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

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 _____

HEBREW NAME _____

HOME ADDRESS _____

_____

CELL PHONE _____

E-MAIL ADDRESS _____

PLACE OF EMPLOYMENT _____

PHONE _____

OCCUPATION/TITLE _____

PARENT 2 NAME _____

HEBREW NAME _____

HOME ADDRESS _____

_____

CELL PHONE _____

E-MAIL ADDRESS _____

PLACE OF EMPLOYMENT _____

PHONE _____

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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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

Can your child have cucumbers? _____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 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?_____

_____

_____

_____

Please update our staff or the director as this information changes.

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	O.P.	66223	Johnson

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

Located at: 6640 W. 143rd St. (Street) Overland Park (City), KS 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 Melisa Gum (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

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.	O.P.		
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Downstairs Library	14200 Lamar Ave.	O.P.		
Signature of Parent or Guardian			**Date Signed**	

Place	Street Address	City	By Vehicle	Walk/Bike
Playroom	14200 Lamar Ave	O.P.		
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**	

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:**_____

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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Payment Options Plan

METHOD OF PAYMENT - Please check one

_____ One Payment - Paid in full by August 15, 2020

_____ Two Payments - 50% due by August 15, 2020 and the balance by December 15, 2020

_____ Check or

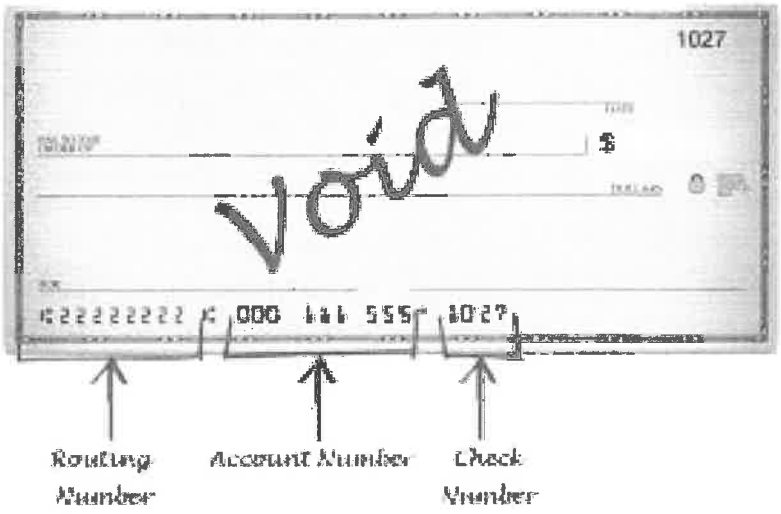
_____ Credit Card Payment - Processed 15th of every month or next business day
Visa, Mastercard or Discover
- **MAXIMUM of two payments per year will be accepted.**

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 _____

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PICK UP AUTHORIZATION 2020-21

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.