THE PLAYHOUSE

GENERAL INFORMATION

Child's Name:	Date of Birth:

Parent/Guardian 1	**Parent/Guardian 2**
Name:	Name:
Phone Number:	Phone Number:
Address:	Address:

In the event that a parent/guardian cannot be contacted, please list one person who can be notified in the case of an emergency.

Name:	Phone:	Relationship:

Please list all people who can pick your child up from care without written consent from a parent/guardian.

1.	2.
3.	4.

AGREED-UPON SCHEDULE AND PAYMENT

The agreed-upon payment amount is $_____ and is due at the start of the _____.

Monday	Tuesday	Wednesday	Thursday	Friday
7:30 - 11:30 □	7:30 - 11:30 □	7:30 - 11:30 □	7:30 - 11:30 □	7:30 - 11:30 □
11:30 - 4:30 □	11:30 - 4:30 □	11:30 - 4:30 □	11:30 - 4:30 □	11:30 - 4:30 □
7:30 - 4:30 □	7:30 - 4:30 □	7:30 - 4:30 □	7:30 - 4:30 □	7:30 - 4:30 □

PAYMENT TERMS

- **Payment Due Date:** Payment is due on the first day of each payment period.
- **Absences:** The payment is the same regardless of absences due to illness, holidays, vacations, or other reasons.
- **Paid Time Off:** We are entitled to 10 days of paid vacation, with advance notice provided regarding vacation dates. We also receive 5 paid sick days.
- **Paid Holidays:** The following days are recognized as paid holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve, Christmas Day, the day after Christmas, and New Year's Eve.

PARENT RESPONSIBILITIES

- **Attendance Communication:** Inform the provider in advance if your child will not be attending, if you will be late, or if you need to pick up early.
- **Authorized Pick-Up:** Notify the provider if someone else will be picking up your child and ensure they have proper identification.
- **Health and Safety:** Ensure that your child is in good health and free of contagious illnesses before arrival.
    - Provide necessary immunization records, medical information, and emergency contacts.
    - Keep your child’s health and immunization records up to date and provide any necessary updates to the provider.
- **Emergency Contact Information:** Keep your contact information and emergency contacts up-to-date and notify the provider of any changes.
- **Confidentiality:** Respect the confidentiality of other children and families in the preschool. Do not share personal or sensitive information regarding other children.
- **Drop-Off and Pick-Up Times:** Adhere to the established drop-off and pick-up times, and notify the provider in advance if changes are needed.
- **Timely Payments:** Make payments on time according to the agreed-upon schedule. Late payments may incur a fee, and failure to make timely payments could result in the termination of care.

LATE POLICIES

- **Late Pick-Up:**
  A $5.00 late fee will be charged for pick-ups made after the designated pick-up window. After the first 5 minutes, a $1.00 per minute charge will apply. Example: If pick-up occurs at 11:36 AM, the late fee will be $6.00.
- **Late Payment:**
  Payments not received by the first day of the month will incur a $5.00 late fee for each additional day. If your child is absent on the first scheduled day, payment is expected on the second scheduled day. If the absence extends beyond the first day, payment arrangements should be made as soon as possible.

SICK CHILD POLICY

- **Illness:**
  Health Department regulations prohibit children with contagious illnesses from being in group care. If your child becomes ill during the day, you will be contacted immediately and asked to pick them up. Please refer to the sick policy for details regarding when a child needs to be excluded from care.
- **Medication:**
  The provider can only administer medication with written authorization, which must include the medication name, dosage, time, and reason for administration. A prescription label is acceptable. Forms for both short-term and long-term medications will be provided.

TERMINATION OF AGREEMENT

Either party may terminate this agreement with two weeks' notice or by making an equivalent tuition payment in lieu of notice. Both parties retain the right to terminate the agreement immediately if there is a substantial violation of the terms.

By signing below, both parties acknowledge and agree to the terms outlined in this contract.

	Signature	Date
Parent/Guardian 1		
Parent/Guardian 2		
Provider 1		
Provider 2		

CCL. 029
Rev. 08/2024

Child Care Licensing Program
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/ChildCareLicensing

Kansas Department of Health and Environment

Medical Record

Medical History

In accordance with K.A.R. 28-4-117 and K.A.R. 28-4-430, a completed medical record shall be on file for all children in care. For a Family Child Care Home, children under 10 years of age and all children living in the home under 16 years of age, a medical record shall be completed. 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 _____ Date of Birth _____ Gender _____
First Last 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): _____

Known allergies or medical conditions: _____

Major changes at home that might affect your child in care: _____

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 (describe): _____

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 Care Licensing Program
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_____		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 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

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/ChildCareLicensing

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 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.

Photo Release Form

Dear Parents/Guardians,

During the course of the year, photos taken at The Playhouse may be posted onto The Playhouse's website/social media. Please choose whether or not you consent to pictures including your child being posted onto the website/social media.

Please sign and return this form.

☐ Yes, I consent for my child to appear on The Playhouse's website/social media.

☐ No, I do not consent for my child to appear on The Playhouse's website/social media.

_____ _____

Signature Date

_____

Child's Name