



# Munchkin Academy Contract

Please read over this contract. Sign, date, and return this copy to the provider. The provider will keep this contract on file and you will receive a copy of this signed contract.

## CHILD INFORMATION

Child's Name:		Date of Birth:	
I'm enrolling my child in the following session:			
Monday through Friday	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Full Day <input type="checkbox"/>
Tuesday & Thursday	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Full Day <input type="checkbox"/>
Monday, Wednesday, & Friday	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Full Day <input type="checkbox"/>

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

1.	2.
3.	4.

## GENERAL INFORMATION

### Hours

Morning: 7:30 am - 11:30 am  
Afternoon: 12:30 pm - 4:30 pm  
Full Day: 7:30 am - 11:30 pm

### Half-Day Pricing

Mon. - Fri.: \$175 per week  
Tue. & Thur.: \$80 per week  
Mon., Wed., & Fri.: \$120 per week

### Full-Day Pricing

Mon. - Fri.: \$325 per week  
Tue. & Thur.: \$150 per week  
Mon., Wed., & Fri.: \$225 per week

Payment is due by cash or check on Monday of each week (or Tuesday if your child attends Tu/Th).

The payment is the same each week, regardless of absences due to illness, holiday, vacation, etc. We will take 10 days of vacation- 5 of those being paid, 5 being unpaid. We will provide you with ample notice of when we plan to take vacation. We do not give ourselves any paid 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, Christmas Eve, and Christmas Day.

### 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. This fee will be added to the next week's payment.

#### Late Payment

Payment is required on the first day of the week that your child attends. A \$5 late fee will apply for each additional day that we do not receive payment. For example, if your child is on a Tues/Thurs schedule, payment is due Tuesday, if payment is not received until Thursday, an additional \$10 will be added. If your child is absent on the first day of their scheduled attendance, this does not apply, and payment would 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 for that week 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 31<sup>st</sup>, 2022.

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



**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 \_\_\_\_\_  
First Last

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
MM/DD/YYYY M/F

**Parent/Guardian Information**

**Parent/Guardian Information**

Name \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City Zip Code

Home Address \_\_\_\_\_  
Street City Zip Code

Home Phone Number \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

E-mail Address \_\_\_\_\_

Best way to contact \_\_\_\_\_

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 \_\_\_\_\_

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					
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>
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: \_\_\_\_\_

### 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): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> 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) <input type="checkbox"/> 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 _____		



**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 #
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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
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Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
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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.

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Signature

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Date

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Child's Name