Enrollment Checklist

Welcome to Living Word Early Learning Center!

Below is a list of documents that will need to be completed and returned to the center director at least 3 days prior to your child's first day of school. Forms may be picked up at the LWELC office and are also available online at www.livingwordearlylearningcenter.com under the Apply Today section.

- ☐ Signed Application for Enrollment & Financial Agreement **(to be discussed with director)**
- ☐ Signed parent handbook acknowledgement
- ☐ Medical Record (CCL. 029)
- ☐ Child Health Assessment (CCL. 029a) **(must be less than one year old)**
- ☐ Authorization for Emergency Medical Care (CCL 010) **(must be notarized)**
- ☐ History of Immunizations **(Please include doctor's record)**
- ☐ Transportation Permission Form
- ☐ Picture and Sunscreen Permission Form
- ☐ Parental Permission Form for Off-Premises Trips (CCL 034)
- ☐ Parent Questionnaire
- ☐ Handbook Agreement
- ☐ Allergy & Asthma Form if child has severe allergy, Epi-Pen Prescribed (if applicable)
- ☐ Custody Documents if applicable
- ☐ Authorization for Dispensing Medication (if applicable)

Here is a list items you will need to supply for your child's first day:

All Students

- Extra set of clothes (underwear, socks, pants, long and short sleeve shirt)
- Water Bottle (labeled)
- Backpack (optional)
- Sunscreen

Full Day Session Attendee's

- Twin Size Cot Sheet (or Twin Size Fitted Sheet) with your child's name on it
- Toothbrush and toothpaste (in plastic baggie in lunch box.)
- Small Blanket with your child's name on it
- Bring cold, nutritious lunches (include a fruit, veggie, protein, grain). LWELC will provide 2% milk during lunch for all Full Day Students.
- Please label your child's lunch box and water bottle

***We will inform you if any of these essentials need to be replenished.

CCL. 034
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

Kansas
Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #	
Living Word Early Learning Center				
Street Address of the Facility	**City**	**Zip Code**	**County**	
2711 Amherst Avenue	Manhattan	66502	Riley	

____________________ may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Linear Trail (behind church)		Manhattan		(circled)
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

LIVING WORD EARLY LEARNING CENTER
OUR PASSION. THEIR FUTURE

2711 Amherst Avenue
Manhattan, KS 66502

Phone: 785.776.2162
E-mail: livingwordchurchelc@gmail.com
Website: livingwordearlylearningcenter.com

Picture Permission

I hereby grant permission to LWELC and to its employees the right to photograph my child(ren) and use the photo or digital production of him/her for the postings within the Center (school website, school FB page, etc.) as well as for slide shows that may be played during family events.

Child's Name:_____

Print Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____

Date:_____

Sunscreen Permission

I hereby grant permission to LWELC and to its employees permission to apply sunscreen to my child(ren) during school hours when necessary.

Child's Name:_____

Print Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____

Date:_____

LIVING WORD EARLY LEARNING CENTER
OUR PASSION. THEIR FUTURE

2711 Amherst Avenue
Manhattan, KS 66502

Phone: 785.776.2162
E-mail: livingwordchurchelc@gmail.com
Website: livingwordearlylearningcenter.com

Transportation Permission

Name of Child(ren): _____

I hereby inform Living Word Early Learning Center that the people listed below are authorized to pick up the above named child(ren) at anytime. Accordingly, LWELC is hereby instructed to release my child(ren) into the care of the following people whenever they come to The Children's Center.

AUTHORIZED PICK-UP PERSON(S)

Name:	Relationship to Child:	Phone Number:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

I understand that: □ Parents/guardians must inform LWELC (call, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not. □ The "Authorized Pick-Up Person" must be at least 18 years old and may be asked to provide a photo ID to the staff. □ This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by:

_____ **Parent/Guardian Signature**

_____ **Date**

* Please include doctor's record of immunizations

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(g)].

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 010
Rev. 3/2017

*Must be Notarized!

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) 559-4244
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 #**
Living Word Early Learning Center	

I hereby authorize LWELC Staff (Name of individual/staff member) and/or LWELC Teachers (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 _____ (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.

*NOTE: MUST BE LESS THAN ONE YEAR OLD

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/KG %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

CCL. 029
Rev. 5/2019

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

Kansas
Department of Health and Environment

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)? 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:**_____

LIVING WORD EARLY LEARNING CENTER
OUR PASSION. THEIR FUTURE

2711 Amherst Avenue
Manhattan, KS 66502

Phone: 785.776.2162
E-mail: livingwordchurchelc@gmail.com
Website: www.livingwordearlylearningcenter.com

Parent Questionnaire

Dear Parents/Guardians,

Please fill out this questionnaire to help us provide your child with a smooth transition and a successful child care experience. Thank you!

1. Has your child been in a childcare setting before? If so, where and for how long?

2. Generally, what time do you drop off in the morning and pick up in the afternoon?

3. Does your child have any items they use for comfort, such as: blankets, toys, stuffed animals?

4. How do you comfort your child when they are upset?

5. What is your child's napping routine at home? How long does the nap usually last?

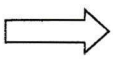
7. What is your child's typical eating schedule? What are some of their favorite foods?

8. Does your child have any special diet, health concern, or allergies that we should know about? If so, what are they?

9. Do you foresee any challenges or difficulties for your child during the school day in the following areas: separation at drop-off, naptime or eating?

10. Do you have any questions or concerns about your child's physical or emotional development?

11. Does your child have siblings at home?



13. What types of activities *indoors or out* does your child like to do?

14. What are your child's favorite songs or rhymes?

15. Does your child have a favorite book or toy? If so, what?

16. Are there any unique words or other languages your child uses that may be helpful for us to know so we may better understand them and support their emergent language skills?

18. Why did you choose Living Word Early Learning Center and how did you find out about us?

19. What is the most important thing we can do for you child?

20. Any other things you feel would be helpful/ important for us to know?

CCL.027
Rev. 5/2017

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

Authorization for Dispensing Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

First and Last Name of Child/Youth _____ Date of Birth _____

Name of Medication (only one medication per authorization) _____ Prescription OR Non Prescription

Reason for Medication _____

Dose _____ Time to be Given _____ **Start Date** _____ **Stop Date**** _____

Name of Licensed Physician, PA or APRN prescribing the medication _____ Phone # of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

Parent's Signature _____ Date Signed _____

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Designated Person to note any comments or remarks about the child's/youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

***Each designated person administering medication is to sign on the back side of this form and identify initials used above.**

*Signature of Designated Person Administering Medication ______________________________ Initialing as__________

*Signature of Designated Person Administering Medication ______________________________ Initialing as__________

*Signature of Designated Person Administering Medication ______________________________ Initialing as__________

*Signature of Designated Person Administering Medication ______________________________ Initialing as__________

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.

★ If applicable

Asthma and Allergy Foundation of America

CHILD CARE ASTHMA/ALLERGY ACTION CARD

ID Photo

Name: _____

Grade: _____ DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Other Contact Information: _____

Emergency Phone Contact #1 _____
Name

_____ _____
Relationship Phone

Emergency Phone Contact #2 _____
Name

_____ _____
Relationship Phone

Physician Child Sees for Asthma/Allergies: _____

Phone: _____

Other Physician: _____

Phone: _____

DAILY ASTHMA/ALLERGY MANAGEMENT PLAN

- **Identify the things that start an asthma/allergy episode**
  (Check each that applies to the child)

  — Animals — Bee/Insect Sting — Chalk Dust — Change in Temperature
  — Dust Mites — Exercise — Latex — Molds
  — Pollens — Respiratory Infections — Smoke — Strong Odors
  — Food: _____
  — Other: _____
  Comments: _____

- **Peak Flow Monitoring** (for children over 4 years old)
  Personal Best Peak Flow reading: _____
  Monitoring Times: _____ _____ _____

- **Control of Child Care Environment** (List any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent an asthma/allergy episode.) _____

- **Daily Medication Plan for Asthma/Allergy**

	Name	Amount	When to Use
1			
2			
3			
4			

OUTSIDE ACTIVITY AND FIELD TRIPS The following medications must accompany child when participating in outside activity and field trips:

	Name	Amount	When to Use
1			
2			
3			

Rev. 5/01

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as _____

_____

or has a peak flow reading at or below _____

- **Steps to take during an asthma episode:**

1. Check peak flow reading (if child uses a peak flow meter).
2. Give medications as listed below.
3. Check for decreased symptoms and/or increased peak flow reading.
4. Allow child to stay at child care setting if: _____

   _____
5. Contact parent/guardian
6. Seek emergency medical care if the child has any one of the following:

→ No improvement minutes after initial treatment with medication.
→ Peak flow at or below _____.
→ Hard time breathing with:
  - Chest and neck pulled in with breathing.
  - Child hunched over.
  - Child struggling to breathe.

→ Trouble walking or talking.
→ Stops playing and cannot start activity again.
→ Lips or fingernails are gray or blue.

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

- **Emergency Asthma Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

_____

_____

ALLERGY EMERGENCY PLAN

- **Child is allergic to:** _____

_____

_____

- **Steps to take during an allergy episode:**

1. If the following symptoms occur, give the medications listed below.
2. Contact Emergency help and request epinephrine.
3. Contact the child's parent/guardian.

- **Symptoms of an allergic reaction include:**

(Physician, please circle those that apply)

→**Mouth/Throat:** itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
→**Skin:** hives; itchy rash; swelling
→**Gut:** nausea; abdominal cramps; vomiting; diarrhea
→**Lung*:** shortness of breath; coughing; wheezing
→**Heart:** pulse is hard to detect; "passing out"
*If child has asthma, asthma symptoms may also need to be treated.

- **Emergency Allergy Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

_____

_____

Physician's Signature **Date** **Parent/Guardian's Signature** **Date** **Child Care Provider's Signature** **Date**

AGREEMENT PAGE

I, have read and understood Living Word Early Learning Center's Parent Handbook and Policies. I am aware of what is expected of me as a parent and understand the importance of my cooperation and understanding. I agree to abide by the policies and procedures as stated.

Signature of Parent/Guardian _____ **Date** _____

Director's Signature _____ **Date** _____

A PHOTO COPY OF THIS PAGE MUST BE PLACED IN THE STUDENT'S FILE.