ASBURY CHURCH
CHILD DEVELOPMENT CENTER & PRESCHOOL

2801 W. 15th Street · Wichita, KS 67208 · 316-942-4490 · www.asburychurch.org
Shandy Kurth, Director · shandy.kurth@asburychurch.org

Child's Name:_____ Year: 2018

Part Time	**Preschool and Pre-K**	**Check**	
Tuesday/Thursday AM	Ages 3-4 8:30-11:30		$85/mo
Tuesday/Thursday PM	Ages 3-4 8:30-11:30		$85/mo
Monday/Wednesday/Friday AM	Ages 3-4 8:30-11:30		$110/mo
Monday/Wednesday/Friday PM	Ages 4-5 8:30-11:30 PreK		$110/mo
Monday – Friday AM	Ages 4-5 PreK		$175/mo
Monday – Friday PM	Ages 4-5 PreK		$175/mo

☐ **Camp Asbury: Start date: $130**

Circle Weekly attendance:

Monday Tuesday Wednesday

Thursday Friday.

- **Hours of use cannot exceed 10 hours per day.**
- **A $85 registration is required each semester to hold your child's spot.**
- **All day care includes breakfast, lunch and afternoon snack.**
- **All paperwork must be completed and turned into director before first day of care.**

Child Development Center - Full Time Care

	Check	
Ages 3 – 5 years Monday - Friday 7:00 am to 6:00 pm		$530/mo
Toddler (2 Year Olds) Monday Friday 7:00 am - 6:00 pm		$560/mo

Childs Schedule:_____ **Registration Paid** ☐

Days **Time**

Parent's Signature: _____ **Date:** _____

Asbury CDC
Emergency Contact Information

Year: 2017-2018 Start Date: _____

Child's First name _____ Middle _____ Last _____

Birth date: _____ Sex: M_____ F _____

Home address: _____
Street City Zip code

Child lives with: Both parents Mother Father Other

1st person to contact in case of an emergency

Name _____ Relationship: _____

Best phone number for contact: _____

Alternate number/e-mail for contact: _____

Employment _____ Work Number: _____

2nd person to contact in case of emergency

Name _____ Relationship: _____

Best phone number for contact: _____

Alternate number /e-mail for contact: _____

Employment _____ Work Number: _____

Authorized persons to pick up other than parents:
(If you need more room please use the back of this form or attach the list to this form.)

1. _____
   Name Address Phone relationship
2. _____
   Name Address Phone relationship
3. _____
   Name Address Phone relationship

Food and Drug Allergies: _____

Any medical conditions we should be aware of: _____

CCL. 029
Rev. 8/2011

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
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 Asbury Child Development Center

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 010
Rev. 8/2013

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
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
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 #**
Asbury Child Development Center	0018955

I hereby authorize Norma Snodgrass and or any Child development Staff (Name of individual/staff member) and/or and or any Church Asbury Staff Member (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 05/01/2017 (MM/DD/YYYY) and 05/30/2020 (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. 029a
Rev. 08/2011

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
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Physician Signature		Date of Illness:	
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 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:

_____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 Development Center Release Form

2017/2018

Please read the information below. Please return this form with your enrollment information.

Pictures:

Throughout the school year, the children participate in a variety of events at school. We like to capture these special moments by taking pictures and/or videotaping. We would like to use these pictures/videos on the web site, Asbury Child Development Center's Face book Page and Instagram and in some of our publications for the School or for Asbury Church. Pictures will only be used by Asbury Child Development Center or Asbury United Methodist Church.

I give permission for my child _____ to have his/her picture taken while attending Camp Asbury.

_____ _____

Parent/legal guardian signature Date

I do not give permission for pictures of my child _____ to be taken at Camp Asbury.

_____ _____

Parent/legal guardian signature Date

Email:

Asbury Preschool is working to become greener with our information system. We are going to offer two ways for parents to receive information from us. You can receive information through email, or you can receive all information in paper form in your child's file. Please fill out the information below so we will know how you would like to receive your information.

We would like to receive our information through e-mail._____

Please print your e-mail address clearly

Mother's e-mail address: _____

Dad's e-mail address: _____

We would like to receive our information in paper form in our child's file _____

E-mail address: _____

Phone number: _____

Dear Parent or Guardian:

Our center has been approved for participation in the Child and Adult Care Food Program (CACFP). The CACFP reimburses the center for the partial cost of meals. Participation in the CACFP enables us to keep our fees lower as well as serve nutritious meals to children in our program.

The parent/guardian must complete Parts 1 and 4 and one of the following options: *Part 2, Part 3A or Part 3B, to determine the amount of CACFP funds the center will be eligible to receive. This form will be placed in our files and treated as confidential information.* ***Note: no white out or erasure should be used. If there is an error cross through, correct, and initial.***

Part 1 FOR CHILD ENROLLMENT:

- CHILD'S NAME: List the first and last name of all children enrolled at this center.
- DATE OF BIRTH: List each child's date of birth.
- TIMES OF CARE, DAYS OF CARE and MEALS SERVED: List the regular times of care for each child by listing their arrival time and leave time, check each day the child will be in care and check each meal type received while in care.
- ETHNICITY/RACE: Using the codes provided, enter the codes for ethnicity and race.
- FOSTER CHILD: If the child is a foster child (the legal responsibility of a foster care agency or the court), please check the box.

Part 2 FOR A HOUSEHOLD RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), TEMPORARY ASSISTANCE FOR FAMILIES (TAF), OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR):

- Complete Parts 1, 2 and 4 on the reverse side.
- Provide the name and case number for the program from which benefits are received.

Part 3A FOR A HOUSEHOLD EXCEEDING THE INCOME GUIDELINES LISTED ON THE CHART BELOW:

- Complete Parts 1, 3A and 4 on the reverse side.

TO CALCULATE ANNUAL INCOME

Weekly Income X 52 • Every 2 Weeks Income X 26 • Twice a Month Income X 24 • Monthly Income X 12

Household Size:	1	2	3	4	5	6	7	Each Add'l Family Member
Annual Income:	$22,311	$30,044	$37,777	$45,510	$53,243	$60,976	$68,709	+ $7,733

Part 3B FOR ALL OTHER HOUSEHOLDS:

- Complete Parts 1, 3B and 4 on the reverse side using the additional information below.
- HOUSEHOLD NAMES: Write the names of everyone in your household not listed in Part 1. Include yourself and all other children, your spouse, grandparents, other relatives and unrelated people in your household. Use a separate sheet of paper if you do not have enough space.
- GROSS INCOME BEFORE DEDUCTIONS: Write the amount of income each person gets on the same line as their name. Use the appropriate column(s): Earnings from Work, Welfare/Child Support/Alimony, Pensions/Retirement/Social Security or Other Income (see list below). Next to the amount of income write how often the income was received. Income is all money before taxes or anything else is taken out. If a person does not have income, check the box for zero income.
  - OTHER INCOME: strike benefits, unemployment compensation, worker's compensation, disability benefits, interest/dividends, cash withdrawn from savings, income from estates/trust/investments, royalties/annuities/rental income, and regular contributions from persons not living in the household.
  - FOSTER CHILDREN: List any personal income received by the foster child under Part 3B. Personal income is (a) money given for the child's personal use, such as clothing, school fees and allowances and (b) all other money the child gets, such as money from his/her family.
  - MILITARY HOUSING BENEFITS: Report off-base housing allowance as income. If the housing is part of the Military Housing Privatization Initiative, do not include as income.
  - SELF-EMPLOYMENT: Report income derived from the business venture less operating costs for net income. The loss from the business cannot be deducted from a positive income earned in other employment. The least possible income is zero.
- SOCIAL SECURITY NUMBER: Write the last four (4) digits of the social security number of the adult household member who signs the form. If the adult household member does not have a social security number, check the box. Use of this information is for CACFP use only and is required.

Part 4 SIGNATURE AND CONTACT INFORMATION:

- Sign and date the application. The form must be signed by the parent or guardian.
- Complete the contact information – name, address, telephone number, and employer information.

ENROLLMENT & INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS
JULY 1, 2017 THROUGH JUNE 30, 2018

Part 1. CHILD ENROLLMENT: Complete the information below for all children in care. If the child is a foster child (legal responsibility of a foster care agency or the court), please check the box.

Last Name, First Name	Date of Birth	Times of Care		Regular Days of Care							Meals Served During Care						Ethnicity/ Race*		Foster Child
		Arrival Time	Leave Time	M	T	W	T	F	S	S	B	A M	L	P M	D	E V	Ethnicity	Race	
																			❑
																			❑
																			❑
																			❑

*Ethnicity (select one): H=Hispanic or Latino or N=Not Hispanic or Latino
*Race (select one or more): W=White, B=Black or African American, I=American Indian or Alaskan Native, A=Asian, or P=Native Hawaiian or other Pacific Islander

Part 2. HOUSEHOLDS RECEIVING BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), TEMPORARY ASSISTANCE FOR FAMILIES (TAF), OR FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR): Complete Parts 1, 2 and 4.

Program Name: _____ Case No. _____

Part 3A. HOUSEHOLDS EXCEEDING THE INCOME GUIDELINES: Complete Parts 1, 3A and 4.

If your family income exceeds the income guidelines (listed on reverse side), check this box ❑

Part 3B. ALL OTHER HOUSEHOLDS – If you do not have a FAP, TAF or FDPIR case number: Complete Parts 1, 3B and 4.

List the Names of All Household Members not listed in Part 1	GROSS INCOME BEFORE ANY DEDUCTIONS (Net for Self Employed) W=Weekly E2=Every 2 weeks 2M=Twice monthly M=Monthly Y=Yearly								Check If ZERO income
	Earnings from Work		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income		
	How much?	How often?	How much?	How often?	How much?	How often?	How much?	How often?	
(Example) Jane Smith	*$200*	*W*	*$150*	*2M*	*$100*	*M*			
1									❑
2									❑
3									❑
4									❑
5									❑
6									❑

Social Security Number of Household Member who signs form:

Last four digits of Social Security Number: XXX- XX -_____ If you do not have a Social Security Number, check this box ❑

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FAP), Temporary Assistants for Families (TAF) or Food Distribution Program on Indian Reservation (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the CACFP.

Part 4. SIGNATURE AND CONTACT INFORMATION:

I certify that all information on this form is true and that all income is reported. I understand that the facility will receive Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose their meal benefits, and I may be prosecuted.

_____ _____
Signature of Parent or Guardian Date

_____
Print Name

_____
Address

_____
City State Zip Code

_____
Daytime Telephone

_____
Employer(s)

FOR CENTER USE ONLY

_____ FAP/TAF/FDPIR HOUSEHOLD

_____ Homeless Documentation from school, emergency shelter, or agency

_____ ANNUAL INCOME: _____ HOUSEHOLD SIZE: _____

_____
Sponsor's Determining Signature Date

_____
Sponsor's Confirming Signature Date

HOUSEHOLD CATEGORY: ❑ Free ❑ Reduced Price ❑ Paid

Foster Child – Free Category
List name of foster child(ren):