Little Wonders Christian Daycare and Preschool Inc. Parent / Provider Contract

Children's names_____

Registration Fee: $90.00 per family per Year. This fee must be paid at time of enrollment.

FORMS

For your child's safety and to comply with state regulations, all enrollment papers must be completed, and on file **BEFORE** your child attends their first day. These forms include an enrollment form, a notarized medical release form, a health form signed by a physician, food program enrollment, and parent/provider contract.

WEEKLY FEES

Fees are due on MONDAY of each week, or the 1ST of each month. Fees may be paid by credit card, check, cash or Vision card.

*10% tuition discount for the second child in the family based on the oldest child's tuition. (This applies to full time children only.)

CHILDERNS' DAILY NEEDS

When your child runs out of an every day needed item we will notify you before the child is completely out. If you have been unable to provide the item before the child is completely out Little Wonders will provide the missing item and charge it to your account.

50 cents per **DIAPER**	$1 per **PULL-UP**
$3 for a pkg. of **WIPES**	$3 for a tube of **DIAPER RASH OINTMENT**
$1 for a **TOOTHBRUSH**	$5 for a bottle of **SUNSCREEN**

OTHER CHARGES

Returned Check Charge - $20.00

Late Payment Charge - $10.00 (for payments not received by 6:00 p.m., Friday)

We will make every effort to work with parents through temporary financial difficulties, such as job layoffs and other unforeseen circumstances. We reserve the right to terminate enrollment of any family who will not make an honest effort to keep up with the proposed repayment schedule.

Hours of Operation

6:30AM to 6:00PM Monday - Friday

ABSENCES – FULL-TIME

1 to 2 absences per week will be full weekly rate.

3 to 5 absences per week will be 60% of the weekly rate.

ABSENCES – PART-TIME

Must pay for all missed days

Termination Policy: Please give us a 2 week notice when leaving.

I agree to pay the rate of_____ per month / week for _____

I agree to pay the rate of_____ per month / week for_____

If child care is paid with Vison card, I understand I am responsible for any remaining charges there may be.

I have received and have read the parent handbook. _____

I understand the policies and have no questions at this time _____

Parent or Guardians Signature_____ Date_____

Providers Signature_____ Date_____

LITTLE WONDERS INFORMATION RECORD

CHILD'S NAME_____ AGE_____

BIRTHDAY_____ SEX M F

ADDRESS_____ CITY_____ ZIP_____

MOTHER'S INFO:
NAME_____
ADDRESS_____
HOME PHONE_____
CELL PHONE_____
EMPLOYER_____
WORK PHONE_____
SOCIAL SECURITY #_____
Email Address _____

FATHER'S INFO:
NAME_____
ADDRESS_____
HOME PHONE_____
CELL PHONE_____
EMPLOYER_____
WORK PHONE_____
SOCIAL SECURITY #_____
Email Address_____

PERSONS AUTHORIZED TO PICK UP YOUR CHILD

NAME_____ ADDRESS_____ PHONE_____

NAME_____ADDRESS_____ PHONE_____

RELATIVE OR FRIEND TO CONTACT IN CASE PARENTS ARE NOT AVAILABLE FOR AN EMERGENCY:

NAME_____ ADDRESS_____ PHONE_____

OTHER IMPORTANT INFORMATION ABOUT YOUR CHILD

DOCTOR'S NAME_____ OFFICE PHONE_____

ALLERGIES_____

PHYSICAL IMPAIRMENT(S)_____

DESCRIBE NAP HABIT_____

DESCRIBE ANY UNUSUAL SLEEP HABITS_____

OTHER CHILDREN IN THE FAMILY/AGES_____

CHILD'S FEARS IF ANY_____

CHILD'S DISPOSITION (HAPPY, RELAXED, ETC.)_____

ANY NERVOUS HABITS? PLEASE DESCRIBE_____

OTHER HELPFUL INFO:_____

WHAT DAYS & HOURS WILL YOUR CHILD ATTEND_____

ATTENDS OR WILL ATTEND WHAT ELEMENTARY SCHOOL_____
TRANSPORTATION FOR SCHOOL, PLEASE CIRCLE WHICH APPLIES: BEFORE AFTER BOTH

OFFICE USE ONLY: DATE STARTED_____ ENDING DATE_____

CCL 010
Rev. 2/2010

Kansas Department of Health and Environment
Child Care Licensing and Registration 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 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) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate.	**License or Certificate #**
Little Wonders Christian Daycare + Preschool Inc.	46534-007

I hereby authorize Laurie Rundberg (Name of individual/staff member) and/or Anyone (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 until further notice (MM/DD/YYYY)

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature only 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: _____

Complete information regarding health care insurance, if applicable.

Health Insurance Policy Name: _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

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

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.

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)? <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.

_____

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:**_____

CCL. 029a
Rev. 8/2013

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