Raising Wildflowers

8232 South Port Drive

Manhattan KS 66502

Phone: (785) 473-8346

Email: shelby@raisingwildflowersmhk.com

Website: raisingwildflowersmhk.com

Instagram: raisingwildflowersmhk

Desired start date for your child_____

Required paperwork that needs to be completed before your child's first day:

_____ Student Questionnaire

_____ Emergency Contact Sheet

_____Permission Sheets

_____ Off Premise Permission Form

_____ Emergency Medical Form

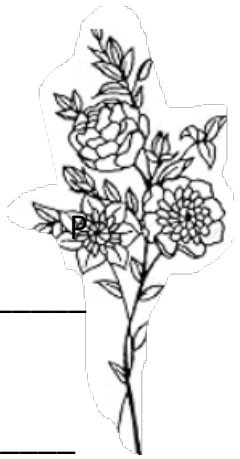
_____ Medical Record

_____ Child Health Assessment

_____ Immunization Record

_____ Registration Fee

_____ First Month's Tuition



Child's Name _____ Date of Birth_____

Parent's Name(s) _____

Siblings Names(s)_____ Age_____

_____ Age_____

_____ Age_____

Has your child been in a childcare setting before?

_____

_____

What are you hoping your child will gain from their childcare experience?

_____

_____

How would you describe your child's personality? (shy, outgoing, etc.)

_____

_____

Describe any special concerns or fears your child may have.

_____

_____

Do you have any other information about your child or your family that you would like us to be aware of?

_____

_____

Parent Contact Information

Name_____

Phone _____ Email _____

Address _____

Place of employment _____

Name_____

Phone _____ Email _____

Address _____

Place of employment _____

Emergency Contacts (minimum of two contacts that can reach you and/or pick up your child in an emergency)

Name _____ Relationship_____

Phone Number _____ Address _____

Email _____

Name _____ Relationship_____

Phone Number _____ Address _____

Email _____

Name _____ Relationship_____

Phone Number _____ Address _____

Email _____

Additional Approved Pickups

Name _____ Relationship_____

Phone Number _____ Address _____

Email _____

Name _____ Relationship_____

Phone Number _____ Address _____

Email _____

Parent handbook acknowledgement

I acknowledge that I have received and read the Parent Handbook and addressed any questions with the director.

Signature and Date _____

Photo Release within our app

I acknowledge that my child's photo will be taken and shared on the feed of other children in their class.

Signature and Date _____

Social Media Photo Permission

You do_____ or do not _____ (mark one) have my permission to share my child's image on the center's social media.

Signature and Date _____

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

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 #**
Raising Wildflowers Childcare Academy	0084781

I authorize center staff ______________________________ (*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 end of care ________________.
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.

CCL.034
Rev. 07/2024

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Permission Form for Children to go Off-Premises

Name of the Facility (exactly as stated on the license)			License #
Raising Wildflowers Childcare Academy			0084781
Street Address of the Facility	**City**	**Zip Code**	**County**
8232 South Port Drive	Manhattan	66502	PT

_____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
Sensory Room	8232 South Port Drive	Manhattan		X
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Natural Playground	8232 South Port Drive	Manhattan		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	

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**	

Developmental History (If you need additional space for any of these questions, please feel free to use a blank piece of paper in addition to this form.)

The purpose of this form is not to exclude any child from care. It allows us to provide individualized Care by identifying specific needs. It allows us to ensure that we are aware of any medical or developmental concerns that may need extra support. It helps us understand your child's temperament, triggers, and coping mechanisms.

- **Child's name and date of birth**_____
- **Birth & Medical History:** Any complications during pregnancy or delivery, birth weight, any chronic health conditions?

  _____
  _____
  _____

- **Developmental Milestones:** Did your child sit up (6-9 mo.), crawl (6-9 mo.), walk (12-14 mo.), and speak their first words (9-12 mo.) within the general age ranges that would be considered standard according to the CDC milestones guidelines? If not please provide information.

  _____
  _____
  _____

- **Daily Routines:** Please provide us with information on sleeping habits, eating habits, and food preferences that we need to know.

  _____
  _____
  _____

- **Toilet Training:** Is your child potty trained? If not have they started to train? What is their level of independence with the routine? (can they pull down their pants, sit themselves, wipe, pull up pants, wash their hands)

  _____
  _____
  _____

Developmental History (If you need additional space for any of these questions, please feel free to use a blank piece of paper in addition to this form.)

- **Behavior & Social Skills:** Tell us about your child's temperament (e.g., shy, active), ability to self-regulate emotions, and how they interact with peers. How does your child express their emotions (e.g., tantrums, verbalizing)?

  _____
  _____
  _____

- **Communication & Interaction:** How does your child communicate (words, sign language, communication device)? Can your child speak in multi-word sentences? If so, how many words on average? Does your child respond to others when they speak to them and how does that responsiveness look?

  _____
  _____
  _____

- **Sensory & Motor Skills:** Does your child have sensitivity to textures of food or clothing? Do they avoid or seek out specific physical activities? (spinning, hanging upside down, etc.)

  _____
  _____
  _____

- **Transitions and Routines:** Does your child have difficulty with transitions or changes in routine? If yes, how do you help them through those moments?

  _____
  _____
  _____

- **Favorite Toys and Activities:** What activities or toys does your child prefer? Do they have favorite characters, books, etc.?

  _____
  _____
  _____

- Does your child have a diagnosis? If yes, what is that diagnosis?

  _____

Developmental History (If you need additional space for any of these questions, please feel free to use a blank piece of paper in addition to this form.)

- Does your child receive services through Infant Toddler Services, the school district, or any private providers? Do they have an IFSP, IEP or 504 plan? If yes, please discuss this with Shelby and provide a copy if possible so we can know how to best serve your child.

  _____

CCL. 029
Rev. 08/2024

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

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 _____

Address _____

Phone Number _____

Name _____

Address _____

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:** _____

CCL. 029a
Rev. 08/2024

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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