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 #**

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

______________________________ (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 ________________ and ________________.
MM/DD/YYYY 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 ________________ by ______________________________.
MM/DD/YYYY 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.

For best results, pull forms one at a time from the center of the booklet.

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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__________________________ (First / Last) Date of Birth__________________________ (MM/DD/YYYY) Gender______ (M/F)

Parent/Guardian Information	**Parent/Guardian Information**
Name__________________________	Name__________________________
Home Address__________________________ (Street / City / Zip Code)	Home Address__________________________ (Street / City / Zip Code)
Home Phone Number__________________________	Home Phone Number__________________________
Work Address__________________________ (Street / City / Zip Code)	Work Address__________________________ (Street / City / Zip Code)
Work Phone Number__________________________	Work Phone Number__________________________
Cell Phone Number__________________________	Cell Phone Number__________________________
E-mail Address__________________________	E-mail Address__________________________
Best way to contact__________________________	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:**________________

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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:**____________

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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

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Participant's Name ______________________ ID# __________

EMERGENCY/PICK-UP INFO

(PLEASE LIST PERSON/S TO CONTACT IF PARENT/GUARDIAN IS UNAVAILABLE)

Emergency Contact #1 ____________ Relationship ____________ Home Phone # ____________

Address ____________ City, State, Zip ____________ Cell/Pager # ____________

Emergency Contact #2 ____________ Relationship ____________ Home Phone # ____________

Address ____________ City, State, Zip ____________ Cell/Pager # ____________

Emergency Contact #3 ____________ Relationship ____________ Home Phone # ____________

Address ____________ City, State, Zip ____________ Cell/Pager # ____________

AUTHORIZED/PICK-UP

(PLEASE LIST ALL PERSONS, NOT LISTED ABOVE OR ON THE FRONT OF THIS FORM, AUTHORIZED TO PICK UP THE CHILD)

Name #1 ____________ Relationship ____________ Phone # ____________

Name #2 ____________ Relationship ____________ Phone # ____________

Name #3 ____________ Relationship ____________ Phone # ____________

UNAUTHORIZED/PICK-UP

(PLEASE LIST ALL PERSONS **WHO MAY NOT PICK UP THE CHILD**, COURT DOCUMENTATION MAY BE REQUIRED.)

Name #1 ____________ Relationship ____________ Phone # ____________

Name #2 ____________ Relationship ____________ Phone # ____________

Name #3 ____________ Relationship ____________ Phone # ____________

TERMS OF AGREEMENT (Your signature confirms your agreement with the following terms):

1. I/We understand that a minimum $10 late pick-up fee will be charged for each child picked up after the scheduled closing time, and an additional $1 per minute fee will be assessed after the first ten minutes. This late pick-up fee must be paid before the child(ren) can return to the program. If a child is not picked up by 6:00pm and no attempt has been made by the parent/guardian to contact the site director or YMCA, staff are required to notify their direct supervisor and call 911. Chronic late pick-up is grounds for dismissal from the CDC program. Per KDHE regulations, a child cannot attend a CDC for more than 10 hours per day.
2. I/We understand that written notice of intent to exit the program must be given to the CDC Site Director a MINIMUM OF TWO WEEKS IN ADVANCE. If adequate notice is not given, I/we understand that two weeks of full payment will be billed to my/our account even though my/our child is not in attendance. If I/we choose to return to the program, I/we understand availability is not guaranteed.
3. I/We the below signed person/parent(s) having legal custody/legal guardianship of said minor, give permission for said minor to attend any YMCA program activities supervised by authorized YMCA staff. Said minor is physically able and mentally prepared to participate in all activities, including nutrition and wellness curriculum.
4. I release the Greater Wichita YMCA, its staff and participating school districts from all claims of injury which may be sustained by enrolled child while participating in any YMCA-sponsored activity, whether caused by the negligence of the YMCA or otherwise. If medical attention is required, I give my permission for such medical care.
5. I/We do hereby grant permission for photos and/or videos of my/our child to be used by the YMCA for promotional purposes. I/We understand that I/we will receive no compensation for such use.
6. I/We understand fully and will abide by the YMCA's policy concerning drop-off and pick-up of children. I/We shall be prepared DAILY to present photo ID to on-site staff to determine my/our identity as authorized persons to pick up my/our child. Further, I/We shall inform others who are authorized to call for our child to present photo ID when picking up my/our child.
7. I/We have enclosed the $25 enrollment fee for the current school year (said fee is NONREFUNDABLE and NONTRANSFERABLE).
8. I/We understand that in the event of withdrawal from the program, my/our child's records are available to me/us upon my/our request.
9. I/We have read and understand all CDC program policies and procedures set forth by the YMCA in its CDC Enrollment Handbook. I/We shall abide by said policies/procedures and will review these with my/our child. I/We support the YMCA in its enforcement of these policies/procedures. I/We understand that the YMCA reserves the right to dismiss any participant who fails to adhere to YMCA CDC Rules and Regulations.
10. I/We agree to pay the above stated weekly fees each Monday during my/our child's enrollment in the CDC program.

____

Parent/Guardian Signature Date

Weekly payment amount ________

PROGRAM BANKDRAFT PLAN

The weekly program draft amount indicated above, less any applicable Third Party payments, will be deducted from my (check one)

☐ Checking Account
☐ Savings Account

for the YMCA CDC Program.

The bankdraft payment plan is a continuous program, however is not designed to exceed the program's end date of __________.

If I wish to exit the CDC program and/or discontinue the weekly draft before the above date, I understand that the YMCA must be NOTIFIED IN WRITING TWO (2) WEEKS PRIOR TO THE FINAL DRAFT.
Initials:_________

- Program rates are subject to change and you will be notified in writing prior to any program adjustments.
- I will notify the YMCA of any change in my bank, account, phone number or home address.
- I understand that, should any transfer not be honored by my bank for any reason, I am responsible for that payment, PLUS any service fees assessed by the YMCA. This is in addition to any service fees assessed by my bank. I also understand that I/my family will be denied access to the CDC program until the balance due is paid.
- A voided check is attached for bank information.

☐ **Please accept my signature below as authorization to begin drafting the indicated account.**

Check One:
___Parent
___Legal Guardian
___Person w/ legal custody

For Office Use Only:
Date rec'd:__________
Time rec'd:__________
Staff Initials:_________

Forms Included:
☐ YMCA Enrollment Form
☐ CCL029 (Medical Record for Day Care)
☐ CCL010 (Emergency Medical Release)

Special Instructions:

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YMCA CHILD DEVELOPMENT CENTER REGISTRATION FORM

ONE FORM PER CHILD EACH YEAR.

Additional forms available online at ymcawichita.org.

A. **$25 ENROLLMENT FEE AND COMPLETED REGISTRATION IS REQUIRED NO LESS THAN SEVEN (7) DAYS PRIOR TO ATTENDANCE.** (All applications are processed in the order received.)

B. **NO CHILD WILL BE ENROLLED WITHOUT COMPLETE RECORDS.** All necessary forms (except CACFP and Income-Based pricing application forms) are included within this handbook and MUST BE COMPLETED WITH PROPER SIGNATURES before enrollment will be accepted.

C. **A YMCA PAYMENT AGREEMENT MUST BE REVIEWED AND SIGNED ON THE FIRST DAY OF SERVICE.** (Please allow for additional time to complete food program and payment forms on your child's first day).

PARTICIPANT INFORMATION

Participant's (Child's) First and Last Name ______________________ Social Security # __ __ __-__ __-__ __ __ __

Primary Address ______________ City, State, Zip ______________ Birthdate ______________ Phone # ______________

Gender: ☐Male ☐Female

Enrollment Date: ______________ Start Date:______________

Schedule: ______AM ______PM CDC Site: ______________

Room: ☐Infant ☐Toddler ☐Pre-school ☐Pre-K

Child lives with:
- ☐ Both Parents (circle one) Same household / Shared custody
- ☐ Mother Only
- ☐ Father Only
- ☐ Guardian
- ☐ Other ______________

PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian Name ______________ E-mail Address ______________

Address (if different from participant's) ______________ City, State, Zip ______________ Home Phone # ______________

Name of (mark one): ☐Employer ☐School ☐Training ______________ Cell/Pager # ______________

Employer/School/Training Address ______________ City, State, Zip ______________ Employer/School/Training Phone # ______________

Marital Status/Custody Arrangements ______________ Work Schedule ______________

Secondary Parent/Guardian Name ______________ E-mail Address ______________

Address (if different from participant's) ______________ City, State, Zip ______________ Home Phone # ______________

Name of (mark one): ☐Employer ☐School ☐Training ______________ Cell/Pager # ______________

Employer/School/Training Address ______________ City, State, Zip ______________ Employer/School/Training Phone # ______________

Marital Status/Custody Arrangements ______________ Work Schedule ______________

SIBLING INFORMATION

(PLEASE LIST SIBLINGS AND AGES - additional names may be attached)

Sibling Name #1 ______________ Relationship ______________ Age ______________

Sibling Name #2 ______________ Relationship ______________ Age ______________

(Complete emergency contact information and sign terms of agreement statement on the back of this form.)

For Office Use Only: Rate:__________ Self:__________ 3rd Party:__________

FT / PT ☐ Student ☐ USD Employee ☐ Community

ENROLLMENT FEE

A $25 enrollment fee is due once per school year for each child participating in the CDC program. This fee is NONREFUNDABLE and NONTRANSFERABLE.

Fee is payable by:
- ☐ Check # ______ attached (payable to YMCA)
- ☐ Credit Card (Visa/MasterCard)
- ☐ Money Order (Accepted only at YMCA locations - Do not mail.)

INCOME-BASED FINANCIAL ASSISTANCE IS AVAILABLE.

Applications are available at any YMCA location, or online at ymcawichita.org. Applicant must present a federal income tax return and two most recent paycheck stubs, government assistance verification, and proof of other assistance, and a letter of denial from the DCF office. Please allow 10 business days for processing your application (see page 6 for more information).

☐ I have been awarded financial assistance from the Child Care and Camp Branch of the YMCA.

WEEKLY FEE PAYMENT

The weekly payment amount indicated on the back of this page is due on the MONDAY of the week of service. Failure to make payments in this fashion may result in dismissal from the program. A $10 late payment fee will automatically be applied for each week that a payment is late. All returned drafts/checks will be assessed a $10 return item charge, in addition to applicable late/bank fees. A money order will be required for future payments. Accounts must be current to participate in CDC programs.

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