Enrollment Contract

2333 Crestline Drive, Lawrence, KS 66047
Ph: 785-856-1622 - Fx: 785-856-1626 - LCDCenter.Org

I _____ contract for the services of L.C.D.C. for the care of my child as specified:
(Print Parent Name)

		Hourly *(1 to 5 Hours)*	Daily Rate *(6 - 10 Hours)*	Weekly Rate *(Up to 12 Hours Per Day, Cannot convert to Hourly)*	Monthly
Infants	2 Weeks to 1 Year	$15 / hour	$85 / Day	$275 / Week	$1100/ Month
Toddlers	1 to 3 Years	$15 / hour	$75 / Day	$240 / Week	$950/ Month
Pre-School School-age	3 and up	$15 / hour	$65 / Day	$200 / Week	$800/ Month

Registration Fee: $100 per Child **Deposit:** 1 Weeks Tuition

(For first weeks Total Tuition, Please speak with Administrative Staff)

***Does not include up to 4% surcharge for credit card payments.*

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

Start Date: _____ **Primary Phone #:** _____

The Center's hours of operation are from 6:30 am to 6:00 pm, Monday through Friday.

My Child will attend the center following Days and Times:

Monday _____ To _____

Tuesday _____ To _____

Wednesday _____ To _____

Thursday _____ To _____

Friday _____ To _____

I agree to pay the Lawrence Child Development Center the amount indicated above for child care services. I understand and agree to pay any additional fees if my child is at the center over the regularly scheduled time. I understand that I will be billed monthly or weekly for child care services regardless of absence and that payment is due Monday. I will give the center two weeks' notice informing of the day the child will be withdrawn. In failing to do so, I will still pay for my child's last week attendance and the tuition deposit will be used as stated in the parent's guide book. If legal costs are concurred by non-compliance of the center's policies, it will be my responsibility to cover all of the court expenses.

Parent Signature: _____ Date: _____

Director Signature: _____ Date: _____

Child & Adult Care Food Program

If the following information is on file on other center forms, you do not need to use this form

CACFP ENROLLMENT FORM

Child's Name: _____

Date of Birth: _____

_____

Parent Signature

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

For Center Use Only

Date Enrolled: _____

Date Terminated: _____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is Prohibited from discriminating on the basis of race, color, national origin, sex. Age, or disability. To file a complaint of discrimination. Write USDA. Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 independence Avenue, SW. Washington. O.C. 20250-g410 0r call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Children's Admission Record

Child's Name: _____ Date of Birth: _____

Admission Date: _____ Termination Date: _____

Parent's Information

Home Address: _____

Guardian Name: _____ Phone Number: _____

- Employer: _____ Work Phone: _____

Guardian Name: _____ Phone Number: _____

- Employer: _____ Work Phone: _____

Emergency Contacts

Name:_____ Relation:_____

- 1st Phone: _____ 2nd Phone: _____

Name:_____ Relation:_____

- 1st Phone: _____ 2nd Phone: _____

Name:_____ Relation:_____

- 1st Phone: _____ 2nd Phone: _____

Persons Authorized to Pick up Child *(Full name as shown on ID, Must show ID to Pick Up Child)*

Name:_____ Name:_____

Name:_____ Name:_____

Name:_____ Name:_____

Name:_____ Name:_____

Developmental Questionnaire

Began Crawling: _____ Sat Alone: _____

Walked: _____ Named Simple Objects: _____

Slept through the night: _____ Right or Left Handed: _____

Does child dress self? _____ Undress Self? _____

Wash and dry hands? _____ Brush Teeth: _____

Began toilet training: _____ Use toilet Independently: _____

Family Questionnaire

Parental Marital Status: Married Separated Divorced Step-Parent

Is the Child Adopted? Yes No Age at Adoption: _____

Does the Child Have Siblings Living in the Household? *(names and ages):* _____

_____

Other Members of Household (include relationship): _____

_____

Has child had group care experience? _____ Where? _____

What method of behavior control is used at home? _____

Child's usual reaction: _____

Food or Other Restrictions: _____

_____

Medical Information

Primary Physician: _____ Physician Phone: _____

Child have Health Insurance? ☐ Yes No ☐ Carrier: _____

Health ID Number: _____ Group Number: _____

Allergies: _____

_____

Consent to have child Treated in case of Emergency *(Print Name)*: _____

I agree to pay all costs and fees incurred for medical treatment as authorized by this consent. I agree to hold Carbondale Child Development Center LLC. harmless for any childhood illness or injury incurred by my child as a result of routine participation in the Center's activities. The information on the Center's required forms is current and accurate to the best of my knowledge. I will promptly notify the Center of any changes.

Parent/Guardian Signature: _____ Date: _____

Director's Signature: _____ Date: _____

The Parents Guidebook is the Center's good-will to the parents. It offers a clear picture of the center's philosophy and addresses the questions most often asked: policies, tuition, fees, etc. The Director has explained the Center's Policies and has reviewed the Parents Guidebook with the parents in order to provide protection and legal documentation for the parents and for the Center.

I agree to abide by these rules and regulations.

Parent's Signature	Date
Director's Signature	Date

CHILD DEVELOPMENT CENTER
LAWRENCE
A Child's Place

Parental Consent And Release Form

Childs Name: _____ Gender: _____ Date of Birth: _____

Address: _____ Home Phone: _____

Parent or Guardian: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Local Emergency person(s) allowed to pick up child with Parental Consent or to contact in case of inability to locate parent(s):

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Child's Physician: _____ Physician Phone: _____

Physician Address: _____ Hospital Preference: _____

Drug or Food Allergies: _____

Publicity Release:

I grant permission for my child to be involved in publicity for the Center, which may include:

(Please check any or all of those you consent to)

Audio ☐ Television ☐ Tape Recording ☐

Photographs ☐ Newspaper ☐ Handiwork ☐

_____ _____

Parent Signature Date

Developmental Assessments

I grant permission for my child to take part in developmental assessments, which will be conducted twice a year. A parent conference will follow each assessment so that any information on my child's developmental progress may be shared.

Parents/Guardian Signature Date:

Activities and Equipment Release

I Grant Permission for my child to use all play equipment, material, and participate in all activities of the center.

Parents/Guardian Signature Date:

Release for Routine Trips Pursuant to K.A.R. 28-4-124

I grant permission for my child to take part in routine trips away from the center premises under the supervision of staff member of the center. This could include walks, rides in strollers, play on the playground, ect. Transportation, if needed, will be provided by vans which are equipped with necessary seat belts. I agree to provide a car seat for my child when requested. Parents will be notified in advance of field trips and special activities, with exception of routine walks. Permission for each routine trip will be granted by signature(s) and dates on the following:

1 Routine Walking Trips within a 1 mile radius of the Center.

Parents/Guardian Signature Date:

2 Gage Park / Topeka Zoo. 6th and Gage.

Parents/Guardian Signature Date:

3 Lawrence Outdoor Aquatic Center / South Park Wading Pool / Indoor Aquatic Center

Parents/Guardian Signature Date:

Child and Adult Care Food Program
ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.				
Child's Name	**Birthdate**	**Age**	**Circle Normal Days/ Print Normal Hours of Care**	**Circle Meals and Snacks Normally Received**
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— **Any household member receiving benefits can establish eligibility for all children in the household.**	**Case Number or Identification Number**

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.	

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

List names (First and Last) of everyone in your household, including foster children	Tell us how much and how often. If no income, write "0". Use net income if self-employed.														
	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	**Today's Date**	**Print Name of Adult Signing**
X____	____________________	**Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN
Address	**City/State/Zip Code**	**Daytime Phone**

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW
Washington, D.C. 20250-9410

FAX: 202-690-7442
EMAIL: program.intake@usda.gov

***Only use this address if you are filing a complaint of discrimination.**

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced Price ☐ Paid

Household Size: _____

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Determining Official **Today's Date**

X_____ _____
Signature of Confirming Official **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective 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(d)].

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. 029
Rev. 8/2013

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) 296-0803
Website: www.kdheks.gov/kidsnet

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_____

Work Address_____
Street City Zip Code

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_____

Work Address_____
Street City Zip Code

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

Best way to contact_____

Names and ages of children in family_____

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary._____

_____

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:

_____

Does your child have any of the following conditions (yes or no)? If yes, provide information on Authorization for Emergency Medical Care form CCL. 010.

☐ Allergies ☐ Frequent sore throats/colds ☐ Ear Aches
☐ Asthma ☐ Speech, Visual, Hearing ☐ Diabetes
☐ Epilepsy/Seizures ☐ Other_____

If yes answered to any above, please provide additional information_____

Have there been major changes at home that might affect your child in care? ◉ No ○ Yes, as follows:

_____

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

_____

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

CCL. 029a
Rev. 8/2013

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/KB %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. 8/2013

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) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
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 #**
Lawrence Child Development Center	736-72

I hereby authorize Teresa Prost, Kenneth Prost, Isabella Bevitt, Brenda Cooper, Chakrya Prost, Sarah Haper (Name of individual/staff member) and/or

_____ (Name of individual/staff member) 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 _____

_____ (First and Last Name of Child or Youth) while said child or youth is in said facility's

custody between the dates of _____ and _____.
MM/DD/YYYY MM/DD/YYYY

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: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

_____

_____

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: _____

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.

CCL. 037
Rev. 8/2013

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) 296-0803
Website: www.kdheks.gov/kidsnet

Guidelines for Exclusion of Children (or Staff Working With Children) Who Are Ill
As Recommended in *Caring for Our Children: National Health and Safety Standards: Guidelines for Out-of-Home Child Care Programs (Third Edition)*

When formulating exclusion policies, it is reasonable to focus on the needs and behavior of the ill child and the ability of staff in the out-of-home child care setting to meet those needs without compromising the care of other children in the group.

Children with fever are managed differently in child care. The presence of fever alone has little relevance to the spread of disease and may not preclude a child's participation in child care. A small proportion of childhood illness with fever is caused by life-threatening diseases, such as meningitis. It is unreasonable and inappropriate for child care staff to attempt to determine which illnesses with fevers may be serious. The child's parents or legal guardians, with the help of their child's health care provider, are responsible for these decisions. Parents should be notified anytime a child has a fever.

A facility should not deny admission to or send home a child because of illness unless one or more of the following conditions exists. The parent, legal guardian, or other person authorized by the parent should be notified immediately when a child has a sign or symptom requiring exclusion from the facility, as described below:

1) **The illness prevents the child from participating comfortably in facility activities;**

2) **The illness results in a greater care need than the child care staff can provide without compromising the health and safety of the other children; or**

3) **The child has any of the following conditions and poses a risk of spread of harmful diseases to others:**

   A. An acute change in behavior including lethargy/lack of responsiveness, irritability, persistent crying, difficulty breathing, uncontrolled coughing, noticeable (spreading) rash, or other signs or symptoms of illness until medical evaluation indicates inclusion in the facility.
   B. Fever (temperature above 101 degrees Fahrenheit orally, above 102 degrees Fahrenheit rectally, or 100 degrees or higher taken auxiliary (armpit)) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). Oral temperature should not be taken on children younger than 4 years (or younger than 3 years if a digital thermometer is used). Rectal temperature should be taken only by persons with specific health training.
   C. Uncontrolled diarrhea, that is, increased number of stools, increased stool water, and/or decreased form that is not contained by the diaper until diarrhea stops; blood or mucus in the stools not explained by dietary change, medication, or hard stools.
   D. Vomiting illness (two or more episodes of vomiting in the previous 24 hours) until vomiting resolves or until a health care provider determines the illness to be non-communicable, and the child is not in danger of dehydration.
   E. Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness.
   F. Mouth sores with drooling, unless a health care provider or health official determines the condition is noninfectious.
   G. Rash with fever or behavior change, until a health care provider determines that these symptoms do not indicate a communicable disease.
   H. Purulent conjunctivitis (defined as pink or red conjunctiva with white or yellow eye discharge), until 24 hours after treatment has been initiated.
   I. Untreated scabies, head lice, or other infestation.
   J. Untreated Tuberculosis, until a health care provider or health official states that the child can attend child care.
   K. Known contagious diseases while still in the communicable stage (chicken pox, streptococcal pharyngitis, rubella, pertussis, mumps, measles, hepatitis A).

CCL. 011
Rev. 8/2013

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) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
Website: www.kdheks.gov/kidsnet

Child Health Assessments

Your child should be seen during the preschool years by a health professional according to the following schedule:

At Birth	6 Months	18 Months	Then 1
1 Month	9 Months	24 Months	per year
2 Months	12 Months		until the
4 Months	15 Months		age of 20

Every child should be seen at least 13 times from birth to school entry. A careful examination of the eyes and ears should be included in the assessment.

Dental Health

A child's initial visit to a dentist should take place within 6 months after the first tooth can be seen, but no later than 1 year of age. Following the initial visit, regular check-ups should be scheduled every 6 months (or twice a year).

In communities where the drinking water is not fluoridated, a dentist should be consulted about an age appropriate fluoride treatment plan.

Social-Emotional Health

Caring for your child's social and emotional health is also an essential part of raising a healthy child. To learn more about age appropriate development tasks as well as ideas for encouraging healthy social and emotional growth, visit: www.brightfutures.org/mentalhealth/pdf/tools.html#families.

Safety

Providing your child with a safe environment to grow is an important part of raising a healthy child. For information about safety precautions and more, visit: www.kdheks.gov/safekids.

Well-Child Visits Should Include

A. Discussion of your child's physical and behavior problems with the physician.

B. A Health Assessment of your child by the physician or nurse approved to perform Health Assessments.
(including important screenings such as vision, hearing and blood tests)

C. Immunizations

- Make sure your child has the necessary immunizations for his/her age. This is important for your child's health.
- Many childhood diseases can be prevented with regular health care visits and up-to-date immunizations.
- Discuss with your child's physician the appropriate course of immunizations.
- Your child's physician will also provide you with Vaccine Information Statements (VISs) prepared by the Centers for Disease Control (CDC) regarding certain vaccinations your child will be given.
- Repeat immunizations as recommended by the Kansas Department of Health and Environment. Your child's physician may also discuss new vaccines with you as they become available.

D. Discussion of your child's health history since the last visit.

E. Written instructions concerning your child's care, diet and recommendations for the solution of any special health problems.

F. Referrals when necessary to other persons for special services.

G. Appointment for next Well-Child Visit.

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at day care homes and centers across the country. Providers are reimbursed for serving nutritious meals that meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities

Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- Child Care Centers: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- Family Day Care Homes: Licensed or approved private homes.
- Afterschool Care Programs: Centers in low-income areas provide free snacks to school-age children and youth.
- Homeless Shelters: Emergency shelters provide food services to homeless children.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following children:

- children age 12 and under,
- migrant children age 15 and younger, and
- youths through age 18 in afterschool care programs in needy areas.

Contact Information

If you have questions about CACFP, please contact one of the following:

Macon County Schools
VIP and SEC Program
PO Box 1029
Franklin, NC 28744
(828) 524-4414

CACFP Unit Manager
Department of Health and Human Services
Division of Public Health
Nustrition Services Branch
1914 Mail Service Center
Raleigh, NC 27699
919-707-5799

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