CHRIST LUTHERAN EARLY EDUCATION CENTER

11720 Nieman Road, Overland Park, KS 66210

APPLICATION FOR ENROLLMENT

2023-2024

For office use only

Age	Full day
3	☐
4	☐
Pre-K	☐

CHRIST LUTHERAN EARLY EDUCATION CENTER
APPLICATION FOR ENROLLMENT 2023-2024

Student's Name: _____ **Date of Birth:** _____

The session(s) have been marked according to the preferences indicated on the Enrollment Request form.

Full Day Multi-age Class: 3 & 4 year old 8:30am – 3:30pm

My child is reliably potty trained. ☐ Yes ☐ No

☐**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

Preschool: **Students who are 3 or 4 by September 1st** **9:00-11:30am**
Students must be reliably potty trained and able to use the bathroom independently.
My child is reliably potty trained. ☐Yes ☐No

☐3 Year Old **Monday & Wednesday** Class ☐3 Year Old **Tuesday & Thursday** Class

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

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

☐**Monday, Tuesday, Wednesday, Thursday**

Friday Discovery: **9:00-11:30am**

☐Friday

Extended Day Options:

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

***Lunch Bunch:** 11:30am-2:30pm ☐Monday/Wednesday ☐Tuesday/Thursday
**Minimum of 2 days per week.*

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

Would you like a pastor to contact you? ☐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:

_____

_____

HEALTH INFORMATION

Any concerns for possible delays in speech, motor skills, hearing, vision or other physical limitations? _____
If yes, please describe:_____

Has the student ever been screened or identified for special services (speech/language, sensory, occupational therapy)? _____ If so, please explain _____
Is your child receiving any services through an outside agency?_____

Any allergies, asthma, or other health concerns? If so, please list and explain procedure for care: _____

_____

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. Asthma or difficulty breathing with exercise ..... ☐Yes ☐No
e. Serious head injury or loss of consciousness ..... ☐Yes ☐No
f. Hearing loss (tubes) ..... ☐Yes ☐No
g. Speech difficulty/therapy ..... ☐Yes ☐No
h. Diagnosis of attention deficit disorder..... ☐Yes ☐No
i. Other (diabetes, heart disease, cancer, bladder infections, etc.) ..... ☐Yes ☐No

**If so, please specify: _____

Any significant problems during pregnancy or at birth (including prematurity):_____

_____

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.
<u>This form must be notarized</u>.

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.

CCL 010
Rev. 5/2020

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	0007159-021

I authorize Christ Lutheran Early Education Center 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 06/01/2023 (MM/DD/YYYY) and 06/01/2024 (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 _____ (MM/DD/YYYY) by_____ (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.