Start Date:_____

Days Attending:_____

Hours Attending:_____

Susanna Wesley School-Age Programs
7433 SW 29th St.
Topeka, KS 66614
785-478-3703
gabby@swumc.org

Enrollment Application for School Year 2019-2020

~ Personal Information ~

Child Name:_____ Sex: _____ Date of Birth: _____

Address: _____ Phone: _____
Street City Zip Code

Mother/ Guardian: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____
Street City Zip Code

Home E-Mail Address:_____

Occupation: _____ Place of Employment: _____ Work Phone: _____

Work Address: _____
Street City Zip Code

Work E-Mail Address:_____

Father/Guardian: _____Home Phone: _____Cell Phone: _____

Home Address: _____
Street City Zip Code

Home E-Mail Address:_____

Occupation: _____ Place of Employment: _____ Work Phone: _____

Work Address: _____
Street City Zip Code

Work E-Mail Address:_____

~ E-Mail Address ~

Please list an e-mail address(s) that you would like us to use for correspondence:

_____

~ Publicity Release ~

I grant permission for my child to be involved in publicity for Susanna Wesley School-Age Program, which may include:
(Please check any or all of those you consent to):

For Center Use Only
_____ Audio / Visual Recording
_____ Photographs for Picture CD

Other
_____ Television
_____ Newspaper
_____Social Media/Website

(over)

~ Medical Conditions ~

Does your child have any drug, food, or pet allergies or is there any other medical conditions we should be aware of:

_____

_____

_____

~ Local Emergency Pick-Up List ~

Person(s) allowed to pick up your child with parental consent, or to contact in case of inability to locate parent(s):

1. Name: _____ Relationship: _____

   Address:_____City:_____Zip:_____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Name: _____ Relationship: _____

   Address:_____City:_____Zip:_____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

~ Doctor and Hospital Information ~

Name of Doctor:_____

Address:_____ City:_____ Zip:_____

Phone Number:_____

Name of Hospital Preference in case of emergency:_____

Health Insurance Policy Name:_____ Policy Number:_____

I certify that all information on this enrollment form is correct:

Parent Signature: _____ Date: _____

A <u>non-refundable</u> one-time registration fee of $<u>55</u> must accompany this application.

How did you hear about us?

_____Capital Journal _____Friend _____Phone Book/which one: _____Sign in front of church

CCL. 358
Rev. 1/2017

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) 296-0803
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY) 08/13/2019

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	**Frequent sore throats/ colds**	**Ear Infections or Aches**	**Heart or Lung Conditions**
Skin Problems	**Asthma**	**Headaches**	**Diabetes**
Vision	**Speech/Communication**	**Hearing**	**Emotion/Behavior**
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
		If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
Single Dose Only	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

CCL 010
Rev. 8/2017

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) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
Website: www.kdheks.gov/kidsnet

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 #**
Susanna Wesley School Age South	0057315-011

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

SWCC STAFF (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 08/13/2019 (MM/DD/YYYY) and 05/21/2020 (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.

Susanna Wesley School-Age Program

Before and After School Care
Contract
Effective for School Year
2019-2020

I, _____ , contract for services with Susanna Wesley Before and After School Program for my child(ren) as specified below:

Address _____

Daytime Phone _____ Home Phone _____

Child's Name _____ Grade _____ Rate $ _____

Child's Name _____ Grade _____ Rate $ _____

Child's Name _____ Grade _____ Rate $ _____

Monthly Fees

Pick up at Indian Hills	**Full-Time (4 or 5 days per week)**
August – May	AM - $100.00 PM - $137.00 Both - $226.00
Pick Up at Farley	**Full Time (4 or 5 days per week)**
August---May	AM--$105.00 PM--$147.00 Both--$242.00

My child(ren)'s enrollment status will consist of the following: _____**Indian Hills or** _____**Farley**

_____ Before School Only AM Arrival Time_____ Departure at 8:40

_____ After School Only PM Arrival Time 3:45 Departure at _____

_____ Before and After School Both AM Arrival Time_____ Departure at 8:40
PM Arrival Time 3:45 Departure at _____

_____Drop In or Break Day

Care will begin (date): _____

(Over)

Additional Fee Information:

****Late Departure Fees**: It is the program's policy to charge an additional fee **for late pick up of $2 per minute per child with no grace period.** This fee is payable the night of the occurrence or the following morning. If fee is not paid your child(ren) will not be allowed to come until payment is made.

****Return Check Fee:** The program's policy is to charge a fee of $40.00 for returned checks. After two returned checks, cashier's check or money order will be required for payment. **We no longer accept cash for payments.**

****Late Payment:** Checks are due by the fifth of each month. After the fifth, a $20.00 late fee will be assessed. Failure to pay fees when due may result in immediate termination of services, unless other arrangements are made.

****Drop-in Policy:** If you need care on a day that your child is not currently enrolled, authorization must be given by the Director/Administrator and is limited to space available. Drop-in Care is $15.00 per session.

****Break Days:** Parents may sign a break day contract for days their child(ren) will attend. Break Days are days in which the school is out of session. The additional fee for these days is $22.00 per child if signed up by deadline. There will be a $30 fee per child for drop-in children.

Contracted Method of Payment

I agree to pay the contracted fee as stated on this contract. Please initial here: _____
Check all that apply and fill in the amount in the space provided:

_____ Semi-Monthly: (Due on the 1st and the 15th of each month): $ _____

_____ Monthly: (Due on the 1st day of each month): $ _____

_____Drop In: $15.00 per session

_____Per Break Day Contract

_____ Check here if you are interested in receiving a receipt for payments. All receipts will be e-mailed.

By signing this contract,

- I acknowledge that I have read the Susanna Wesley School-Age Handbook posted on the Susanna Wesley United Methodist Churches website www.swumc.org and agree to be bound by its policies.
- I agree to complete and return the required forms before attendance at Susanna Wesley can begin.
- I understand that I am to keep Susanna Wesley updated on any changes to my Enrollment Application and or my Contract. I also understand this may mean filling out a new Enrollment Application or Contract.

I also understand that any change in enrollment must be approved by the Director/Administrator and must be accompanied by a new Enrollment/Contract for Fees form. Any change in enrollment requires a two-week written notice period regardless of child's attendance. Tuition payment for the last two weeks needs to be given at time of notice. Susanna Wesley reserves the right to terminate this contract at any time and for any reason.

THE PROGRAM RESERVES THE RIGHT TO INCREASE FEES UPON 30-DAY NOTICE.

Mother's Signature: _____ Date: _____

Father's Signature: _____Date:_____
**Both Mother and Father's signatures are required to complete enrollment. Please speak with Administrator for special circumstances.