LUTHERAN • CHILD • DEVELOPMENT • CENTER

ENROLLMENT APPLICATION

Child Information

Child's full name _____ Nickname _____ Age _____

Date of birth ___/___/___ Sex ____ Child's Address _____

Phone Number _____ City/State _____ Zip Code _____

Daily Arrival Time _____ Daily Departure Time _____

Elementary School your child attends if applicable: _____

Ethnicity: ___White (Non-Hispanic) ___Black/African American ___Hispanic/Latino ___Other

Mother/Guardian

Name _____ Home Phone ( ) _____

Home Address _____

Employer _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Cellular Phone ( ) _____ Email _____

Father/Guardian

Name _____ Home Phone ( ) _____

Home Address _____

Employer _____ Occupation _____

Business Address _____ Business Phone ( ) _____

Cellular Phone ( ) _____ Email _____

Office use only:

Registration Fee: $95.00 _____
Tuition _____
Classroom _____
Estimated Start Date _____

Family Information

Child lives with ( )Mother ( )Stepmother ( )Legal Guardian
( )Father ( )Stepfather ( )Grandparent

Church Affiliation: ___LCMS ___Other LCMS ___Other Denomination
___No Church Member

Persons to contact in case of an emergency, if parents cannot be reached

Name _____ Relationship _____ Phone _____

Address _____

Name _____ Relationship _____ Phone _____

Address _____

Name _____ Relationship _____ Phone _____

Address _____

Person(s) having permission to pick up your child or children (*must be 18 years or older*)

Name _____ Relationship _____ Phone _____

Address _____

Name _____ Relationship _____ Phone _____

Address _____

Name _____ Relationship _____ Phone _____

Address _____

Please notify us if anyone else will be picking up your child. If they are not listed above, and we have no other written instructions from you, we will NOT allow them to leave with your child.

Physician Information

Doctor's Name _____ Phone _____
Dentist's Name _____ Phone _____
Hospital Preference _____

*****in case of emergency, students will be transported to the closest hospital**
Allergies/Medical Conditions

Are there any allergies or medical conditions we need to be aware of? If so, please explain in detail:

_____
_____
_____
_____
_____

Concerns:

Are there any issues we need to be aware of (new sibling, recent move, loss of loved one, etc.)?

_____
_____
_____
_____

Enrollment Needs

Infant Care (6wks-12mo) _____
Toddler Care (12mo-24mo) _____
Two's (24mo-36mo) _____
Preschool (3yrs+potty trained) _____
Prekindergarten (4yrs by Aug. 31) _____
½ Day Kindergarten Enrichment _____
Before School Care _____
After School Care _____
Before & After School Care _____
½ day Prekindergarten (M/T/W/TH) _____ A.M.

Day of the Week	Time of Day	Number of Hours	Number of Children
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Signature of Parent/Guardian _____ Date _____

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 #
Open Arms Lutheran Child Development Center	0035952-013

I hereby authorize Angela Thrasher (Name of individual/staff member) and/or the Open Arms 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 until care is terminated (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.

CCL. 029
Rev. 3/2017

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

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_____

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:**_____

CCL. 029a
Rev. 3/2017

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

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:** _____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PL

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

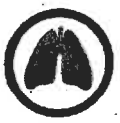
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

Open Arms Lutheran Child Development Center
Parent Agreement

please initial each item and sign below

_____ Open Arms Lutheran Child Development Center agrees to provide childcare and developmentally appropriate curriculum for _____ enrolled on
Monday Tuesday Wednesday Thursday Friday (circle)

_____ The tuition rate for the service is _____. Payment is due on **Monday** of each week for our full time programs. Payment is due on the **first** (1st) of each month for the part time preschool programs. A $25.00 per child, per week late payment fee will be assessed to all accounts not paid on time. If tuition is not paid for two (2) consecutive weeks, your child will be unable to return to Open Arms until the account is paid in full.

_____A registration fee of $95.00 for one child or $145 for a family is due upon enrollment and annually on September 1st.

_____ Open Arms requires two (2) weeks written notice if you decide to terminate enrollment. The full tuition is due during these two weeks.

_____ Medication is administered only with a medication authorization form including the date, name of child, name of medication, and dosage. Prescription medications **must** be in the original pharmacy container. Medications are kept in the office locked in a cabinet, or in a refrigerated lock box in the kitchen.

_____ My child will not be permitted to enter or leave the Center without being escorted by an authorized person. The teacher will be notified daily upon the arrival and dismissal of my child.

_____ Open Arms operates from 6:30am-6:00pm. It is imperative that the office be notified as soon as possible if a parent is going to be late for any reason. For every fifteen (15) minutes, beginning 5 minutes after your program end time, a $25 late pick up fee will be charged to the parent account for each child. If the parent/guardian fails to notify the school, management will attempt to reach the parents and/or emergency contacts. If management is unable to contact responsible parties, authorities will be notified.

_____ I acknowledge that it is my responsibility to keep my child's record current to reflect any significant changes as they occur such as telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records.

_____ The Center agrees to keep me informed of any incidents, injuries, and illnesses and adverse reaction to medication that may occur to my child.

_____ Open Arms agrees to obtain written permission from me before my child can participate in routine transportation, field trips, photographs, and special activities that take place away from the Center.

_____ In the event of an emergency that involves my child, and if Open Arms is unable to contact me, I hereby authorize any medical care.

_____ I have received a copy, read, and agree to abide by the policies and procedures as outlined in the Open Arms Parent Handbook and Operating Policies and Procedures. Furthermore, I understand that Open Arms reserves the right to add, remove, or change policies as necessary. Written notification will be provided for all policy changes.

Parent/Guardian Signature _____ Date _____
Director Signature _____ Date _____

Open arms®

LUTHERAN - CHILD - DEVELOPMENT - CENTERS

Dear Parents,

We would like your permission to take pictures of your child's various activities during the day. We would like to share their fun and activities with our congregation in our monthly newsletter, our website, and/or for classroom purposes. No personal information about your child will be publicly published (name, age, etc). If you have any questions, please ask in the office.

Please fill in your child's name, circle whether you give permission for each of the possible uses, and sign.

Name of Child _____

Monthly Newsletter	yes	no
Website	yes	no
Classroom Purposes	yes	no
Closed Group Social Media	Yes	no

Parent Signature_____ Date_____

Open arms
LUTHERAN • CHILD • DEVELOPMENT • CENTER

Sickness Exclusion Policy

A child must be symptom free for a minimum of 24 hours (without the use of medication), and can return to Open Arms only after they have been out for one full day that coincides with regular 6:30 a.m. to 6:00 p.m. business hours.
Contagious illnesses include, but are not limited to:

- Vomiting
- Rash (possibly longer than 48 if open sores or oozing)
- Fever above 100°
- Infectious disease, including, but not limited to:
  - Flu
  - Hand Foot & Mouth
  - Rota Virus
  - Strep
  - Pink eye
- Head lice or other infestation

If there is an acute change in behavior including lethargy/lack of responsiveness, irritability, persistent crying, difficulty breathing, uncontrolled coughing, or other signs or symptoms of illness, the child will also fall into the rules of exclusion, set forth above, in order to return to their classroom.