

## 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 # \_\_\_\_\_

## 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 totter, 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

### **Supervision and Safe Sleep Plan**

I have reviewed and understand the Supervision and Safe Sleep Plan.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
Date

### **Sunscreen Permission**

I give permission for Christina's Childcare to apply sunscreen to my child in an effort to prevent sunburn.

\_\_\_\_\_  
**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

**Medical Emergency Treatment**

I give Christina Middleton and Jason Middleton , my child’s day care provider, permission to administer first aid and/or CPR to my child, \_\_\_\_\_ and/or permission for my child to be transported by car or ambulance to a hospital for emergency medical treatment when I cannot be reached or when delay would be dangerous to my child’s health.

\_\_\_\_\_  
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

**Photography and Website permission**

\_\_\_\_\_ I give permission for my child to be photographed.

\_\_\_\_\_ Photos may be posted on Christina’s Childcare Facebook page. The face book page is locked for only parents of current children may see photos

\_\_\_\_\_ Photos may be posted for advertising purposes and on Christina’s Childcare website.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

# WELCOME!!!

## 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?





## 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 1<sup>st</sup> 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 \$ 300 \_\_\_\_\_  
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 04/27/2023



**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**

**Parent/Guardian Information**

Name \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City Zip Code

Home Address \_\_\_\_\_  
Street City Zip Code

Home Phone Number \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

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 \_\_\_\_\_

**Persons authorized to pick up the child or to notify in case of emergency (other than the parents):**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

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: \_\_\_\_\_

Any known allergies or medical conditions of child:  
\_\_\_\_\_  
\_\_\_\_\_

Any major changes at home that might affect your child in care:  
\_\_\_\_\_  
\_\_\_\_\_

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 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>
<b>Diphtheria, Tetanus, Pertussis (DTaP)</b>						
<b>Poliomyelitis (IPV/OPV)</b>						
<b>Measles, Mumps, Rubella (MMR)</b>						
<b>Hepatitis B (HepB)</b>						
<b>Varicella (VAR)</b>			Hx of Disease: Physician Signature		Date of Illness:	
<b>Hemophilus Influenzae Type B (Hib)</b>						
<b>Pneumococcal Conjugate (PCV)</b>						
<b>Hepatitis A (HepA)</b>						
<b>Rotavirus</b> **Recommended <8 mo of age; not required						
<b>Influenza(Flu)</b> ** 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:** \_\_\_\_\_







**PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS**

Name of the Facility (exactly as stated on the license) <b>Middleton Family Daycare</b>			License # <b>0059288</b>	
Street Address of the Facility <b>8617 Greenwood Lane</b>		City <b>Lenexa</b>	Zip Code <b>66215</b>	County <b>Johnson</b>

\_\_\_\_\_ may go to the following locations off the premises **with** adult supervision:

**First and Last Name of Child or Youth**

Place <b>Neighborhood Trail</b>	Street Address <b>87th/Hallet</b>	City <b>Lenexa</b>	By Vehicle	Walk/Bike <b>Walk</b>
Signature of Parent or Guardian <b>X</b>			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	

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	

-----

**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	



**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. <b>Middleton Family Daycare</b>	License # <b>0059288</b>
---	-----------------------------

I authorize Christina / 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 Termination.  
MM/DD/YYYY MM/DD/YYYY

**\*\*Please make sure to complete insurance info below\*\***

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: \_\_\_\_\_  
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
---------------------------------	-------------

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 <u>Kansas</u> 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: _____

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.