INMAN AFTER SCHOOL PROGRAM

Student Enrollment Form

Student Information

Legal Name _____ Preferred Name _____

DOB _____/_____/_____ Gender M/F Grade Level _____

Race: African American / American Native / Alaska Native / Asian / Native Hawaiian / Hispanic

Pacific Islander / White

T-Shirt Size Youth _____ Adult _____

Parent/Guardian Student resides with _____

Home Address _____ City _____ Zip Code _____

Mailing Address _____ City _____ Zip Code _____

Home Phone (_____) _____ Student Cell Phone (_____) _____

Home E-Mail _____

Names/Grade Levels of Siblings

_____ _____

_____ _____

_____ _____

Parent/Guardian Information

Parent #1 _____ Phone No. (_____) _____

Relationship to Student _____ Live with student at physical address ☐ Yes ☐ No

Employer _____

Work E-Mail _____ Work Phone No. (_____) _____

Parent #2 _____ Phone No. (_____) _____

Relationship to Student _____ Live with student at physical address ☐ Yes ☐ No

Employer _____

Work E-Mail _____ Work Phone No. (_____) _____

Parent #3 _____ Phone No. (_____) _____

Relationship to Student _____ Live with student at physical address ☐ Yes ☐ No

Employer _____

Work E-Mail _____ Work Phone No. (_____) _____

Parent #4 _____ Phone No. (_____) _____

Relationship to Student _____ Live with student at physical address ☐ Yes ☐ No

Employer _____

Work E-Mail _____ Work Phone No. (_____) _____

Child Name: _____

Additional STUDENT EMERGENCY CONTACT INFORMATION (non-parent/guardian)

Other Emergency Contact _____

Relationship to Student _____ Phone No. (_____) _____

Other Emergency Contact _____

Relationship to Student _____ Phone No. (_____) _____

Other Emergency Contact _____

Relationship to Student _____ Phone No. (_____) _____

Days attending program:

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Inman After School Program Pick-up Authorization Form

Child's Name _____

Parent/Legal Guardian _____

Please list any individual you wish to authorize to pick up your child from our program this school year. If you need to make changes to this list, please contact us and keep the list current. Appropriate ID must be shown at pick up.

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any individual NOT authorized to pick up your child from the after-school program.

1. _____
2. _____

I, _____, attest that I have filled out the above information. I understand that I must give prior notice to the Inman After School Program if anyone other than the above-listed individuals is to pick up my child.

Parent Signature _____ Date _____

Inman After School Program Activity/Photo Release

I, _____, the undersigned parent or legal guardian of _____, do hereby give my permission for my child to participate in the scheduled activities of Inman After School Program. Furthermore, I hereby release and discharge Inman After School Program, and its authorized representatives, board members, council members, and professional or volunteer staff from all liability of any kind which might be asserted in behalf of said minor or to myself against the aforementioned program, its authorized representatives, board members, council members, and professional or volunteer staff, absent of gross negligence or willful and wanton misconduct. Finally, in the event of an accident or medical emergency, if the said staff or representatives are unable to contact me as legal guardian, I hereby grant permission to said staff or representatives to administer necessary first aid, and/or take said minor to the nearest medical facility for additional medical treatment.

I give the Inman After School Program permission to photograph my child participating in the After School Program activities and use those photographs in promotional materials for the program.

_____ *(Please initial)*

Parent Signature _____ Date _____

Inman After School Program Parent Handbook Acknowledgment

I, _____, the undersigned parent/guardian of _____, have received and reviewed the parent handbook for the Inman After School Program. I agree to/understand the following:

- I understand the rules and regulations of the Inman After School Program and will help my child to follow them.
- I understand that if I have any questions about the rules and regulations and how they are applied, I may ask a staff member at any time.
- I understand that the Inman After School Program provides a snack as part of the program, and that I will notify the staff of my child's food allergies.
- I understand that my child will not be allowed to leave the building unless I, or a person I have designated ahead of time, have signed him/her out.
- I understand that I must provide written authorization in order for Inman After School staff to dispense medication to my child.
- I understand that it is my responsibility to keep my child's records current to reflect any significant changes as they occur.
- I understand that I will be informed of any incidents, including illness, injury, exposure to communicable disease, and behavioral problems, that include my child.

Parent Signature _____ Date _____

Health Information

If my child has a minor issue, such as headache, I give Inman After School Program staff permission to give children's over-the-counter medication such as Tylenol or Advil to my child.

(Parent signature) _____

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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

Kansas
Department of Health and Environment

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

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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 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

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: _____
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**

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: _____

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.