בית שלום
CONGREGATION
Beth Shalom

ROSE FAMILY Early Childhood Education Center
14200 Lamar Avenue • Overland Park, Kansas 66223 • www.bethshalomkc.org
School (913) 647-7285 • Synagogue (913) 647-7279 • Fax (913) 647-7278

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The ultimate place to learn, love and grow

EMERGENCY INFORMATION

(Please fill out as completely as possible)

TODAYS DATE: _____

CHILD'S NAME _____ **DATE OF BIRTH** _____ **WEIGHT** _____

HEBREW NAME _____ **NICKNAME** _____

NAME FOR CUBBIES _____

ALLERGIES _____

WHAT IS THE REACTION? _____

PARENT 1 NAME _____	**PARENT 2 NAME** _____
HEBREW NAME _____	HEBREW NAME _____
HOME ADDRESS _____	HOME ADDRESS _____
_____	_____
CELL PHONE _____	CELL PHONE _____
E-MAIL ADDRESS _____	E-MAIL ADDRESS _____
PLACE OF EMPLOYMENT _____	PLACE OF EMPLOYMENT _____
PHONE _____	PHONE _____
OCCUPATION/TITLE _____	OCCUPATION/TITLE _____

PEDIATRICIAN'S NAME _____ PHONE _____

ADDRESS _____

HOSPITAL PREFERENCE _____

IN CASE OF AN EMERGENCY *(PARENTS WILL BE NOTIFIED FIRST)*, PLEASE LIST EMERGENCY CONTACTS WE CAN REACH BESIDE YOURSELVES ***(PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY WITH ANY CHANGES)****:*

1) _____ HOME PHONE _____

RELATIONSHIP _____ CELL PHONE # _____

2) _____ HOME PHONE _____

RELATIONSHIP _____ CELL PHONE # _____

3) _____ HOME PHONE _____

RELATIONSHIP _____ CELL PHONE # _____

INITIAL _____

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STUDENT INFORMATION SHEET

CHILD'S NAME _____

ARE THERE ANY PHYSICAL PROBLEMS OR LIMITATIONS WE SHOULD KNOW ABOUT? _____

_____

DOES YOUR CHILD TAKE ANY MEDICATIONS REGULARLY? IF SO, PLEASE LIST THE NAME(S), THE DOSE, AND THE REASON FOR THE MEDICATION.

_____

_____

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES IN THE PAST?_____

_____

PLEASE LIST CONTAGIOUS DISEASES AND DATES_____

_____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? WHEN? FOR HOW LONG? FOR WHAT? _____

_____

BROTHERS AND SISTERS:

NAME	BIRTHDATE	SCHOOL ATTENDING

WHAT WOULD YOU LIKE YOUR CHILD TO GET OUT OF THIS YEAR'S SCHOOL EXPERIENCE?

_____

_____

_____

_____

_____

_____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SCHOOL EXPERIENCE? _____

WHAT ARE YOUR CHILD'S FEARS?_____HOW DOES HE/SHE REACT TO THEM?_____

HOW DO YOU COMFORT YOUR CHILD?_____

HOW DO YOU DISCIPLINE YOUR CHILD?_____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SPEECH AND LANGUAGE DEVELOPMENT?_____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S MOTOR DEVELOPMENT? _____

HAS YOUR CHILD EVER HAD A SPEECH & LANGUAGE, MOTOR OR BEHAVIORAL EVALUATTION? YES_____NO_____

IF ANSWER IS YES, BY WHAT AGENCY AND DOES YOUR CHILD RECEIVE THERAPY?_____

IS THERE ANY INFORMATION THAT WE SHOULD HAVE TO BE MORE EFFECTIVE WITH YOUR CHILD? HOW CAN WE BE OF THE MOST HELP TO YOU? _____

ANY OTHER ADDITIONAL CONCERNS?_____

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NEW STUDENT INFORMATION SHEET

Child's Name _____

Parents Names _____

Were there any concerns at birth?

_____

_____

_____

When did your child first sit up? _____

When did your child first crawl? _____

When did your child first walk? _____

First Words? _____

What were they? _____

Does your child speak in complete sentences? _____

What language do you speak at home? _____

Other than Beth Shalom, are there any previous Nursery School, camp or day care experiences your child has had? If so, where and how long? Was it a positive experience?

_____

_____

_____

_____

_____

OVER

Has your child been left with a baby sitter? ____Yes ____No. How often?_____

_____

Anything special or concerns we should know about your child? _____

_____

_____

_____

_____

_____

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STUDENT INFORMATION SHEET

CHILD'S NAME _____

ARE THERE ANY PHYSICAL PROBLEMS OR LIMITATIONS WE SHOULD KNOW ABOUT? _____

_____

DOES YOUR CHILD TAKE ANY MEDICATIONS REGULARLY? IF SO, WHAT, HOW MUCH AND FOR WHAT? _____

_____

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES IN THE PAST? _____

_____

PLEASE LIST CONTAGIOUS DISEASES AND DATES _____

_____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? WHEN? FOR HOW LONG? FOR WHAT? _____

_____

BROTHERS AND SISTERS:

NAME	BIRTHDATE	SCHOOL ATTENDING

WHAT WOULD YOU LIKE YOUR CHILD TO GET OUT OF THIS YEAR'S SCHOOL EXPERIENCE?

_____

_____

_____

_____

_____

_____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SCHOOL EXPERIENCE? _____

WHAT ARE YOUR CHILD'S FEARS? _____ HOW DOES HE/SHE REACT TO THEM? _____

HOW DO YOU COMFORT YOUR CHILD? _____

HOW DO YOU DISCIPLINE YOUR CHILD? _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SPEECH AND LANGUAGE DEVELOPMENT? _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S MOTOR DEVELOPMENT? _____

HAS YOUR CHILD EVER HAD A SPEECH & LANGUAGE, MOTOR OR BEHAVIORAL EVALUATTION? YES_____NO____

IF ANSWER IS YES, BY WHAT AGENCY AND DOES YOUR CHILD RECEIVE THERAPY? _____

IS THERE ANY INFORMATION THAT WE SHOULD HAVE TO BE MORE EFFECTIVE WITH YOUR CHILD? HOW CAN WE BE OF THE MOST HELP TO YOU? _____

ANY OTHER ADDITIONAL CONCERNS? _____

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Toddler, Mini-School & 3's Questionnaire

Child's Name _____

Can your child have juice? _____Yes _____No

Do you dilute the juice? _____Yes _____No

Can your child have popcorn? _____Yes _____No

Can your child have raw carrots? _____Yes _____No

Can your child have raw celery? _____Yes _____No

*We serve 2% milk with snacks. ***If you would like your child to have something other than this, you will need to supply it.* Please let the teacher know.***

What raw fruits does your child eat? _____

_____

What vegetables does your child eat?_____

_____

What are your child's favorite foods? _____

_____

Is your child toilet trained? _____ Yes _____ No

If not, are they in _____Diapers_____Pull-ups

Terminology used to express toileting needs_____

_____

Does your child have a security item? _____ Yes _____ No

What is it? _____

What does your child call it? _____

Does your child use a _____pacifier, _____blanket, _____stuffed animal?
Please make sure your child has this/these items at school during the day for security*.

Is there anything else you would like us to know?_____

_____

_____

_____

<u>Please update our staff or the director as this information changes.</u>

CCL 010
Rev. 2/2010

Kansas Department of Health and Environment
Child Care Licensing and Registration Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785)296-1270 Fax: (785)296-0803
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) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate.	**License or Certificate #**
Beth Shalom Early Childhood Education Center	005-7829-003

I hereby authorize Beth Shalom (Name of individual/staff member) and/or Director / Staff (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 beginning of care (MM/DD/YYYY) and care terminated (MM/DD/YYYY).

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature [redacted]

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: _____

Complete information regarding health care insurance, if applicable.

Health Insurance Policy Name: _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

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.

CCL. 029
Rev. 8/2011

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 296-0803
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_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Work Address_____
Street City Zip Code

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_____

Work Address_____
Street City Zip Code

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

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:_____

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
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Physician Signature		Date of Illness:	
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
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:

_____DTP ____Pertussis Only ____Tetanus ____Polio ____MMR ____Rubella Only ____Hep A _____Hep B

Hib _____PCV7 ____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. 08/2011

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/KB % 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. 035
Rev. 3/2017

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 Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS GROUP OF CHILDREN TO ONE LOCATION

Name of Facility (exactly as stated on the license)			License #
Beth Shalom Early Childhood Center			0057829-012
Street Address of Facility	**City**	**Zip Code**	**County**
14200 Lamar Ave	OP	66223	Johnson

Children or Youth listed below may go on an off-premise trip to: Freedom Bank

Located at: 6640 W. 143 St (Street) Overland Park (City) Johnson (County)

on AS NEEDED IN CASE OF EMERGENCY (MM/DD/YYYY)

Time of Departure: _____ Estimated Time of Return: _____

Children or Youth will be traveling by: _____ Vehicle X Walking

Children or Youth will be supervised at all times by the following staff:

Staff Name Judy Jacks Berman (First Last) Staff Name Debbie Beznovsky (First Last)

Staff Name Phyllis Kalender (First Last) Staff Name _____ (First Last)

FIRST AND LAST NAME OF CHILD OR YOUTH	PARENT/GUARDIAN SIGNATURE GRANTING PERMISSION (Include First and Last Name)

CCL. 034
Rev. 3/2017

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 Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
Beth Shalom Early Childhood Center			0057829-012
Street Address of the Facility	**City**	**Zip Code**	**County**
14200 Lamar Ave	Overland Park	66223	Johnson

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

Place	Street Address	City	By Vehicle	Walk/Bike
Goldsmith Hall	14200 Lamar Ave	OP		(Walk circled)
Signature of Parent or Guardian →			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Downstairs Library	14200 Lamar Ave	OP		(Walk circled)
Signature of Parent or Guardian →			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			**Date Signed**	

Over The Counter Medication Permission Form

We, _____,
(names of parents)
give permission to the Nursery School administration and staff to administer the following OTC medications to our child, _____as deemed necessary by the Director or her assistant. The staff will attempt to call for your approval.

Child's Weight: _____

_____Children's Tylenol (Acetaminophen) **_____Dosage**

_____Benadryl **_____Dosage**

_____Children's Advil (Ibuprofen) **_____Dosage**

_____Calamine Lotion

_____Sunscreen

_____ _____
Signature Date

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PICK UP AUTHORIZATION 2019-2020

No child will be turned over to an adult other than a parent unless we have written authorization from you. Please complete the following authorization, affix your signature and return it to the school as soon as possible. Please make sure this is updated as your arrangements change.

My child _____ is to go home **ONLY** with the following family members, friends or other care givers: Please provide cell phone numbers below.

_____ Cell Number _____ Relationship _____

_____ Cell Number _____ Relationship _____

_____ Cell Number _____ Relationship _____

_____ Cell Number _____ Relationship _____

_____ Cell Number _____ Relationship _____

_____ Cell Number _____ Relationship _____

ADDITIONAL COMMENTS:

_____

(Parent's Signature) (Date)

****Remember: Please send a note if anyone other than your carpool will be taking your child home****

PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY IF THERE IS ANY CHANGE IN CARPOOL AUTHORIZATION.

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Payment Options Plan

METHOD OF PAYMENT - Please check one

_____ One Payment - Paid in full by August 15, 2019

_____ Two Payments - 50% due by August 15, 2019 and the balance by December 15, 2019

_____ Check or

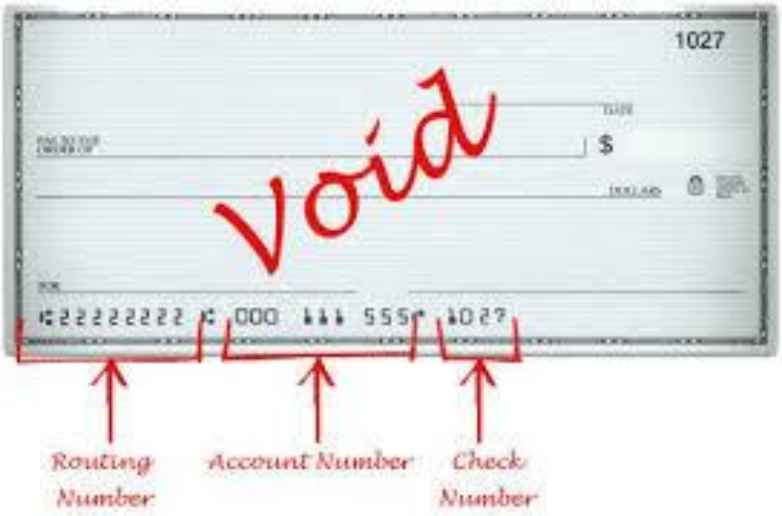
_____ Credit Card Payment - Processed 15th of every month or next business day
Visa, Mastercard or Discover
- **MAXIMUM of two payments per year will be accepted.**

Credit Card # _____Expiration Date _____CVC_____

_____ Nine Payments – 1/9 due every month, August 2019 through April 2020

Automatic Bank Transfer (ABT) - Processed 20th of each month, or next business day
- Automatically withdrawn from checking or savings account

Please provide a VOIDED check that shows your bank routing and account number.



Printed Name _____

Signature _____ Date _____