



Student Registration Form

Child's Full Name		D.O.B		Age		Phone	
Street Address		City				State	Zip

Parent Information

Father/Guardian's Name		Occupation	
Work Phone		Cell. Phone	DL #
Email Address			
Preferred Method of Contact			
Mother/Guardian's Name		Occupation	
Work Phone		Cell. Phone	DL #
Email Address			
Preferred Method of Contact			

Additional Family Information

Siblings & Ages	
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Emergency Information

Preferred Hospital	
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Emergency Contacts

Contact #1		Phone #		Relationship	
Contact #2		Phone #		Relationship	

Allergies/Dietary Needs

Please list any allergies or special dietary needs your child may have.	
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The following people may pick up my child from Agape Montessori School

Name		Relationship	
Name		Relationship	
Name		Relationship	
Name		Relationship	
Name		Relationship	



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. Agape Montessori School	License # 0065848-008
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I hereby authorize Christine Dawson (Name of individual/staff member) and/or Other Agape 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 _____ and Present.
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 if required by the local hospital or clinic.	Date Signed
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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 _____ by _____.
MM/DD/YYYY 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: _____



**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

Parent/Guardian Information

Name _____

Name _____

Home Address _____

Home Address _____

Street City Zip Code

Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Work Address _____

Work Address _____

Street City Zip Code

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) _____

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.

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent sore throats/colds | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Speech, Visual, Hearing | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> 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: _____

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					
	1 st	2 nd	3 rd	4 th	5 th	6 th
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:** _____

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): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> 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) <input type="checkbox"/> 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	



Sunscreen/Neosporin Consent Form

I hereby give Agape Montessori School Staff my permission to apply the provided sunscreen on my child, _____ (child's name) as needed.

Parent Signature

Date

I hereby give Agape Montessori School Staff my permission to apply Neosporin on my child, _____ (child's name) as needed.

Parent Signature

Date



IMAGE RELEASE CONSENT FORM

As part of our education program we take photographs of children in action as they participate in the classrooms, field trips, parties, etc. Please indicate below in what ways we may use images of your child. In any use of these images, names and other personal information will **NOT** be identified, unless first discussed with the parent.

- Images of my child(ren) may be used for art projects.
- Images of my child(ren) may be displayed around the facility.
- Images of my child(ren) may be collected in my child's portfolio.
- Images of my child(ren) may be used as part of Agape Montessori School pamphlets, brochures, curriculum, and informational booklets .
- Images of my child(ren) may be used on the Agape Montessori School Website.
- Please **do not** use ANY images of my child(ren) in ANY way.

I have read the above description and give my consent for the use of the images as indicated above.

Child(ren)'s name(s): (please print)

Parent/Guardian Signature

Parent/Guardian Name (please print)

Date



PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license) Agape Montessori School			License # 0065848-008	
Street Address of the Facility 14435 S Blackbob Rd	City Olathe	Zip Code 66062	County Johnson	

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

Place On Agape Property Outside Fenced Area	Street Address 14435 S Blackbob RD	City Olathe	By Vehicle	Walk/Bike X
Signature of Parent or Guardian <input checked="" type="checkbox"/>			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	

Food Informational Sheet

Child's Name _____

Drinks Bottles:

Please describe drinking schedule including type of milk, amount served (in ounces), as well as how often, or at what times he/she drinks:

How do you serve the bottle (temperate)? _____

Eats Baby Food: Your child must try new foods at home at least twice before bringing to school.

Please describe eating schedule including types of food (fruit, vegetable, cereal, oatmeal), amount served (in table spoons), as well as how often, or at what times he/she eats:

Eats Table Food: We typically serve **Milk** (Whole under 2 years, 2% over 2 years) with lunch and **Juice** with snacks. Please indicate what you would prefer your child drink at these meal times:

Lunch: Whole Milk _____ 2% Milk _____

AM Snack: Milk _____ Juice _____ Water _____

PM Snack: Milk _____ Juice _____ Water _____

Can he/she drink without a lid? Yes _____ No _____

Food Allergies: _____

Additional Information: _____

(If at any time this information should change, please fill out a new informational sheet)

Parent's Signature _____

Date _____



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

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label.

Medication #1		
_____ First and Last Name of Child or Youth		
_____ Name of Medication		
_____ Reason for Medication		
_____ Dose	_____ Time to be Given	_____ Stop Date
_____ Name of Licensed Physician/Nurse Practitioner prescribing the medication (_____)		
_____ Phone number of Health Care Provider		
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.		
_____ Parent's Signature		_____ Date

Medication #2		
_____ First and Last Name of Child or Youth		
_____ Name of Medication		
_____ Reason for Medication		
_____ Dose	_____ Time to be Given	_____ Stop Date
_____ Name of Licensed Physician/Nurse Practitioner prescribing the medication (_____)		
_____ Phone number of Health Care Provider		
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.		
_____ Parent's Signature		_____ Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

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

