

Raising Wildflowers
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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

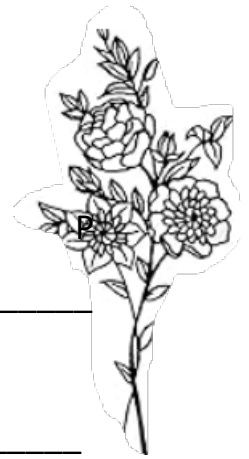
_____ Child Health Assessment

_____ 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 _____



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 #
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I authorize _____ (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 _____.
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
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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.

Permission Form for Children to go Off-Premises

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	

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.
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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 _____
First Last

Date of Birth _____ Gender _____
MM/DD/YYYY M/F

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home/Cell Phone Number _____

Home/Cell Phone Number _____

Work Phone Number _____

Work 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 _____

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: _____

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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						
	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.; 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:** _____



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

To complete the required forms, use **BOTH** of these QR codes.

Use this code to complete the **Demographic Form and Consents**:



Use this code to complete the **Ages and Stages Questionnaire's (ASQ:3 & ASQ:SE-2)**:



To complete the Ages and Stages Questionnaire's please access the following URL by typing it into your Browser or by clicking on the QR code:

<https://www.asqonline.com/family/9ba399>.

Make sure to select the first option, "I am completing both the ASQ: SE-2 and ASQ-3 questionnaires" Both assessments must be completed in full. Enter your child's DOB along with weeks premature (put "0" if not premature). Once you arrive on the home page select: "I am screening my child today" under each questionnaire type to successfully complete both requested questionnaires. Please be sure to scroll to the bottom of each page to select the green "Submit" then "Enter Results" buttons.