:		E-Mail Address:	

EMERGENCY CONTACTS

Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.

Contact Name #1:		Contact Name #2:		Contact Name #3:	
Relationship:		Relationship:		Relationship:	
Cell Phone:		Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:		Home Phone:	
Employer Phone:		Employer Phone:		Employer Phone:	

CUSTODY

Name of person PROHIBITED from picking up your child:	

If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order.

PERMISSIONS

☐ I give permission for my child to participate in ***WALKING TRIPS*** within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated.

☐ I give permission for my child to be ***PHOTOGRAPHED*** during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet.

☐ I ***DO NOT*** give permission for my child to participate in ***WALKING TRIPS*** within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated.

☐ I ***DO NOT*** give permission for my child to be ***PHOTOGRAPHED*** during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet.

RECEIPT OF POLICIES	I (we) attest that all of the information on this application is accurate, and that I (we) have received the following information: ☐ Little Bugs Daycare Handbook (Policies and Procedures)

MEDICAL INFORMATION	
Child's Health Care Provider:	
Health Care Provider Phone:	
Health Care Provider Address:	
Name Of Insurance Company/Hmo:	
Group #:	
Identification #:	
Subscriber's Name On Insurance Card:	
Known Allergies (including medication):	
Medication My Child Is Taking:	
List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations:	

HEALTH STATEMENT	As the parent/guardian of the above named child, I certify that he/she is in good physical health and may participate in the normal activities of the program and has no conditions or specific needs that require specific accommodations, unless otherwise indicated in the medical information provided above or an attached Universal Health Record or a Care Plan for Children with Special Health Needs. Parent/Guardian Initials:
EMERGENCY TREATMENT	As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified. Parent/Guardian Initials:

Parent/Guardian Signature #1:	Date:	Parent/Guardian Signature #2:	Date:

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_____

Child's Name_____
First Last

Date of Birth_____ Gender_____
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 _____
Address _____
Phone Number _____

Name _____
Address _____
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:**_____

CCL. 029a
Rev. 05/2020

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
Rev. 5/2020

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

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 #**

I authorize _____ (*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 _____.
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.

CACFP ENROLLMENT FORM

Note to Parents/Guardians: Your child(ren) is enrolled for care at a child care center that participates in the Child and Adult Care Food Program (CACFP). By participating in this program, the center is serving a variety of nutritious foods to your child(ren) and receiving reimbursement to assist with food costs. To meet program requirements, the center is required to have parents complete enrollment information annually for each child enrolled for care. This form will be placed in our files and treated as confidential information.

		Times of Care		Regular Days of Care							Meals Served During Care						Ethnic/Race*	
Last Name, First Name	**Date of Birth**	Arrival Time	Leave Time	M	T	W	T	F	S	S	Br	AM Sn	Lu	PM Sn	Dn	Ev Sn	Ethnicity	Race

***ETHNICITY (Select one and enter in chart above):** **H**=Hispanic or Latino or **N**=Not Hispanic or Latino
***RACE (Select one or more and enter in chart above):** **W**=White, **B**=Black or African American, **I**=American Indian or Alaskan Native, **A**=Asian, or **P**=Native Hawaiian or Other Pacific Islander

Name and Address:

_____
Print Name

_____
Address

_____
City State Zip Code

_____
Daytime Telephone

Signature:

_____
Signature of Parent or Guardian

_____
Today's Date

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Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) **mail**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

(2) **fax:**
(833) 256-1665 or (202) 690-7442; or

(3) **email:**
program.intake@usda.gov

This institution is an equal opportunity provider.