Christina & Jason Middleton
8617 Greenwood Lane Lenexa, KS 66215
913-544-6273

# ENROLLMENT AGREEMENT

I,_____(parent/guardian) do hereby place, _____(Child/ren) in the licensed day care home and under the direct supervision of Christina & Jason Middleton (day care providers) beginning on _____(start date). I/We have read and will comply with all the provisions contained herein and shall at this time enter into the financial agreement given to us. This agreement is subject to review January 1st and is renewed annually thereafter. Any changes made by the provider will be made in writing and mutually agreed upon.

**WEEKLY FEES –**

Child's Name_____Hours in Care __Full Time__Charge $____$325_____
Child's Name_____Hours in Care _____Charge $_____
Child's Name_____Hours in Care _____Charge $_____

_____ (Initials) I/we agree that after the 2 week trial period, one month written notice will be given before termination of this contract agreement. Failure to provide one months' notice will result in continuation of financial obligations as stated here and in the policy handbook.

_____(Initials) I/we agree that the deposit of first and last week fees is nonrefundable if care does not start on the agreed upon date and if one months' notice is not given upon termination.

I, Christina Middleton, have reviewed and discussed this handbook with _____ (parent/guardian) and agree to provide child care for _____ (children) to be placed in my home on _____ (date).

Signatures:

Parent/Guardian_____Date_____

Parent/Guardian_____Date_____

Provider's Signature __Christina Middleton_____Date_____08/27/2026_____

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# ENROLLMENT FORM

**Child's Name**_____Birthdate_____Age_____
Date of Enrollment:_____

Parents:
Mother_____
Place of employment_____
Normal Working Hours_____
Work Phone_____
Home Phone_____Cell Phone_____
Home Address_____
Marital Status_____
Email Address:_____

Father_____
Place of employment_____
Normal Working Hours_____
WorkPhone_____
Home Phone _____Cell Phone_____
Home Address_____
Marital Status_____
Email Address:_____

Child's Primary Residence: With Mother With Father With Both Parents

Pease list all members of the child's household including ages of children: _____
_____
_____

Emergency Contacts other than the parents:
Name_____Day #_____ Home #_____
Address _____
Relationship_____

Name_____Day #_____ Home #_____
Address _____
Relationship_____

Names of other persons authorized to remove child from care:
_____
_____

Parent/Guardian Signature_____ Date_____
Child's Name_____
Child's Physician_____ Phone #_____

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# PERMISSIONS

**Parent's Handbook**

I have received a copy of the Parent's Handbook. I have reviewed the handbook and understand that the policies in the handbook may change with one month's notice.

_____ _____

Parent Signature Date

**Travel and Activity Agreement**

I give Christina's Childcare, my child's day care provider, permission to leave the child care home for neighborhood walks, walks to the park, backyard activities, etc. I understand that I will be notified in advance of any field trips or special trips to places requiring seats necessary for safe traveling by car and will have a separate permission slip for each field trip.

Comments or concerns noted:

_____

I understand that ride-on toys, teeter totters, slide, sprinklers and other toys are used on a regular basis I will not hold the caregiver responsible for injuries incurred while using equipment at the child care home, providing my child/ren is/are supervised, and the equipment is in good repair.

_____ _____

Parent Signature Date

**Behavior and Discipline Plan**

I have reviewed and understand the Behavior and Discipline plan as outlined in the Parent Handbook.

_____ _____

Parent Signature Date

**Parental Visit Notice**

I understand that I am able to visit this Family Day Care home at any time during the hours that my child is in care. If it is during nap/quiet time, I will do my best not to disturb any of the other children in the day care.

_____ _____

Parent Signature Date

# Potty Training Policy

Before potty training, work with your child on the basics – dressing and undressing themselves, sitting on the potty, and telling when the diaper is dirty. When your child stays dry all night, during nap periods, is off the bottle, and is bothered by soiled or wet diapers, these are signs that your child is ready to begin the process of potty training. When starting potty training, we, the providers and the parents, must work together to make this a success. Pull-ups with easy-open Velcro sides are required during the training process.

Potty training will begin at home. Please communicate with us as you start potty training. When your child has regular success at home, we can begin potty training at Daycare. Please note that toilet training in the daycare environment can be more complex than at home. Friends and toys can distract a child from recognizing the need to go potty. Also, note that the provider is balancing the needs of other children, which may distract the provider from meeting the child's potty needs.

- Your child will be asked to go potty at least every hour. If your child asks to use the potty, they will be assisted whenever they ask.
- Your child must remain in pull-ups with easy-open Velcro sides until they have gone two weeks without accidents during awake hours to ensure we have a clean and sanitized environment for all of our friends. We can quickly put the child in a diaper over nap until naptime dryness can be achieved.
- During potty training, the child will need loose-fitting pants/shorts/skirts with elastic that they can easily pull up and down. No buttons, snaps, or overalls, please. The goal is to have the child achieve independent success during potty training.
- Please bring five extra sets of pants and underwear once we have transitioned to underwear. Please note that KS Regulations do not allow us to rinse soiled diapers or clothing.
- Boys are encouraged to learn to train in the seated position. This position helps better empty the bladder and encourages the child to learn to have bowel movements on the toilet. It is challenging for toddlers/preschoolers to aim; they get discouraged if they wet themselves.
- Parents MUST have the provider's agreement before sending the child in underwear.

Children potty train in different ways and ages. The process can and should be pretty easy. If your child is truly ready and able to communicate, potty training should not be a long, drawn-out, frustrating battle of wills. It is rare for a child to be trained at home at precisely the same time as in the group daycare setting. Our job is to work together to support and guide the child positively through this developmental milestone.

I understand and agree to the above policy:

Parent Signature_____Date _____

Parent Signature_____Date _____

# Illnesses and Exclusion Policy

If your child displays one of the following symptoms, KDHE requires that you keep your child home for at least 24 hours, free of symptoms and fever-reducing medication.

- The illness prevents the child from participating comfortably in facility activities.
- The illness results in a greater care need than the childcare staff can provide without compromising the health and safety of the other children.
- The child has any of the following conditions and poses a risk of spreading harmful diseases to others:
  - An acute change in behavior, including lethargy/lack of responsiveness, irritability, persistent crying, difficulty breathing, uncontrolled coughing, noticeable (spreading) rash, or other signs or symptoms of illness until medical evaluation indicates inclusion in the facility.
  - The child is irritable, continuously crying, or requires more attention than we can provide without hurting the other children's health, safety, or well-being in our care.
  - Fever:

| | |
|---|---|
| Ear (tympanic) | At or above 100 degrees Fahrenheit |
| Rear (rectally)<br>*Most accurate | At or above 101 degrees Fahrenheit |
| Armpit (axillary) | At or above 99 degrees Fahrenheit |
| Forehead<br>(Temporal artery)<br>**Least accurate | At or above 100 degrees Fahrenheit |
| Orally (not to be taken on children less than four years) | At or above 100 degrees Fahrenheit |

*If you have administered a fever reducer such as Tylenol (acetaminophen) or Motrin (ibuprofen), then the temperature should be taken at least 4 hours after the last dose of Tylenol and 6 hours after the last dose of ibuprofen to ensure the fever reducer is not lowering the temperature.

# Disease and Symptom Exclusion Policy

| | |
|---|---|
| COVID – 19 | ○ If over two years - Exclude for five days following onset of symptoms or test date if asymptomatic, return and mask through day 10. Close contacts should be masked for ten days from the last date of exposure. Test on day 6.<br>○ If under two years, exclude ten days from the onset of symptoms or test date. Close contacts should be excluded ten days from the last date of exposure. Test on day 6. If negative, may return to care on Day 7. |
| Diarrhea | Diarrhea free for 24 hours without the aid of medication |
| Vomiting | Must be vomit-free for 24 hours |
| Rash | Rash with fever/behavior change excluded until seen by the physician |
| Pink Eye / Eye discharge | Exclude until on doctor-prescribed medication for 24 hours. |
| Fever with or without symptoms | Fever-free for 24 hours without the aid of medication |

| | |
|---|---|
| Fifth Disease | Exclude until fever-free 24 hours without medication; no longer contagious once the rash has appeared. |
| Hand, Foot and Mouth Disease | Exclude until fever-free for 24 hours without the aid of medication and no open sores/lesions. |
| Impetigo | Exclude until treated for 24 hours with antibiotics. |
| Influenza | *Physician Diagnosed*: Exclude for five days following onset of illness. If fever persists for more than five days, continue exclusion until 24 hours fever-free without the aid of medication. |
| Lice | Exclude until 24 hours after one or more treatments. |
| Measles | Exclude for four days after onset of rash; susceptible contacts that are not age-appropriately vaccinated within 72 hours of first exposure shall be excluded for 21 days following the last exposure to an infectious case. |
| MRSA | If lesions can be covered, then there is no exclusion. If lesions cannot be covered, exclude them until lesions have crusted over. |
| Mononucleosis | Fever-free for 24 hours without the aid of medication |
| Pertussis (whooping cough) | Exclude until completion of appropriate antibiotic therapy |
| Ringworm | Exclude until after treatment; no activities involving skin-to-skin contact until lesions are completely healed. |
| Rubella | Exclude for seven days following onset of rash; susceptible contacts shall be excluded for 21 days following last exposure to the case. |
| Streptococcal disease (scarlet fever and strep sore throat) | Exclude for 24 hours following initiation of antimicrobial therapy; if not receiving therapy, exclude for ten days following onset of symptoms. |
| Chickenpox | Exclude until all lesions have formed scabs and crusted over. |

If your child begins to show these symptoms, the provider will notify the parent and ask you to come to pick up your child immediately (within the hour, or the provider will contact emergency contact)

I understand:

____ I must pick up my child within 60 minutes of being notified of an illness.
____ That fever-free is an average temperature (98.6°) without a fever reducer such as Tylenol or Ibuprofen.
____ If I give my child a fever reducer, I must wait 4 hours for Tylenol and 6 hours for Ibuprofen before checking their temperature. Their temperature must then remain normal for 24 hours before returning to care.

Parent Signature_____Date _____

Parent Signature_____Date _____

# Safe Sleep Policy

The providers have received training on Reducing the Risk of SIDS and Using Safe Sleep Practices. To provide a safe sleep environment, we will follow these guidelines:

- The temperature of the sleeping room will not exceed 75 degrees.
- All infants and children will be visually checked every 15 minutes.
- Infants will be placed on their back position for sleeping to reduce the risk of SIDS.
- No items are allowed in the infant's sleeping area.
- Children (12 months and up) will sleep in pack-in-play or cot with individual sheets, pillows, and blankets that will be washed weekly or when soiled.
- Infants (0-12 months) will sleep in a pack-in-play with a fitted sheet that will be washed weekly or when soiled.
- Infants will not be allowed to sleep in car seats, swings, or bouncers. If an infant falls asleep in one of these devices, they will be moved to their pack-in-play.
- When infants can quickly turn over from back to stomach, they will be placed on their back to sleep but allowed to roll to whatever position they prefer for rest.
- Cameras are present in the sleeping spaces.

I have read the full safe sleep and supervision policy (pg. 13-14 of this handbook) and agree to the above policy:

Parent Signature_____Date _____

Parent Signature_____Date _____

# Cream and Spray Parent Approval List

The following creams and sprays may be applied according to label directions to care for my child. If you prefer a different product, please bring it labeled with your child's name.

| Lotion | Yes | No |
|---|---|---|
| ◊ Aquaphor | ☐ | ☐ |
| ◊ Petroleum Jelly/Vaseline | ☐ | ☐ |

## Sunscreen (6 months & older*)

Please provide sunscreen each summer. I will have some on hand in the event you forget.

| | | |
|---|---|---|
| ◊ Aveeno Baby Continuous Protection Sensitive Skin SPF 50 | ☐ | ☐ |
| ◊ Various brands of spray sunscreen | ☐ | ☐ |

## Bug Spray (2 months & older*)

| | | |
|---|---|---|
| ○ Off! Family Care Smooth & Dry Insect Repellant | ☐ | ☐ |

## Hand Sanitizer (24 months & older*)

| | | |
|---|---|---|
| ○ Any alcohol-based hand sanitizer | ☐ | ☐ |

*Age recommendation according to the American Academy of Pediatrics.

Parent Signature_____Date _____

Parent Signature_____Date _____

# COVID – 19 Guidelines

**Updated October 6, 2022**

The length of the COVID-19 exclusions will be determined by the age of the cheerful or exposed child and their ability to wear a mask properly while in care, in coordination with the Johnson County Health Department, KDHE, and CDC guidelines. These guidelines may change at any time.

If over two years old and capable of masking:

- COVID-19 COVID-19-positive child shall be excluded for five days following the onset of symptoms or test date if asymptomatic. They may return on Day 6 and mask through Day 10 if symptoms have drastically improved and are free for at least 48 hours.
- If exposed to close contact with COVID-19, the child may attend daycare masked for ten days from the date of exposure. The child should test on Day 6.

If under two years or incapable of masking –

- COVID-19 – 19 Positive Child shall be excluded for ten days from the onset of symptoms or test date if asymptomatic.
- If exposed to close contacts who have COVID-19, the child should be excluded ten days from the last date of the exposure. The child should test on day 6. If negative, may return to care on Day 7 if symptoms have drastically improved and fever-free for at least 48 hours.

I understand and agree to the above policy:

Parent Signature_____Date _____

Parent Signature_____Date _____

# Photo Release Policy

We would appreciate it if parents complete this consent form to allow their children to be photographed during special events or activities organized at Christina's Childcare. For a child to have their photograph taken, they must have a consent form on file.

If you do not want to have your child photographed, please feel free to indicate this in the section below. Please ensure your child is aware if you object, so we don't hurt their feelings if we do not take a picture of them.

As the parent of a child/children at Christina's Childcare, I agree to the following:

- I understand that my child(ren), whose name(s) are listed below, may be photographed at Christina's Childcare during regular daycare hours, field trips, or activities.
- I understand that photographs may be used to create gifts and crafts.
- I understand these photographs may be used in school newsletters, the Daycare website, or Christina's Childcare Facebook page. (The Facebook page is only accessible to current daycare families)
- I permit my child(ren) to be photographed, and their images may be used for advertising purposes on Daycare Listings websites.

The following are the names of my children attending Christina's Childcare:

_____

(  ) I have read and understood the above and agree to have my child(ren) photos posted on Daycare listing websites, newsletters, and Christina's Childcare Facebook page.
(  ) No, I do not wish to have any child(ren) photographed.

Parent Signature_____Date _____

Parent Signature_____Date _____

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913-544-6273

# GENERAL INFO

**EATING:**

Food Likes/Dislikes:

Food Allergies:

Comments:

**SLEEPING:**

Napping Schedule:

Any comfort needs:

Comments:

**BATHROOM:**

Is your child Potty Trained?

What does your child say when he/she wishes to use the toilet?

Comments:

**ALLERGIES:**

Does your child have any known allergies? If YES, Please list:

**PLAY:**

Favorite activities:

Favorite Toys: Favorite Book:

Does your child play well with other children?

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**FEARS:**

Does your child have any fears? Please describe:

**SPECIAL NEEDS:**

Please describe any medical, physical or emotional needs your child may have that may require special attention:

Comments:

***Please describe your child's typical day:***

- 
- 
- 
- 
- 
- 
- 
- 
- 
- 
- 

CCL. 029
Rev. 08/2024

Child Care Licensing Program
Curtis State Office Building
Kansas Department of Health and Environment
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

Kansas Department of Health and Environment

# 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 _____ Date of Birth _____ Gender _____
First Last MM/DD/YYYY M/F

**Parent/Guardian Information**

Name _____

Home Address _____
Street City Zip Code

Home/Cell Phone Number _____

Work Phone Number _____

E-mail Address _____

Best way to contact _____

**Parent/Guardian Information**

Name _____

Home Address _____
Street City Zip Code

Home/Cell Phone Number _____

Work Phone Number _____

E-mail Address _____

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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Rev. 08/2024

Child Care Licensing Program
Curtis State Office Building
Kansas Department of Health and Environment
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/Childcare Licensing

Kansas Department of Health and Environment

# 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): ☐ 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 pages if necessary) ☐ 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 |

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Curtis State Office Building
Kansas Department of Health and Environment
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

Kansas
Department of Health and Environment

# 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 #** |
|---|---|
| Middleton Family Daycare | 0059288 |

I authorize Chrisitna and Jason Middleton ____________ (*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 upon termination ______________.
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** |
|---|---|
| | |

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

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.

# Health Insurance Information

| | |
|---|---|
| Child's Name: | |
| Parent Name: | |
| Parent Name: | |
| Insurance Plan Name: | |
| Insurance Plan ID #: | |
| Insurance Group #: | |
| Insurance Subscriber Name: | |

Please Include copy of Insurance card front and back.

Front:

Back:

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Curtis State Office Building
Kansas Department of Health and Environment
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/Childcare Licensing

Kansas Department of Health and Environment

# Permission Form for Children to go Off-Premises

| Name of the Facility (exactly as stated on the license) | | | License # |
|---|---|---|---|
| Middleton Family Childcare | | | 0059288 |
| Street Address of the Facility | City | Zip Code | County |
| 8617 Greenwood Lane | Lenexa | 66215 | 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/Bike |
|---|---|---|---|---|
| Neighborhood Trail | 84th and Hallet | Lenexa | | x |
| 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 | |

**Day Care Connection (DCC)**
913-529-1200

# Child & Adult Care Food Program (CACFP)
# ENROLLMENT FORM

OCTOBER 1ST, 2025-
SEPTEMBER 30TH, 2026

****PLEASE NOTE****

**CHILDREN CANNOT BE CLAIMED ON YOUR MENUS BEFORE THE DATE THE PARENT SIGNS THIS FORM!**

**THANK YOU!!!**

**PROVIDER'S Name** _____ **PHONE** _____

**Only parents/guardians** may complete info for each child enrolled.

***Note to Parents/Guardians:*** Your child(ren) is enrolled for care at a family day care home which participates in CACFP through DCC. By participating, the provider is serving a variety of nutritious foods to your child(ren) & receiving reimbursement to assist with food costs.

***Important:*** You may receive a parent audit confirmation request to verify attendance & meals served. Your cooperation helps assure the continuance of this federally funded nutrition-education program.

**Check:** ❑ NEW Enrollment for this family **OR** ❑ UPDATED info for this family

| Child's First & Last Name ***PRINT*** | Date of Birth | Normal Arrival Time | Normal Pick-Up Time | **Circle Normal Days of Care & Meals** | | | | | | | | | | | | | Ethnicity/ Race* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | **Normal** Days of Care | | | | | | | **Normal** Meals Received During Care | | | | | | Ethnicity | Race |
| | | | | Su | M | T | W | Th | F | Sa | Bkfst | AM Snck | Lnch | PM Snck | Dnr | BT Snck | | |
| | | | | Su | M | T | W | Th | F | Sa | Bkfst | AM Snck | Lnch | PM Snck | Dnr | BT Snck | | |
| | | | | Su | M | T | W | Th | F | Sa | Bkfst | AM Snck | Lnch | PM Snck | Dnr | BT Snck | | |
| | | | | Su | M | T | W | Th | F | Sa | Bkfst | AM Snck | Lnch | PM Snck | Dnr | BT Snck | | |

*** Ethnicity:**
**H** - Hispanic or Latino
**N** - Not Hispanic or Latino

**Race:** (choose all that apply)
**I** - American Indian or Alaska Native
**A** - Asian
**B** - Black or African American
**P** - Native Hawaiian or Pacific Islander
**W** -White

**Complete this section ONLY if your child is under 1 year of age:**

**FORMULA** offered by child care provider: _____
**Check 1:** (must be iron-fortified & manufactured in USA)

❑ I **accept** above named formula for my infant.

❑ I **decline** above named formula for my infant. **I will provide** formula.

❑ I will provide **breast milk**. ❑ I will **breastfeed onsite** (when available).

**If providing breast milk, check 1 below:**

❑ I accept above named supplement formula.

❑ I will provide supplement formula.

**SOLID FOODS-Complete *this section if your infant is ready for solid foods.***

❑ I ACCEPT the following solid foods, provided by my provider (appropriately textured), to be served to my infant:

❑ Iron-fortified Infant Cereal ❑ Grains ❑ Veggies ❑ Fruits ❑ Infant meat/meat alt

❑ I DECLINE the following solid foods, provided by my provider, to be served to my infant. Instead, I WILL PROVIDE (check all which may apply):

❑ Iron-fortified Infant Cereal ❑ Grains ❑ Veggies ❑ Fruits ❑ Infant meat/meat alt

_____
***PRINT ABOVE*: PARENT/GUARDIAN FIRST & LAST NAME**

**Address** _____ **Apt #** _____

**City, State, Zip** _____

**Home #** _____ **Cell Ph#** _____

**Work Place** _____

**Email Address** _____

**Parent/Guardian Signature X** _____

**Date X** _____

***CHILDREN CANNOT BE CLAIMED BEFORE THIS DATE***

**USDA is an equal opportunity provider 10/25**