Mater Dei Child Care Center Enrollment Form

Enrollment Information

Start Date: _____ Exit Date: _____ Days of Care Needed: Mon Tue Wed TH Fri

Hours of Care - Drop-off Time: _____ Pick-up Time: _____ [ ] Male [ ] Female

Child's Information

Full Name: _____ Date of Birth: _____

Home Address: _____ Allergies: _____

Child's Physician: _____ Phone Number: _____

Parent/Guardian Information

Mother's Name: _____ Cell Number: _____

Address: _____ Occupation: _____

Employer's Name _____ Work Number: _____

Father's Name: _____ Cell Number: _____

Home Address: _____ Occupation: _____

Employer's Name _____ Work Number: _____

Email Address: _____

Emergency Contact (Other than Parents)

Name: _____ Phone: _____ Relationship: _____

Authorized Pick-Up Persons

1. Name: _____ Phone: _____ Relationship: _____

2. Name: _____ Phone: _____ Relationship: _____

Parent/Guardian Signature

Signature: _____ Date: _____

Toddler Daily Care Information Form

Please complete this form to help us provide the most loving and consistent care for your child.

Child Information

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

Nickname (if any): _____ Classroom _____

Sleep & Nap Routine

1. How many naps does your child take each day?

☐ One nap
☐ Two naps
☐ Other: _____

2. Typical nap times (please list approximate times):

_____

3. How long does your child usually nap?

_____

4. Does your child use any of the following to sleep? (Check all that apply)

☐ Pacifier
☐ Special blanket
☐ Favorite stuffed toy (please describe): _____
☐ Other: _____

5. Does your child have a sleep routine you follow at home (rocking, singing, bottle, etc.)?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Feeding & Milk Information

1. What type of milk does your child drink? (We use whole milk for Toddles)

- ☐ Breastmilk
- ☐ Formula (Brand: _____)
- ☐ Whole milk
- ☐ 2% milk
- ☐ Other: _____

2. Does your child use a:

- ☐ Bottle
- ☐ Sippy cup
- ☐ Open cup
- ☐ Other: _____

3. Feeding schedule (times and amounts):

_____

_____

4. Are there any feeding concerns or allergies we should be aware of?

☐ Yes ☐ No

If yes, please explain:

_____

Additional Comfort or Routine Notes

Please let us know anything else that helps your child feel safe and comforted at nap or feeding time.

_____

_____

Parent/Guardian Name (Printed): _____

Signature: _____ Date: _____

Mater Dei Child Care Center
Parents Financial Agreement/Internet Banking Agreement

Name _____ Phone Home (cell) _____

Address _____ Phone (work) _____

City _____ State _____ Zip _____

Father's Email _____

Mother's Email _____

Child's Name _____ Age Group _____

Child's Name _____ Age Group _____

Mater Dei Child Care Center's Tuition Rates:

Age Group	Weekly	Bi-weekly
Toddlers	$200	$400
Pre School	$180	$360
School Ager	$180	Christmas Break & Spring Break

School-age for school Day out & Drop-in Care $50 daily if space is available
Late Fee $15 weekly/by 5:30 PM, Tuesday

I agree to pay $_____ weekly or bi-weekly (Circle one)
Yearly Registration fee of $50 per child is due on August 1st
All rates subject to change. Hours or operation: 6:30AM – 5:30PM
Two week written notice is required if withdrawing from program.

I (we) hereby authorize Mater Dei Parish hereinafter call Company to initiate debit entries to my or our ( ) checking or ( ) savings account indicate below at the depository institution named below. Hereinafter called Depository and to debit the same to such account. Debits from account will be made weekly or bi-weekly on Tuesdays. Attach a voided check if new to center or if account has changed.

Depository Name _____ City _____ Zip _____

Routing # _____ Account # _____

This authorization is to remain in full force and effect until Company has received Written Notice from me to terminate in such time and manner as to afford Company and Depository a reasonable opportunity to act on it.

_____ _____
Parent's Signature Date

_____ _____

CCL. 029
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/Childcare Licensing

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_____
First Last

Date of Birth_____ Gender___
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:_____

CCL. 029a
Rev. 06/2024

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/Childcare Licensing

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____	✓ If Normal	**Weight:** ____ LB/KG %ILE____ If Abnormal - Comments
Physical Examination		
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

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
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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 #**
Mater Dei Child Care Center	0000238

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.

ENROLLMENT/INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Food Assistance Program (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	**Case Number or Identification Number**

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	Today's Date	Print Name of Adult Signing
X________________________________	______________	Social Security Number (SSN) (last four digits) XXX-XX- ☐ Check if no SSN

Address	City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced Price ☐ Paid

Household Size: _____

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Determining Official **Today's Date**

X_____ _____
Signature of Confirming Official **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.

CCL 034
Rev. 3/2020

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

Kansas

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
Mater Dei Child Care Center			238-020
Street Address of the Facility	**City**	**Zip Code**	**County**
911 SW Clay	Topeka	666606	Shawnee

First and Last Name of Child or Youth may go to the following locations off the premises with adult supervision:

Place	Street Address	City	By Vehicle	Walk/Bike
4 block distance around Center		Topeka		✓
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Mater Dei Church	1114 SW 10th	Topeka		✓
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Mater Dei School	934 SW Clay	Topeka		✓
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Topeka Public Library	1515 SW 10th	Topeka	✓	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Garfield Pool	1600 NE Quincy	Topeka	✓	
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
GA Frozen Cust	1301 SW 6th Ave	Topeka		✓
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Bowling West Ridge	1935 SW West Port Dr.			
Signature of Parent or Guardian			**Date Signed**	