Raising Wildflowers

8232 South Port Drive

Manhattan KS 66502

Phone: (785) 473-8346

Email: shelby@raisingwildflowersmhk.com

Website: raisingwildflowersmhk

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Desired start date for your child_____________________________

Required paperwork that needs to be completed before your child's first day:

______ Student Questionnaire

______ Emergency Contact Sheet

______Permission Sheets

______ Off Premise Permission Form

______ Emergency Medical Form

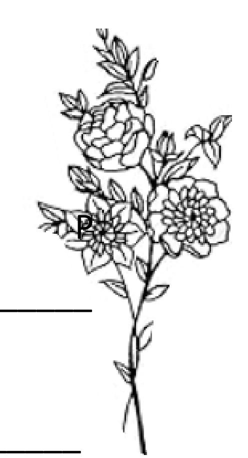
______ Medical Record

______ Child Health Assessment

______ Immunization Record

______ Registration Fee

______ First Month's Tuition



Child's Name ____________________________ Date of Birth___________________

Parent's Name(s) ______________________________________________________

Siblings Names(s)______________________________________ Age_____________

______________________________________ Age_____________

______________________________________ Age_____________

Has your child been in a childcare setting before?

______________________________________________________________________

______________________________________________________________________

What are you hoping your child will gain from their childcare experience?

______________________________________________________________________

______________________________________________________________________

How would you describe your child's personality? (shy, outgoing, etc.)

______________________________________________________________________

______________________________________________________________________

Describe any special concerns or fears your child may have.

_____________________________________________________________________

_____________________________________________________________________

Do you have any other information about your child or your family that you would like us to be aware of?

____________________________________________________________________

_____________________________________________________________________

Parent Contact Information

Name_______________________________________________________________

Phone ____________________________ Email ______________________________

Address _____________________________________________________________

Place of employment __________________________________________________

Name_______________________________________________________________

Phone ____________________________ Email ______________________________

Address _____________________________________________________________

Place of employment __________________________________________________

Emergency Contacts (minimum of two contacts that can reach you and/or pick up your child in an emergency)

Name ________________________________________ Relationship______________

Phone Number ___________________ Address ______________________________

Email ______________________________

Name ________________________________________ Relationship______________

Phone Number ___________________ Address ______________________________

Email ______________________________

Name ________________________________________ Relationship______________

Phone Number ___________________ Address ______________________________

Email ______________________________

Additional Approved Pickups

Name ________________________________________ Relationship______________

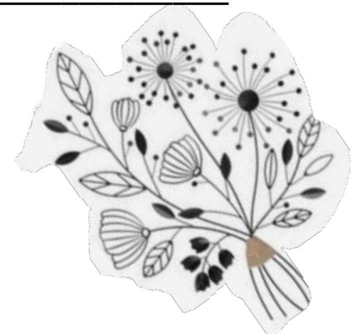
Phone Number ___________________ Address ______________________________

Email ______________________________

Name ________________________________________ Relationship______________

Phone Number ___________________ Address ______________________________

Email ______________________________



Parent handbook acknowledgement

I acknowledge that I have received and read the Parent Handbook and addressed any questions with the director.

Signature and Date ______________________________________________________

Photo Release within our app

I acknowledge that my child's photo will be taken and shared on the feed of other children in their class.

Signature and Date ______________________________________________________

Social Media Photo Permission

You do________ or do not ________ (mark one) have my permission to share my child's image on the center's social media.

Signature and Date ______________________________________________________

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Rev. 07/2024

Curtis State Office Building
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1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

# 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 #** |
|---|---|
| | |

I authorize ______________________________________________________(*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 ______________ and ___________________.
MM/DD/YYYY MM/DD/YYYY

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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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 off premised from the facility.

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Kansas
Department of Health and Environment

# Authorization for Administering Medications to Children and Youth Short-Term Medications (Prescription and Non-Prescription)

**Prescription medication** 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 or youth 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.

**Medication #1**

First and Last Name of Child/Youth Date of Birth

Name of Medication

Reason for Medication

Dose Time to be Given Stop Date

Name of Licensed Physician/PA/APRN prescribing the medication

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

**Parent's Signature** **Date**

**Medication #2**

First and Last Name of Child/Youth Date of Birth

Name of Medication

Reason for Medication

Dose Time to be Given Stop Date

Name of Licensed Physician/PA/APRN prescribing the medication

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

**Parent's Signature** **Date**

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE.
Designated Person to note any comments or remarks about the child's/youth's appearance below on this form.
*Each designated person administering medication is to sign below on this form and identify initials used.

| Date mm/dd/yy | Time | Name of Medication | *Initials | Date mm/dd/yy | Time | Name of Medication | *Initials |
|---|---|---|---|---|---|---|---|
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# Permission Form for Children to go Off-Premises

| Name of the Facility (exactly as stated on the license) | | | License # |
|---|---|---|---|
| Street Address of the Facility | City | Zip Code | County |

______________________________________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 |
|---|---|---|---|---|
| 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 | |

| 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 | |

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## For School Age Children or Youth Only

**I hereby authorize my school age child**

______________________________________________ ________________

**First and Last Name of Child or Youth** **Birth Date MM/DD/YYYY**

**To walk/bike to and from the following location(s) without adult supervision:**

| **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** | |

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Child Care Licensing Program
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Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

# Medical Record

## Medical History

In accordance with K.A.R. 28-4-117 and K.A.R. 28-4-430, a completed medical record shall be on file for all children in care. For a Family Child Care Home, children under 10 years of age and all children living in the home under 16 years of age, a medical record shall be completed. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment. The Medical Record is 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 ________________ (MM/DD/YYYY) Gender ______ (M/F)

| **Parent/Guardian Information** | **Parent/Guardian Information** |
|---|---|
| Name ________________________ | Name ________________________ |
| Home Address ________________________ (Street / City / Zip Code) | Home Address ________________________ (Street / City / Zip Code) |
| Home/Cell Phone Number ________________ | Home/Cell Phone Number ________________ |
| Work Phone Number ________________ | Work 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 ________________________ | Name ________________________ |
| Address ________________________ | Address ________________________ |
| Phone Number ________________________ | Phone Number ________________________ |

Child's Physician ________________________ Phone Number ________________________

Hospital Preference (for emergencies): ________________________________________________

Known allergies or medical conditions: ________________________________________________

Major changes at home that might affect your child in care: ________________________________________________

Additional information or special instructions that will help the person caring for your child: ________________________________________________

**Parent/Guardian Signature: ________________________________________ Date: ______________**

Date of annual review: ______________ Parent/Guardian Initials: ____________ Provider Initials: ____________

Date of annual review: ______________ Parent/Guardian Initials: ____________ Provider Initials: ____________

Date of annual review: ______________ Parent/Guardian Initials: ____________ Provider Initials: ____________

Date of annual review: ______________ Parent/Guardian Initials: ____________ Provider Initials: ____________

# Medical Record:

## Medical History Cont. - 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.; not required | | | | | | |
| **Influenza (Flu)** *Recommended annually >6 mo.; 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 _____Hep A _____Hep B

_____Hib _____PCV _____Varicella _____Other (describe): ________________________________________

**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:** ________________

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# Medical Record:

## Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

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 Family Child 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.

**Child's Name** ______________________________________________ **Date of Birth**____________________
First Last

| Health history and medical information pertinent to routine child care and emergencies (describe, if any):<br>☐ None | Do you see this child for regular health supervision:<br>☐ Yes ☐ No |
|---|---|
| Allergies to food or medicine (describe, if any):<br>☐ None | |
| List current medications (if any):<br>☐ 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 pages if necessary)<br>☐ None | | |

| **Signature of Licensed Physician or Nurse approved for Child Health Assessment** | | **Date** |
|---|---|---|
| Print the Name of the Individual Signing Above | | Phone Number |
| Address | City | Zip Code |

*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. |
|---|---|
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