TINY TITANS

FAMILY HANDBOOK/ENROLLMENT AGREEMENT

NAME OF CHILD: _____

Parent Initials:

_____ Yes, I have read the handbook/policies and agree to comply with the rules and regulations regarding health, clothing, payment and other items specified within. I also understand that a copy of this agreement will be placed in my child's personal file.

_____ Yes, I have been informed of reasons my child may be dismissed.

_____ Yes, I have been informed of days the facility is closed.

_____ Yes, I understand payments are a set rate weekly, with only drop in care differing.

_____ Yes, I understand 2 weeks' notice and payment must be given when taking my child out of care.

_____ Yes, I understand there is a 2-week adjustment period. It starts on _____and ends on_____. At the end of the period, staff and parents will discuss if the child has or has not adjusted; If my child has not adjusted to care, my child will be dismissed from care effective immediately.

_____ Yes, I understand these are the following pick up and drop off times: _____drop-off _____pick-up. If pick up is after stated time (after closing) I will pay $1 per minute for being late.

_____ Yes, I am officially enrolling my child in Tiny Titans - Decatur County Childcare.

The start date for my child will be: _____

Director's Signature Date:

_____

Parent's Signature: Date:

_____

CCL. 029
Rev. 5/2019

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

Kansas Department of Health and Environment

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

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

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

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 #**

I hereby authorize _____ (Name of individual/staff member) and/or

_____ (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 _____ (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.027
Rev. 5/2017

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

Kansas Department of Health and Environment

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

Prescription medications 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 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.

First and Last Name of Child/Youth _____ Date of Birth _____

Name of Medication (only one medication per authorization) _____ Prescription OR Non Prescription

Reason for Medication _____

Dose _____ Time to be Given _____ **Start Date** _____ **Stop Date**** _____

Name of Licensed Physician, PA or APRN prescribing the medication _____ Phone # of Physician, PA or APRN

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

Parent's Signature _____ Date Signed _____

**Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Designated Person to note any comments or remarks about the child's/youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

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

CCL.026
Rev. 5/2017

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

Kansas Department of Health and Environment

Authorization for Dispensing 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/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

(_____)_____
Phone Number of Physician, PA, or APRN

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

(_____)_____
Phone Number of Physician, PA or APRN

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

CCL. 035
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

Kansas
Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS GROUP OF CHILDREN TO ONE LOCATION

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

Children or Youth listed below may go on an off-premise trip to:_____

Located at:_____
Street City County

on _____.
(MM/DD/YYYY)

Time of Departure:_____ Estimated Time of Return:_____

Children or Youth will be traveling by: _____ Vehicle _____ Walking

Children or Youth will be supervised at all times by the following staff:

Staff Name_____ Staff Name _____
First Last First Last

Staff Name _____ Staff Name _____
First Last First Last

FIRST AND LAST NAME OF CHILD OR YOUTH	PARENT/GUARDIAN SIGNATURE GRANTING PERMISSION (Include First and Last Name)

CCL. 034
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

Kansas
Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

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	

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	

Media Release Authorization

Authorization:

I authorize the use and disclosure of my child's voice, photographic and/or video images, and or/ testimonial for public relations, marketing, new media, and charitable goals, and I hereby waive my right to compensation for such used by reason of the foregoing authorization. I and my successors or assigns hereby hold Little Paws Daycare and USD 316 staff, and any other persons participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this disclosure.

Purpose:

The photographic/video images, and/or testimonial will be used for: social media, public relations, marketing, news media, and charitable goals and/or other advertising purposes.

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by Little Paws Daycare via registered mail or delivered personally to the daycare director. Revocation affects disclosure moving forward and is not retroactive. This authorization will remain in effect unless it is revoked.

Parent Signature:

Name: _____ Date: _____

Signature: _____

Authorized Pick-Up List

The people listed below have my authorization to pick up my child from the program. I will inform my child's director/teacher, each time a special pick-up is necessary. I understand that my child will only be released to individuals listed below, if I am unavailable. I also realize that they will be required to provide proper identification each time that they arrive at the center. If an individual is not listed on this form, a telephone call WILL NOT be sufficient to release the child to that individual.

Mother's Signature _____

Father's Signature _____

Child's Name _____

Please Print:

Name	Relation to Child	Phone
Name	Relation to Child	Phone
Name	Relation to Child	Phone
Name	Relation to Child	Phone
Name	Relation to Child	Phone
Name	Relation to Child	Phone

If more, please list on back of page.

These people are NOT allowed to pick up my child. PLEASE NOTE: A copy of the court decision for custody cases MUST be on file in order for the program NOT to release a child to his/her non-custodial parent.

Name	Relation to Child
Name	Relation to Child

COL_011
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

Child Health Assessments

Your child should be seen during the preschool years by a health professional according to the following schedule:

At Birth	6 Months	18 Months	Then 1
1 Month	9 Months	24 Months	per year
2 Months	12 Months		until the
4 Months	15 Months		age of 20

Every child should be seen at least 13 times from birth to school entry. A careful examination of the eyes and ears should be included in the assessment.

Dental Health

A child's initial visit to a dentist should take place within 6 months after the first tooth can be seen, but no later than 1 year of age. Following the initial visit, regular check-ups should be scheduled every 6 months (or twice a year).

In communities where the drinking water is not fluoridated, a dentist should be consulted about an age appropriate fluoride treatment plan.

Social-Emotional Health

Caring for your child's social and emotional health is also an essential part of raising a healthy child. To learn more about age appropriate development tasks as well as ideas for encouraging healthy social and emotional growth, visit: www.brightfutures.org/mentalhealth/pdf/tools.html#families.

Safety

Providing your child with a safe environment to grow is an important part of raising a healthy child. For information about safety precautions and more, visit: www.kdheks.gov/safekids.

Well-Child Visits Should Include

A. Discussion of your child's physical and behavior problems with the physician.

B. A Health Assessment of your child by the physician or nurse approved to perform Health Assessments.
(Including important screenings such as vision, hearing and blood tests)

C. Immunizations

- Make sure your child has the necessary immunizations for his/her age. This is important for your child's health.
- Many childhood diseases can be prevented with regular health care visits and up-to-date immunizations.
- Discuss with your child's physician the appropriate course of immunizations.
- Your child's physician will also provide you with Vaccine Information Statements (VISs) prepared by the Centers for Disease Control (CDC) regarding certain vaccinations your child will be given.
- Repeat immunizations as recommended by the Kansas Department of Health and Environment. Your child's physician may also discuss new vaccines with you as they become available.

D. Discussion of your child's health history since the last visit.

E. Written instructions concerning your child's care, diet and recommendations for the solution of any special health problems.

F. Referrals when necessary to other persons for special services.

G. Appointment for next Well-Child Visit.

Parents need to provide the following for their children at the daycare:

6 weeks-potty trained:

diapers/pull ups

diaper cream

bottles (if necessary)

pacifier (if necessary)

3 changes of clothes

1 pair of socks

sunscreen

chapstick

3 pack kleenex

Framed 5 x 7 family picture (optional)

Potty Trained and up:

1 change of clothes

1 pair of socks

sunscreen

chapstick

3 pack kleenex

Framed 5 x 7 family picture

*each child may bring a lovey (blanket or stuffed animal) to keep at the daycare

FEES POLICY

Policy:

Fees are to be paid by the 10th of each month. Fees are based on enrollment, not attendance (NO fee decreases for sick/missed days or statutory holidays/assigned vacation days).

Procedure:

1. It is the parent/guardian's responsibility to keep all information (i.e.: relationships status, work/school status, address, phone number etc...) current with Tiny Titans daycare.

2. Parents are responsible for all monthly fees.

3. Monthly fees must be paid by the 10th of each month.

4. Upon enrollment, parents must pay for childcare for the upcoming month.

5. If fees are outstanding after the 15th of the month, the child will not be accepted at the daycare on the 16th or any other day there after until fees are paid in full.

6. Fees are as follows:
   Infants (0 months-potty trained toddlers): $150/week
   Potty Trained Toddlers and above: $140/week

*Please note that some months have 5 weeks.
*Fees are subject to change.

Drop in space: $30/day

After school care: $15/day

Full-Time when there is no school - $28/day.

*To move to the potty-trained pay scale, your child must have less than 2 accidents per day for 2 consecutive weeks, documented by provider. If you enroll your child as potty trained and they have more than 2 accidents per day for 2 consecutive weeks, you will be charged for an unpotty trained spot for the following month, documented by provider. If your child becomes potty trained while in care, they will move to the potty trained pay scale for the next month.

Consideration:
None