CCL 010
Rev. 3/2017

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 #**
Little Learners Early Childhood Center, Inc.	0061277 0073314

I hereby authorize Christi Eaton and Kim Maples (Name of individual/staff member) and/or a current 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 _____ (MM/DD/YYYY) and until care is terminated. (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. 029
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

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_____
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
_____Asthma
_____Epilepsy/Seizures
_____Frequent sore throats/colds
_____Speech, Visual, Hearing
_____Other_____
_____Ear Aches
_____Diabetes

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:**_____

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(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:

_____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. 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/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

Little Learners

Early Childhood Center

Making Memories, Marking Milestones

Child Profile

Child's Full Name:	Nicknames: (Name that you would like your child to be called at school)	
Sex: [ ]M [ ]F	Age:	Date of Birth:
Address:		
City:	State:	Zip Code:
Mother's Name:	Phone:	Cell Phone:
Address: (If different from above)		
City:	State:	Zip Code:
Email Address:		
Mother's Place of Employment:	Occupation:	
Employer's Address:	Work Phone:	
Father's Name:	Phone:	Cell Phone:
Address: (If different from above)		
City:	State:	Zip Code:
Father's Place of Employment:	Occupation:	
Employer's Address:	Work Phone:	
Email Address:		
May we use your email address(es) for communications from Little Learners? Yes No	May we include your child in our Family Directory to help families plan play dates and birthday parties? Yes No	

Revised 9/4/2013

Names of Siblings:	Ages of Siblings:
Parent/Guardian with legal custody:	Parents are: [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Single

Does anyone else care for your child on a regular basis? If yes, who and relation?

Previous Child Care Providers and Experience:

How would you describe your child's overall health?

Diseases or serious injuries?

Disabilities?

Food Allergies:	Medicine Allergies:
Other Allergies:	Frequent Ear Infections? Frequent Colds?

Regular Medications:

How does your child behave when sick?

Emergency Contacts

Name:	Phone:
Name:	Phone:

Back-up Child Care Provider

Name:	Phone:
Name:	Phone:

Eating Behaviors

[ ] Drinks from a cup [ ] Cup w/lid [ ] Bottle [ ] Uses spoon [ ] Uses fork

What are your child's eating habits at home?

What are some of your child's favorite foods?

What are some of the foods your child dislikes?

Sleeping Behaviors

Does your child sleep through the night? [ ] Yes [ ] No

Does your child take a morning nap? [ ] Yes [ ] No Afternoon nap? [ ] Yes [ ] No

How long does your child nap? Morning _____ Afternoon _____

(Please include approximate times)

Does your child have anything special to sleep with?

What is your child's usual mood upon awakening?

Toilet Habits

Does your child wear? [ ] diapers [ ] pull-ups [ ] underwear

What does your child wear at naptime? [ ] diapers [ ] pull-ups [ ] underwear

Is diaper rash a problem? [ ] Yes [ ] No If yes, what do you use?

Is diarrhea or constipation a problem? [ ] Yes [ ] No If so, please describe?

Is your child toilet trained? [ ] Yes [ ] No Currently training? [ ] Yes [ ] No

Can your child indicate his/her bathroom needs? [ ] Yes [ ] No

Does your child have frequent "accidents"? [ ] Yes [ ] No

What words does your child use for: urination _____ bm's _____

Playing

Does your child enjoy playing alone?	Does your child prefer playing with older, younger, or children of the same age?(circle)

How does your child get along with other children?

Where does your child prefer to play? [ ] Indoors [ ] Outdoors

Does your child have any fears?

What are some things that make your child angry?

How do you comfort your child?

What are some activities your child likes?

What are some activities your child dislikes?

What are your child's favorite books?

What are your child's favorite toys?

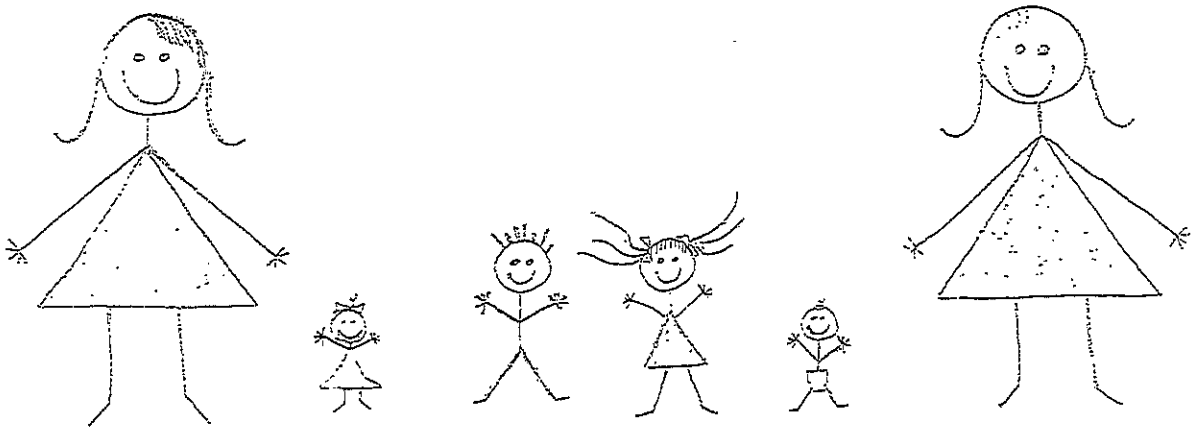
What form of discipline is most often used at home?

Other Information

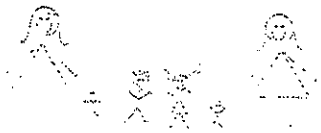
Please describe your child and add any additional information that you feel will help the teachers at Little Learners meet the needs of your child.

How did you hear about Little Learners? (circle all that apply)

Friend/Referral Yellow Pages Sign Web Search Website Newspaper



Revised 9/4/2013



Little Learners

Early Childhood Center

Making Memories, Marking Milestones

External Non-Prescription Preparations Form

Child's Name:	Date of Birth:
Height:	Weight:

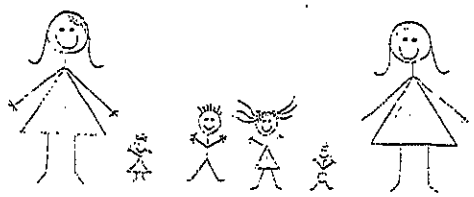
I hereby give the teacher(s) at Little Learners' permission to use or apply one or more of the following external preparations, in accordance with the directions for use on the container. I understand that this form is valid for the entire time my child attends Little Learners. I understand it is my responsibility to request a new form should I wish to change this information.

Product	Yes/No	Comments
Baby Wipes	Yes/No	
Band-aids	Yes/No	
Antibiotic Ointment	Yes/No	
First-aid Spray	Yes/No	
Sunscreen	Yes/No	
Insect Repellent	Yes/No	
Desitin®	Yes/No	
Vaseline®	Yes/No	
Lip Balm	Yes/No	
Hand Lotion	Yes/No	

By signing below, you agree that this is a legally binding form. Providing false information could result in termination of child care services.

Parent's/Guardian's Signature	Date

Revised 1/8/2008



Little Learners

Early Childhood Center

Making Memories, Marking Milestones

Permission to Photograph

I, _____, give permission for the teacher(s) at Little Learners
(parent's/guardian's name)
to photograph my child, _____, for the following purposes:
(child's name)

Type of Use:	Please Circle One Response in Each Row	
	Grant Permission	Decline Permission
Individual Photographs: I give permission for Little Learners to take individual pictures of my child to be shared with me.	Yes	No
Sharing Individual and Group Photographs: I give permission for Little Learners to take individual and group pictures of my child to be shared in scrapbooks, on classroom and hallway bulletin boards, and in parent newsletters. I also give permission for my child to be included in group pictures which may be shared with other parents through Tadpoles.	Yes	No
Graduation Slide Show: I give Little Learners permission to include my child's pictures in a slide show that will be shown at Graduation and will be given as a gift to those graduating from Little Learners.	Yes	No
I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment. _____ Parent's/Guardian's Signature _____ Date		

CCL.034
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
Phone 785-296-1270 Fax 785-296-0803
Website: www.kdhe.state.ks.us/kidsnet/

PARENTAL PERMISSION FORM FOR OFF-PREMISE TRIPS

Name of the facility exactly as stated on the license or certificate			License/Certificate #
Little Learners Early Childhood Center Inc			0i127106
Street Address of the Facility	**City**	**Zip Code + 4**	**County**
26121 W Valley Pkwy	Olathe	66061	Johnson

_____ 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
Sidewalk	26121 W Valley Pkwy	Olathe		
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk
parking lot	26121 W Valley Pkwy	Olathe		
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk
Building Perimeter	26121 W Valley Pkwy	Olathe		
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk
East Bldg	26115 W Valley Pkwy	Olathe		
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk
West Bldg	26121 W Valley Pkwy	Olathe		
Signature of Parent or Guardian			**Date Signed**	

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

Waiver and Release for Babysitting Services

PLEASE READ CAREFULLY BEFORE SIGNING.
THIS IS A RELEASE OF LIAIBLITY AND
WAIVER OF CERTAIN LEGAL RIGHTS.

Little Learners Early Childhood Center, Inc. does not promote or sponsor private babysitting services for children outside of any services offered or approved by Little Learners Early Childhood Center, Inc. ("outside babysitting"). The undersigned expressly acknowledge that Little Learners Early Childhood Center, Inc. is not a party to any outside babysitting agreement reached between any parent and/or legal guardian and any individual, including an individual who is currently employed by Little Learners Early Childhood Center, Inc.

The undersigned hereby assume all risks associated with the outside babysitting services provided by any current employee. The undersigned understand that Little Learners Early Childhood Center, Inc. selects and screens its staff members only for its own programs and services. As such, Little Learners Early Childhood Center, Inc. does not make any recommendations, guarantees, warranties, or representations as to any outside babysitting services provided by any of its employees. The undersigned understand any individual providing outside babysitting services is not a representative of, nor an agent for, Little Learners Early Childhood Center, Inc.

I agree that the minor child for whom I am parent or legal guardian shall be bound by this agreement. I hereby release and waive all claims against Little Learners Early Childhood Center, Inc. and its officers and directors, including any and all causes of action and claims for liability whatsoever, whether for personal injury or property damage, arising out of any incident, occurrence, exposure, injury, or damage that occurs in connection with the outside babysitting services described herein, which I or the minor child for whom I am parent or legal guardian can hereby legally waive. If any part of this Agreement is held unenforceable, I agree to be bound by the remaining parts.

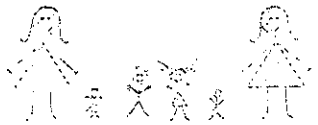
Dated:

_____ _____

Printed Name of Parent/Guardian Signature

_____ _____

Printed Name of Parent/Guardian Signature



Little Learners

Early Childhood Center

Making Memories, Marking Milestones

Child Pick Up Form

The following people HAVE permission to pick up my child, _____, from Little Learners.
(child's name)

Name:	Relation:
Address:	Phone Number:

Name:	Relation:
Address:	Phone Number:

Name:	Relation:
Address:	Phone Number:

The following people DO NOT have permission to pick up my child, _____.

Name:	Relation:
Address:	Phone Number:

Name:	Relation:
Address:	Phone Number:

Anyone unfamiliar to the teacher(s) at Little Learners will be required to show a photo ID. Under no circumstance will the child be released to anyone other than those listed with permission on this form without written permission from a parent/guardian.

Parent's/Guardian's Signature:	Date

EXHIBIT 1

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS (ACH DEBITS)

☐ ADD (New Participant)	☐ CHANGE (Financial Institution and/or Account #)	☐ DELETE (Cancel Participation)

☒ Fixed Amount and Date Account Authorization

I (we) hereby authorize Little Learners, (the "Company", to initiate debit entries and if necessary, initiate credit correction or adjustment entries to my (our) account at the financial institution indicated below.

I (we) understand that should the regularly scheduled debit date fall on a weekend or a federal holiday, the debit shall occur on the following banking date.

☐ Variable Amount and Date Account Authorization

I (we) hereby authorize _____, (the "Company", to initiate debit entries and if necessary, initiate credit correction or adjustment entries to my (our) account at the financial institution indicated below.

I (we) understand that should the regularly scheduled debit amount vary above the set range, we will receive written notification from the Company of the new amount no later than ten (10) calendar days before the scheduled transfer date. If the scheduled date of the debit changes (other than for a weekend or federal holiday when the debit shall occur on the following banking date), I (we) will receive written notice from the Company no later than seven (7) calendar days before the new scheduled transfer date.

Please attach a voided check or financial institution verification letter for account validation.

☐ CHECKING ☐ SAVINGS

Depository Financial Institution		Branch
Address		
City	State	Zip Code
Amount/Range to Debit $_____ Weekly		Debit Date
Recurrence (Circle One): (Weekly)		

TRANSIT ROUTING NUMBERS	ACCOUNT NUMBER INFORMATION
⑆	

This authority is to remain in full force and effect until the Company has received written notification from me (or either of us) of its termination in such a time and manner as to afford the Company and the Depository Institution a reasonable opportunity to act on it.

Name(s) - Please Print			
Address	City and State	Zip Code	
Signed	Date	Signed	Date

THIS FORM IS TO BE RETAINED BY THE COMPANY AS A MATTER OF RECORD. PLEASE RETAIN A COPY FOR YOUR RECORDS.