CHRIST LUTHERAN EARLY EDUCATION CENTER

11720 Nieman Road, Overland Park, KS 66210

APPLICATION FOR ENROLLMENT

2021-2022

For office use only

Age	Full day
3	☐
4	☐
Pre-K	☐

CHRIST LUTHERAN EARLY EDUCATION CENTER
APPLICATION FOR ENROLLMENT

Student's Name: _____ Date of Birth: _____

Check the session(s) you are interested in enrolling your child based upon availability.

Full Day: 3 – 5 year old 8:00am – 4:30pm Complete this section only.* Select a minimum of 2 full days.

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Extended Day Options: * Minimum of 2 days per option

Before Care: 8:30-9:00 am ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Lunch Bunch: 11:45-3:30 pm ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Parent's Day Out: **2 ½ - 3 ½ year old** **9:00-11:30am Half Day** **9:00-2:30pm Full Day**

Monday ☐Half Day ☐Full Day Tuesday ☐Half Day ☐Full Day

Wednesday ☐Half Day ☐Full Day Thursday ☐Half Day ☐Full Day

Friday ☐Half Day ☐Full Day

Preschool: **Students who are 3 or 4 by September 1st** **9:00-11:30am**
Students must be potty trained and able to use the bathroom independently.

☐3 Year Old Tuesday & Thursday Class ☐*3 Year Old Monday & Wednesday Class*
(Interested in M/W- if available)

☐4 Year Old Monday-Wednesday-Friday Class ☐4 Year Old Tuesday-Thursday-Friday Class

AM Pre-K: **5 years old by October 31st** **9:00-11:30am (must attend all four days)**

☐Monday, Tuesday, Wednesday, Thursday

Lunch Bunch: **11:30am -2:45 pm** ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday
Minimum of 2 days

STUDENT INFORMATION

Student's Legal Name: _____ Nickname: _____

☐ Boy ☐Girl Birth Date: __/__/____ Home Phone: _____

Street Address: _____

City & State: _____ Zip Code: _____

Primary email address to use for correspondences: _____

Church child attends: _____ Baptized: ☐Yes ☐No

Mother/Guardian

Name: _____Relationship to Student: _____

Street Address: _____

City & State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer: _____Work Phone: _____

Church Affliation:_____

Father/Guardian

Name: _____Relationship to Student: _____

Street Address: _____

City & State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer: _____Work Phone: _____

Church Affliation:_____

STUDENT INFORMATION continued

Does student live with both parents? (Please check one.)☐ Yes☐No

If no, please provide the following information on the non-custodial parent:

Name: _____

Relationship to student: _____

Address: _____City/State_____

Phone: _____ Cell Phone:_____

Email: _____

Does the non-custodial parent have permission to pick up the student? YES NO

If no, please complete the following Explanation of Custodial Arrangement: (Attach a copy of the court order specifying restrictions_____

_____

_____

SOCIAL HISTORY

Siblings:

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Tell us how your child interacts with parents, siblings and/or other members in the household:

_____

_____

SOCIAL HISTORY continued

Other children in the neighborhood? _____

Has child received extensive care by someone other than parents? _____

By whom? _____ In own home or outside home? _____

Has child had group-play experiences such Story Time, MOPS, or Sunday School, etc.?_____

_____

Special remarks concerning the child: (example: challenges, needs or fears) _____

_____

_____

_____

CONTACTS

Person(s) **other than** parents authorized to take your child from school*:

Name: _____Relationship: _____

Home Phone: _____Cell Phone: _____

Address: _____City & State_____

Name: _____Relationship: _____

Home Phone: _____Cell Phone: _____

Address: _____City & State _____

*Both parents will be assumed to have permission to take the child unless written revocation is submitted.

HEALTH INFORMATION

List medication(s) taken regularly: _____
(Note: proper physician permission forms must be on file if medication is to be administered during school day.)

List previous hospitalizations or surgery: _____

Does the student have or had he/she had the following medical problem(s):

a. Serious allergies (medication, food, insect bites) ……☐Yes ☐No
b. Seizures ……☐Yes ☐No
c. Headaches or migraines……☐Yes ☐No
d. Serious head injury or loss of consciousness ……☐Yes ☐No
e. Asthma or difficulty breathing with exercise ……☐Yes ☐No
f. Hearing loss (tubes) ……☐Yes ☐No
g. Speech difficulty/therapy ……☐Yes ☐No
h. Diagnosis or attention deficit disorder……☐Yes ☐No
i. Other (diabetes, heart disease, cancer, bladder infections, etc.) ……☐Yes ☐No

**If so, please specify: _____

Does the student experience emotional or behavioral challenges that impact their daily life? If so, please describe: ____

_____

_____

_____

Does the student have a health disability that impacts education, requires special equipment, therapy or assistance? If yes, please describe: _____

_____

Person to be called in case of need (other than mother, father or guardian) if parent/guardian can't be reached:

Name: _____ Phone: _____

Signature of parent or guardian_____ Date_____

Please be sure to complete the *Authorization for Emergency Medical Care* on the next page.
This form must be notarized.

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

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 #**
Christ Lutheran Early Education Center	**0007159-018**

I authorize **Christ Lutheran Early Education Staff** ______________________ (*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 **06/01/2021** (MM/DD/YYYY) and **07/31/2022** (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.