2017 SummerFUN! Passport Kids!

Enrollment Application

Name of Child: ______________________ **Age:** ________ **DOB:** ________

Address: ______________________ **City/State/Zip:** ______________________

Child: # ______ **of #**______ **total enrolling**

Reservation Schedule:

When will your child be having fun at WFS?

Mon-Friday 7am-6pm		Mon	Tues	Wed	Thur	Friday
Club AM	7-9am	( )	( )	( )	( )	( )
Camp AM	9-Noon	( )	( )	( )	( )	( )
Camp DAY	9-4pm	( )	( )	( )	( )	( )
Camp PM	1-4pm	( )	( )	( )	( )	( )
Club PM	4-6pm	( )	( )	( )	( )	( )

Circle the weeks your child be attending

MAY	JUNE	JULY	AUG
Wk 1: 5/30	Wk 2: 6/05	Wk 6: 7/03	Wk 10: 7/31
ALL 12 Weeks	Wk 3: 6/12	Wk 7: 7/10	Wk 11: 8/07
	Wk 4: 6/19	Wk 8: 7/17	Wk 12: 8/14
	Wk 5: 6/26	Wk 9: 7/24	

Note: Closed Memorial Day 5/29 and 4th of July

Comments: ____

Fees:

Per Child: $30 non-refundable application fee
Full Time: $150 per week (M-F, 7am-6pm); Siblings $125 per week
Part Time: $45 per day; Half Day $35 (7am-12pm or 1pm-6pm)
Drop In: $50 per day with no advance notice; if space available
Food: You bring the lunch, we do the snacks

Payment Schedule & Reservation Changes:

Payment is due in full the first of each week
Automatic bill payment is available - ask us how!
One week notice requested for change in schedule
No shows are still responsible for full payment

Parent / Guardian #1:

Name: ______________________________________

Address: ______________________ **City/State/Zip:** ______________________

Phone #s: Cell ______________ Home ______________ Work ______________

Email: ______________________ **Employer:** ______________________

Parent / Guardian #2:

Name: ______________________________________

Address: ______________________ **City/State/Zip:** ______________________

Phone #s: Cell ______________ Home ______________ Work ______________

Email: ______________________ **Employer:** ______________________

I understand the fees and payment expectations for the schedule selected, along with lunch expectations if applicable.

Signature of Parent / Guardian: ______________________ Date: ______________

CCL. 029
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

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)? 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					
	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:**____________

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

CCL 010
Rev. 6/2015

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
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 #**
Wichita Friends School	0030202-012

I hereby authorize Director and Staff (Name of individual/staff member) and/or Pam Jessup | Courtney Stratton (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 ______ child's name ______ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of May 29, 2017 (MM/DD/YYYY) and until end of care (MM/DD/YYYY)

X

Signature of Parent or Guardian	**Date Signed**

X

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.)

N/A

______
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.