

Country Child Care

Enrollment Packet

In order to complete your child's enrollment - This packet and the "Please Sign and Return" packet must be completed.



**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 **Country Child Care Inc.**

Child's Name _____
First Last Middle

Date of Birth _____ Gender _____
MM/DD/YYYY M/F

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Employer _____

Employer _____

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell Phone Number _____

E-mail Address _____

E-mail Address _____

Best way to contact _____

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) _____ Please specifically name a hospital.

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: _____

For all children in child care facilities and family day care homes, 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.

SECTION I.

Section II. Complete this section only if your child is exempted from the laws requiring immunizations [K.S.A. 65-508(d) and K.S.A. 65-519(c)].

☐ (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.

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

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. Country Child Care Inc.	License # 15505
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I authorize **Country Child Care and Appointed Caregivers/Staff** (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 MM/DD/YYYY and Indefinite 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:

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

Family: _____

Photography Release for Minor Child or Children

I hereby authorize Country Child Care, Inc. to publish photographs taken during daily activities, field trips, and other special events, of myself and/or the minor child or children listed below, for use on the Country Child Care Facebook page.

I hereby release and hold harmless Country Child Care from any reasonable expectation of privacy or confidentiality for myself and for the minor child and children listed below associated with the images specified above. Further, I attest I am the parent or legal guardian of the child or children listed below and that I have full authority to consent and authorize Country Child Care to use their likeness.

I acknowledge and agree that publication of said photos confers to rights of ownership or royalties whatsoever.

I understand that the pictures will not have any captions that include the name of the minor child or children in the photos.

Authorization:

YOUR Printed Name: _____

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to child or children: _____

Names and Ages of Minor Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____



No Pictures

The goal is to share the pictures from field trips, daily activities, and special events with our parents so they may get to see an inside look into what their children are doing each day. **If you decide to not sign the paper, please sign below and your child will not have their pictures taken for the Country Child Care Facebook page.**

YOUR Printed Name: _____

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to child or children: _____