Paperwork Completed _____

Rev. 1/2025

School Start Date: September 2025

ENROLLMENT FORM

ASCENSION LUTHERAN PRE-SCHOOL

Child's Full Name _____ Birthdate _____

Name to be used at school _____ Sex – M ☐ F ☐

Home Address _____ Zip Code _____

Phone Number (_____) _____ Email _____

Father's Name _____ Work Phone (_____) _____ Cell Phone (_____) _____

Mother's Name _____ Work Phone (_____) _____ Cell Phone (_____) _____

Name of Child's Doctor _____ Phone (____) _____

Emergency Contact (other than parent) _____ Phone (_____) _____

Who will be transporting him/her to and from preschool? _____

TO HELP US UNDERSTAND YOUR CHILD

Names and ages of other children in the family _____

_____

_____

_____

Father's Occupation _____

Mother's Occupation _____

Does your child have any special health problems (asthma, food allergies, etc.)? Explain:

_____

Is your child left or right-handed? _____

Church membership or religious preference: _____

How did you hear about Ascension Preschool: (please check one)

My other children attended here ☐ Friend Referral ☐ Saw on social media ☐ Other ☐

Additional information you consider important: _____

Desired Session: (check one)

☐ Mon-Wed Preschool (Mon and Wed mornings 9:00-11:15 am)

☐ Tues-Thurs Preschool (Tues and Thurs mornings 9:00-11:15 am)

☐ Mon-Wed-Fri Pre-K (Mon and Wed afternoons 1:00-3:15 pm and Fri mornings 9:00-11:15am)

☐ Tues-Thurs-Fri Pre-K (Tues, Thurs, and Fri afternoons1:00-3:15pm)

CCL.010
Rev. 07/2024

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

Kansas
Department of Health and Environment

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 #**

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**

- -

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. 029
Rev. 07/2024

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Kansas Department of Health and Environment

Medical Record

Medical History

In accordance with K.A.R. 28-4-117, a completed medical record shall be on file for all children in care under 10 years of age and all children living in the home under 16 years of age. 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_____ 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)_____

Any known allergies or medical conditions of child:_____

_____

Any major changes at home that might affect your child in care: _____

_____

Please provide 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

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:_____

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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