Susanna Wesley Preschool

7433 SW 29th St. Topeka, KS 66614 785-478-3703
swcc@swcctopeka.org

Enrollment Application for Preschool 2019 - 2020

Start Date _____

~ Personal Information ~

Please give COMPLETE address and phone information

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

Address: _____ Phone: _____
Street City Zip Code

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

Home Address: _____
Street City Zip Code

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

Work Address: _____
Street City Zip Code

Father/Guardian: _____Home Phone: _____Cell Phone: _____

Home Address: _____
Street City Zip Code

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

Work Address: _____
Street City Zip Code

~ E-Mail Address ~

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

_____

~ Publicity Release ~

I grant permission for my child to be involved in publicity for the center, which may include:
(Please **initial** any or all of those you consent to):

For Center Use Only	Other	Facebook
_____ Audio / Visual Recording	_____ Television	_____ Closed school page
_____ Photographs for the Center	_____ Newspaper	_____ Public Page

~ Medical Conditions ~

Does your child have any drug, food, or pet allergies or is there **anything else** 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):
*Please give **COMPLETE** address and phone information/**Local** contacts only*

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 ~

*Please give **COMPLETE** address and phone information*

Name of Doctor: _____

Address:_____ City:_____ Zip:_____

Phone Number:_____

Name of Hospital Preference in case of emergency:_____

Parent Signature: _____ Date: _____

A registration fee of $65 must accompany this application
Fees are NON-REFUNDABLE

How did you hear about us?

_____

Susanna Wesley Preschool Programs

Contract for Fees 2019 - 2020

I,_____, contract for services of the Susanna Wesley Preschool for my child as specified below:

Child's Name _____Age_____DOB_____

My child will attend on the following days (check one):

PRESCHOOL 2 ½ - 4 years old

_____ T/Th 9 – 11:30 a.m. (born prior to 3/1/16)

_____M/W/F 9 – 11:30 (born prior to 9/1/15)

_____ M/W/F 12:45 – 3:15 (born prior to 9/1/15)

PRE-KINDERGARTEN – 4 by 8/31/18

_____ M-F 9:00 – 11:30

_____ Extended Day –Thursday-11:30-3:15

Contracted Method of Payment

Tuition is based on a 9 month school year and is a set fee. Payments may be made yearly or monthly.
Adjustments will **not** be made for number of days attended per month, vacations, or illness.
Yearly tuition is due by August 1, 2018
Tuition is paid one month in advance and is due on the 1st. Payment is considered late and subject to a late fee on the 6th.
If payment is not received by the 10th enrollment in the program will be subject to termination.
I am eligible for the multi-child discount (10% off 2nd child) _____
Please indicate payment preference.

2 Days a week	$1305.00 yearly_____	5 Days a week	$2250.00 yearly_____
	$145.00 monthly_____		$250.00 monthly_____
3 Days a week	$1530.00 yearly_____	Extended Day Option	$405.00 yearly_____
	$170.00 monthly_____		$45.00 monthly_____

Additional Fee Information:

Late Departure Fees: It is the center's policy to charge an additional fee for late pick up. Charges are $1.00 per child per minute with no grace period.
Return Check Fee: The center's policy is to charge a fee of $40.00 for returned checks. After two returned checks, cash or money order will be required for payment.
Late Payment: A five day grace period exists for each method of payment. Payment is considered late and subject to a late fee on the 6th. If payment is not received by the 10th enrollment in the program will be subject to termination.
By signing this contract,

- I acknowledge that I have read the Susanna Wesley Preschool Handbook posted on the website www.swumc.org and agree to be bound by its policies.
- I have read this contract and agree to pay the above stated tuition and any other fees that I may incur

I also understand that any change in enrollment must be approved by the Director. **Any change in enrollment requires a two-week notice regardless of child's attendance. Tuition payment for the last two weeks will need to be given at time of notice**. No changes to the fee schedule will be approved prior to the completion of this form.

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

Completed paperwork, $65 registration fee, and September tuition must be turned into the office by August 1, 2019 for your child to keep a reserved spot. Incomplete paperwork will be returned and your child's spot will not be reserved until all paperwork is properly filled out and on file in the office.

Mother's Signature: _____Date: _____

Father's Signature: _____ Date: _____

CCL. 029
Rev. 3/2018

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

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

Susanna Wesley Preschool Illness Exclusion Policy

Child's Name: _____ DOB: _____

~ Illness / Exclusion Policy ~

Kansas State Child Care Licensing
Child Care Exclusion Policy for Sick Children

Conditions for Exclusion from Child Care	Conditions for Returning to Child Care
1. Axillary (armpit) temperature of 100.0F or higher with a behavior change.	1. Free of fever for 24 hours without use of fever-reducing medication.
2. Symptoms and signs of possible severe illness such as unusual lethargy, uncontrolled coughing, irritability, persistent crying, difficulty breathing, wheezing, or other unusual signs.	2. Symptom free or physician's written approval to return.
4. Diarrhea (two watery stools in a 4 hour period or one large volume watery stool mixed with blood).	4. Free of diarrhea (watery stools) for 24 hours and able to take food.
5. Vomiting, upset stomach with more than just "spitting up".	5. Free of upset stomach and vomiting for 24 hours and able to take food.
6. Yellowish tint to skin or eyes and/or unusually dark, tea-colored urine.	6. Symptom free or physician's written approval to return.
7. Red, watery or draining eye(s).	7. All discharge from the eye(s) has stopped or physician's approval to return.
8. Severe itching of the body or scalp and/or constantly scratching the head (i.e. lice, scabies).	8. After treatment, including free of lice and nits.
9. Infected areas of the skin with crusty, yellow, gummy, dry area or rash, (i.e.: Impetigo, Chicken Pox or Ring Worm).	9. Skin sores are healed or 24 hours after treatment has started or physician's written approval to return.
10. Fainting or seizures (other than pre-existing conditions) or general signs of listlessness, weakness, drowsiness, flushed face, headache or stiff neck.	10. Symptom free or physician's written approval to return.
11. Mouth sores with excessive drooling.	11. Physician's written approval to return.
12. Rash with fever or behavior change.	12. Physician's written approval to return.
13. Known contagious disease while in communicable stage.	13. Physician's written approval to return.

I have read and understand the above Susanna Wesley Child Care Illness and Exclusion Policy. I will abide by it's guidelines.

Parent/Guardian Signature: _____

Date: _____

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

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 Child Care Center	0000607-019

I hereby authorize Patty Jolley (Name of individual/staff member) and/or Susanna Wesley 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 _____ (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.) XXXXX

_____
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. 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

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
Susanna Wesley Child Care Center			0000607-019
Street Address of the Facility	**City**	**Zip Code**	**County**
7433 SW 29th St.	Topeka	66614	Shawnee

_____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
South grassy play area	7433 SW 29th St.	Topeka, KS		X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
East grassy play area	7433 SW 29th St.	Topeka, KS		X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Parking lot	7433 SW 29th St.	Topeka, KS		X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Sanctuary	7433 SW 29th St.	Topeka, KS		X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Atrium	7433 SW 29th St.	Topeka, KS		X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Outreach Hall	7433 SW 29th St.	Topeka, KS		X
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Susanna Wesley Preschool Program

Allergy Care Plan

Please complete and return the questionnaire below. It is also required that this form be completed, signed, and returned **even if your child has no allergies.** Thank you.

Child's Name _____

Classroom Teacher for the 2018-2019 school year _____

☐ **My child has no known allergies.**

☐ **My child is allergic to the following (please list each allergen separately):**

Allergen: _____

Symptoms to look for: _____

Action steps when symptoms appear: _____

_____

_____

Allergen: _____

Symptoms to look for: _____

Action steps when symptoms appear: _____

_____

_____

All medication and authorization forms must be on file in preschool office before child can attend.

_____	_____	_____	_____
Parent signature	Contact phone #1	Alt. Contact Phone	Date

HOME AND FAMILY INFORMATION FORM

CHILD'S NAME_____ **DOB**_____

1. Siblings (names and ages)

_____

2. Other significant adults in the family (friends, sitters, etc.) _____

_____

3. Pets (names and types)_____

4. Language(s) spoken in the home or with other family/friends _____

5. Church Home _____

6. Special fears or issues _____

7. Help needed in toileting/words your child might use to express these needs

_____

8. Has your child had peer group experiences? Where?_____

9. What creative materials does your child enjoy?_____

10. How does your child interact with other children (shy, outgoing, etc)?_____

_____

11. What do you hope your child learns in preschool this year?_____

_____

12. What is your child's favorite snack?_____

13. What other information would be helpful for us to know about your child?

_____