



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

Start Date: _____
Days Attending: _____
Hours Attending: _____

Enrollment Application for 2021 – 2022 School Year

Personal Information

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

Address: _____
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

Medical Conditions

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

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: _____ Hospital of 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 non-refundable one-time registration fee of \$65 must accompany this application.

How did you hear about us?

_____ Capital Journal

_____ Friend

_____ Sign Out Front

_____ Phone Book/which one _____



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. 28-4582(e)(2).

Name of facility exactly as stated on the license. Susanna Wesley School Age South	License # 0057315-013
----------------------------------------------------------------------------------------------	---------------------------------

I authorize _____ Elisha Haverkamp / Susanna Wesley Child Care _____ (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

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: _____
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
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 _____ by _____.
MM/DD/YYYY Name of Person

(Seal, if any.)

Signature of notarial officer

Title (and Rank)

My appointment expires: _____

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.



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)
--------------------------------------------------	------------------------	-----------------------------------	------------------------------------------------

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

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

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

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

Mother/ 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?

Select 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?
X	X	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
	DPT, DT*, TD (*DT only if child is allergic to DTP)	//	//	//	//	//
	POLIO	//	//	//	//	
	MMR	//	//			
Single Dose Only	RUBEOLA (MEASLES)	//	//			
	MUMPS	//	//			
	RUBELLA (GERMAN MEASLES)	//	//			
	HIB (Hemophilus Infl. 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
------------------------------------------	-------------



Susanna Wesley School-Age Program

Before and After School Care Contract

Effective for School Year

2021 – 2022

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

Before School: \$95/mo

After School: \$140/mo

Before and After School: \$235/mo

My child(ren)'s enrollment status will consist of the following:

_____ Before school only with arrival time of _____ am.

_____ After school only with a departure time of _____ pm.

_____ Before and after school with a morning arrival time of _____ am and afternoon departure of _____ pm.

_____ Drop-In before or after school care - \$15 / session.

_____ Break days care - \$25 / day.

Care will begin on the _____ day of _____, 20_____.

Please see reverse side for additional fee information.

Additional Fee Information:

- ❖ **Late Departure Fees:** It is the program's policy to charge an additional fee for late pick up. Fees are as follows: **\$15 for the first ten minutes and a \$1 per minute per child for each minute following, 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 \$30.00 for returned checks. After two returned checks, a cashier's check, money order or online payment will be required. **We no longer accept cash for payments.**
- ❖ **Late Payment:** Checks are due by the fifth of each month. After the fifth, a \$10.00 late fee will be assessed. Possible termination of services will be assessed if/when you receive four late fee notices. Please contact the director *immediately* if additional payment arrangements need to be 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, approval may be limited due 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 \$25.00 per child if signed up by deadline.

Contracted Method of Payment

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

_____ Bi- Weekly: (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: \$25 per day

Please initial here: _____

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 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.

THIS 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.**