Munchkin Academy Contract

CHILD INFORMATION

Child's Name:		Date of Birth:	
I'm enrolling my child in the following session:			
Monday through Friday	Morning ☐	Afternoon ☐	Full Day ☐
Tuesday & Thursday	Morning ☐	Afternoon ☐	Full Day ☐
Monday, Wednesday, & Friday	Morning ☐	Afternoon ☐	Full Day ☐

PARENT/GUARDIAN'S INFORMATION

Parent/Guardian 1	Parent/Guardian 2
Full Name:	Full Name:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Home Address:	Home Address:

EMERGENCY INFORMATION

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 to Child:

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

1.	2.
3.	4.

GENERAL INFORMATION

Hours	Half-Day Pricing	Full-Day Pricing
Morning: 7:30 am - 11:30 am	Mon. - Fri.: $795 per month	Mon. - Fri.: $1,400 per month
Afternoon: 12:30 pm - 4:30 pm	Mon., Wed., & Fri.: $540 per month	Mon., Wed., & Fri.: $960 per month
Full Day: 7:30 am - 4:30 pm	Tue. & Thur.: $360 per month	Tue. & Thur.: $680 per month

Payment is due by cash or check on the first day of each month that your child attends.

The payment is the same each month, regardless of absences due to illness, holiday, vacation, etc. We reserve the right to 10 days of paid vacation. We will provide you with ample notice of when we plan to take vacation. We are paid for 5 sick days. The days we are closed on and paid for are as follows: New Years Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, Christmas Eve, Christmas Day, the day after Christmas, and New Year's Eve.

PARENT RESPONSIBILITIES:

- Bring and pick up your child at the times agreed upon.
- Call or text in advance if your child will not be here or if you will be arriving late or picking up early.
- Call if someone else is to pick up your child and make sure they have identification.
- Comply with the Sick Child Policy and Late Policy.

Session 1/AM	Session 2/PM	Full Day
Arrival: 7:30 am - 7:45 am	Arrival: 12:30 pm - 12:45 pm	Arrival: 7:30 - 7:45 am
Dismissal: 11:15 am - 11:30 am	Dismissal: 4:15 pm - 4:30 pm	Dismissal: 4:15 - 4:30 pm

LATE POLICY:

Late Pick Up

We charge a $5.00 late fee for anytime after the pick up window. After the first 5 minutes late, it's an additional $1.00 per minute. For example, pick up at 11:36am would be $6.00 extra.

Late Payment

Payment is required on the first day of the month that your child attends. A $5 late fee will apply for each additional day that we do not receive payment. If your child is absent on the first day of their scheduled attendance, this does not apply, and payment will be expected on their second day of scheduled attendance. However, if they will be missing more than that initial day, arrangements should be made to make payment at the earliest convenience.

SICK CHILDREN:

Health Department regulations prohibit a contagious child in group care. If your child becomes sick during the day, you will be notified and expected to pick up your child immediately. Please refer to the "Sick Child Policy" for further details on illness. We can only give medication if we have written authorization including what is to be given, when, dosage and why medication is needed. A prescription label is acceptable. We will provide forms for both short-term and long-term medications.

TERMINATION:
This agreement may be terminated by either party with two weeks notice or with equivalent tuition payment. Both parties reserve the right to terminate without notice if the other party is in substantial violation of the agreement. Both parties agree to accept this agreement as a binding contract.

This contract voids any previous contracts. This contract is in effect until December 31st, 2024.

Parent Signature:	Date:
Provider Signature 1:	Date:
Provider Signature 2:	Date:

CCL. 029
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
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

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are 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 Phone Number_____

Employer_____

Work Phone Number_____

Cell Phone Number_____

E-mail Address _____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Employer_____

Work Phone Number_____

Cell 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 _____ Name _____
Address _____ Address _____
Phone Number _____ Phone Number _____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows: _____

_____

_____

Any known allergies or medical conditions of child:

_____

_____

Any major changes at home that might affect your child in care:

_____

_____

Please provide additional information or special instructions that will help the person caring for your child:

_____

_____

Parent/Guardian Signature:_____ **Date:**_____

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
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 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(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 ____HepA _____HepB ____Hib
_____PCV ____Varicella ____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:**_____

CCL. 029a
Rev. 05/2020

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

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 Licensed Day Care Homes, Group Day 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. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

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 sheets if necessary) ☐ None	
Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

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 #**

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.

Photo Release Form

Dear Parents/Guardians,

During the course of the year, photos taken in the classroom may be posted onto Munchkin Academy'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 Munchkin Academy's website/social media.

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

_____ _____

Signature Date

_____

Child's Name