

Word of Life Preschool & Childcare Center



3811 N. Meridian Wichita, Ks. 67204
Phone (316)838-5683
Fax (316)838-0567

Student Information

Name _____ Age _____ Sex _____
Last First Middle

Address _____ Phone _____
Street City State Zip

Date of Birth _____

Family Information

Father's Name _____ Home Phone _____
Father's Address _____ Cell Phone _____
Employment _____ Work Phone _____
SS# _____

Mother's Name _____ Home Phone _____
Mother's Address _____ Cell Phone _____
Employment _____ Work Phone _____
SS# _____

Marital Status: Married ___ Separated ___ Divorced ___ Single ___ Partnered ___

Other Children at home: _____ age _____ age _____
_____ age _____ age _____

I affirm all information in this application is true and accurate to the best of my knowledge.

Father's or Guardian's Signature _____ Date _____

Mother's or Guardian's Signature _____ Date _____

Thank you,

Word of Life Preschool & Childcare Center

CCL 010
Rev. 9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Day Care Unit: Phone: 785-296-1270 Fax: 785-296-0803
Foster Care Unit: Phone 785-368-7015 Fax: 785-296-7025
Website: www.kdhe.state.ks.us/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. Word of Life Preschool & Childcare Center	License or Certificate #0024883.001
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I hereby authorize **Diana Fraser** (Name of individual/staff member) and/or

Any Other Staff Member from Word of Life Ministry's (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 _____ and **Until Terminated** MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	Date Signed
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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 _____ by _____ MM/DD/YYYY 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.

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/bcclr/index.html



MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES AND FAMILY DAY CARE HOMES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in registered family day care homes or licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessments are transferable when the child moves to another licensed child care facility or family day care home.

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

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Work Address _____
Street City Zip Code

Work Address _____
Street City Zip Code

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 _____

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) _____

1. 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: _____

2. Does your child have any of the following conditions? Please answer yes or no.

____ 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 _____

3. Have there been major changes at home that might affect your child in care? ___ No ___ Yes, as follows: _____

4. Please provide additional information or special instructions that will help the person caring for your child. _____

Signature of Parent/Guardian _____ Date: _____

History of Immunizations

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.

Child's Name: _____ Date of Birth: _____
First Last MM/DD/Y

SECTION I.

Vaccine	Record the Month, Day and Year that each Dose of Vaccine was Received					
	1 st	2 nd	3 rd	4 th	5 th	6 th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)						
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
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 laws requiring immunizations [K.S.A. 65-508(d) and K.S.A. 65-519(c)].

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:

_____ DTP _____ Pertussis Only _____ Tetanus _____ Polio _____ MMR _____ Rubella Only _____ Hep A _____ Hep B
 Hib _____ PCV7 _____ 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 Child Health Assessment is optional for children in Registered Family Day Care Homes. 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. Any Health Assessment Form should be attached to the KDHE Medical Record Form.

Child's Name _____ Date of Birth _____

Past Health History (Developmental – Illness – Hospitalization) _____

Allergies _____

Current Medications _____

Nutritional Status _____

Physical Examination

Height _____
Head _____
EENT _____
Teeth _____
Heart _____
Lungs _____

Weight _____
Abdomen _____
GU _____
GYN _____
Skeletal _____
Neurological _____

Screening Tests (Dates Done and Results)

Vision _____
Hearing _____
Speech _____
DDST _____
Lead _____

TBC. Test _____
Sickle Cell _____
HGB. _____
U.A. _____
Other _____

Diagnosis:

Recommendation:

Do you see this child for regular health supervision: Yes _____ No _____

Signature of Licensed Physician or Nurse Approved for Child Health Assessments

Date (MM/DD/YYYY)

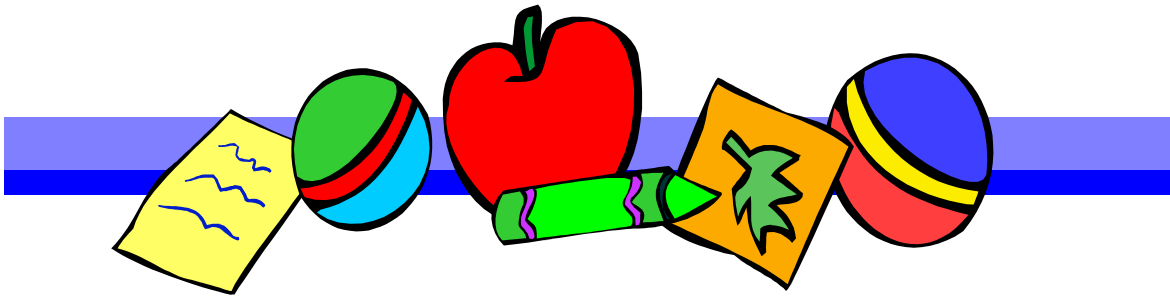
Print the Name of the Individual Signing Above

Phone number

Address of Physician or Nurse

City

Zip Code



SUPPLY LIST

1. Small blanket and pillow
2. Toothbrush with a cap
3. Wipes (1 box)
4. Complete change of clothing in a zip-lock bag, weather appropriate.
5. Glue stick (Toddlers-5 yrs)
6. Watercolors (Toddlers-5 yrs)
7. Markers-washable (Toddlers-5 yrs)
8. Play-doh (Toddlers-5 yrs)
9. Crayons-24 pack (Toddlers-5 yrs)
10. School supply box (room 1)

Toddler & Nursery (IF NEEDED)

1. Diapers (1 pack)
2. Wipes (1 box)
3. Rash ointment
4. Baby food
5. Pacifier
6. Bottle/with a cap
7. Water

Please mark child's name on each item with permanent marker.
We prefer Play-doh brand supplies they seem to last longer.