Thank you for your interest in enrolling at Ascension Lutheran Preschool for the 2024-2025 school year!

To enroll your child and reserve a spot in next year's class, we need you to complete the attached enrollment form (white page) with your current information and pay the $50.00 enrollment fee. The enrollment fee is what holds your spot until the fall.

Ascension Preschool
@Ascension-Preschool

venmo

The yellow health forms and the green appointment of agent form need to be returned as soon as possible. Your child won't be able to attend school in the fall until they are on file. Make sure that you sign the front and back of the general health form (the two-sided yellow form) and have your doctor fill out the other yellow form. We have included a document that lists the vaccinations required by the state of Kansas, so we hope this helps as you fill out the immunization portion of the health form. If your child does not have the appropriate number of each shot, please take them to the doctor and get these shots before you return your form.

The green appointment of agent form needs to be witnessed or notarized. (Just one of the two...not both). Also make sure to include your health insurance information. Our church secretary, Mrs. Bressler is a notary so she can notarize it and witness it for you if you like.

Our Get Acquainted Day will be Wednesday, Sept. 4 or Thursday, Sept. 5, depending which class your child is enrolled in. I will be emailing out a school calendar once all our dates are set sometime early summer. We can't wait to have your child in class next year. Thanks!

Rev. 11/2023

Paperwork Completed _____
School Start Date: September 2024

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 circle one)
My other children attended here Friend Referral Saw advertisement on church marquee Other

Additional information you consider important: _____

Session Enrolled in:	Mon-Wed Preschool 9:00-11:15am	Mon-Wed-Fri Pre-K 1:00-3:15pm (MW) 9:00-11:15am (F)	Tues-Thurs. Preschool 9:00-11:15am	Tues-Thurs-Fri Pre-K 1:00-3:15pm

CCL. 029
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
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

Kansas
Department of Health and Environment

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 September 2024 Name of Child Care Facility Ascension Lutheran Preschool

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 _____
Employer _____
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 _____
Employer _____
Work Phone Number _____
Cell 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 _____

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: _____

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:** _____

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(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 ____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:**_____

Immunization Requirements for the 2023 - 2024 School Year

K.A.R. 28-1-20 defines immunizations required for any individual who attends school or a childcare program operated by a school. Below are the requirements for the indicated school year. Please carefully review the requirements. The usual number of doses required are listed; however there are exceptional circumstances that could alter the number of doses a child needs. If you have questions about your child's immunization status, contact your child's primary care provider or local health department.

Proof of receiving the required immunizations must be provided to the school prior to the student attending the first day of school.

Early Childhood Program Operated by a School Ages 4 Years and Under

Vaccine	Requirement
DTaP/DT (diphtheria, tetanus, pertussis)	4 doses
IPV (polio)	3 doses
MMR (measles, mumps, rubella)	1 dose
Varicella (chickenpox)	1 dose*
Hepatitis A	2 doses
Hepatitis B	3 doses
Hib (haemophilus influenza type B)	4 doses**
Prevnar (pneumococcal conjugate)	4 doses**

KDG - Grade 6

Vaccine	Requirement
DTaP/DT (diphtheria, tetanus, pertussis)	5 doses
IPV (polio)	4 doses***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis A	2 doses
Hepatitis B	3 doses

Grade 7

Vaccine	Requirement
Tdap (tetanus, diphtheria, pertussis)	1 dose~
IPV (polio)	4 doses***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis A	2 doses
Hepatitis B	3 doses
Meningococcal (MenACWY)	1 dose

Grades 8-9

Vaccine	Requirement
Tdap (tetanus, diphtheria, pertussis)	1 dose~
IPV (polio)	4 doses***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis A NEW FOR GRADES 8 & 9	2 doses
Hepatitis B	3 doses
Meningococcal (MenACWY)	1 dose

Grade 10

Vaccine	Requirement
Tdap (tetanus, diphtheria, pertussis)	1 dose~
IPV (polio)	4 doses***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis B	3 doses
Meningococcal (MenACWY)	1 dose

Grades 11-12

Vaccine	Requirement
Tdap (tetanus, diphtheria, pertussis)	1 dose~
IPV (polio)	4 doses***
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis B	3 doses
Meningococcal (MenACWY)	1-2 doses See below:

Students entering 11th and 12th grade having received no previous dose of MenACWY: One dose is required for school entry and this completes the series. *Those having received one previous dose of MenACWY, **and** it has been at least 8 weeks since the first dose:* A second dose is required and this completes the series.

Notes

* Varicella (chickenpox) vaccine is not required if child has had disease **and** disease is documented by physician signature. Without a physician signature, vaccine is still required even if you believe your child has had chickenpox disease.

** Total doses needed depend on vaccine type and child's age when doses were administered.

*** Three doses are acceptable if the 3rd dose was given after 4 years of age and there are at least 6 months between the second and third doses.

~ All students in grades 7-12 must have one dose of Tdap regardless of the interval since the last dose of DTaP or Td.

Additional ACIP RECOMMENDED Vaccines Not Required for School Entry

Influenza (Flu): Annual vaccine recommended for everyone 6 months of age and older.

HPV (Human Papillomavirus) Vaccine:

2 doses recommended at age 11 years See below:

2 doses needed if series started at 11-14 years

3 doses needed if series started at 15 years or older

Provided by the Jefferson County Health Department

CCL. 029a
Rev. 05/2020

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

CCL 010
Rev. 5/2020

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

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 #**
Ascension Lutheran Preschool	0007107-001

I authorize Ascension Lutheran Preschool Staff - Kendra Herbig (*caregiver/staff*) who
Chantel Dehncke and Debbie Goltl
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 Sept. 2024 (MM/DD/YYYY) and May 2025 (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 _____ (MM/DD/YYYY) by _____ (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.