



NEW STUDENT INFORMATION SHEET

Child's Name _____

Parents Names _____

Were there any concerns at birth?

When did your child first sit up? _____

When did your child first crawl? _____

When did your child first walk? _____

First Words? _____

What were they? _____

Does your child speak in complete sentences? _____

Other than Beth Shalom, are there any previous Nursery School, camp or day care experiences your child has had? If so, where and how long? Was it a positive experience?

Has your child been left with a baby sitter? ____ Yes ____ No. How often? _____

Anything special or concerns we should know about your child? _____



**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

Parent/Guardian Information

Name _____

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Work Address _____
Street City Zip Code

Work Address _____
Street City Zip Code

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 _____

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: _____

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 st	2 nd	3 rd	4 th	5 th	6 th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Physician Signature		Date of Illness:	
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
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:
 _____DTP _____Pertussis Only _____Tetanus _____Polio _____MMR _____Rubella Only _____Hep A _____Hep B
Hib _____PCV7 _____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/KB %ILE _____	
Physical Examination	<input checked="" type="checkbox"/> 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	



Toddler, Mini-School & 3's Questionnaire

Child's Name _____

Can your child have juice? _____ Yes _____ No

Do you dilute the juice? _____ Yes _____ No

Can your child have popcorn? _____ Yes _____ No

Can your child have raw carrots? _____ Yes _____ No

Can your child have raw celery? _____ Yes _____ No

We serve 2% milk with snacks. If you would like your child to have something other than this, you will need to supply it.* Please let the teacher know.

What raw fruits does your child eat? _____

What vegetables does your child eat? _____

What are your child's favorite foods? _____

Is your child toilet trained? _____ Yes _____ No

If not, are they in _____ Diapers _____ Pull-ups

Terminology used to express toileting needs _____

Does your child have a security item? _____ Yes _____ No

What is it? _____

What does your child call it? _____

Does your child use a _____ pacifier, _____ blanket, _____ stuffed animal?
Please make sure your child has this/these items at school during the day for security*.

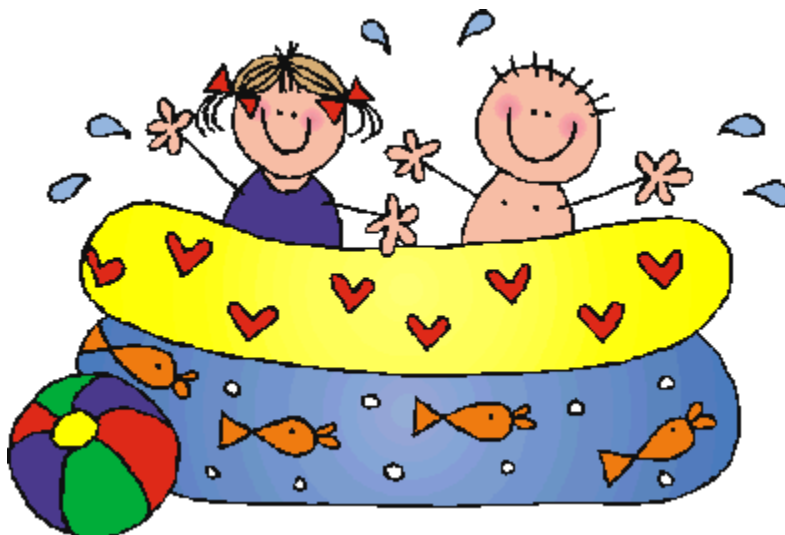
Is there anything else you would like us to know? _____

Please update our staff or the director as this information changes.

CAMP SUPPLY LISTS

TODDLERS & MINI SCHOOL	THREE'S FOUR'S FIVE'S
2 Complete changes of clothes (<i>labeled</i>) including underwear & socks in a <i>zip-lock bag</i> with child's name on front	Complete change of clothes (<i>labeled</i>) including underwear & socks in a <i>zip-lock bag</i> with <i>child's name on front</i>
Swim diapers and a bathing suit	Bathing suit
Swim shoes or sandals with heel strap (that can get wet)	Swim shoes or sandals with heel strap (that can get wet)
1 box of tissues	1 box of tissues
Towel (<i>labeled</i>)	1 box of wipes (refills ok)
A special animal or blankie to help your child feel comfortable	Towel (<i>labeled</i>)
A package of disposable diapers if not using the toilet regularly	1 picture of your child
A cup with a top (Toddlers only) to be sent home each day for washing	Backpack or canvas tote bag
1 picture of your child	
Backpack or canvas tote bag	

**** Please label everything! ****





ROSE FAMILY Early Childhood Education Center
 14200 Lamar Avenue • Overland Park, Kansas 66223 • www.bethshalomkc.org
 School (913) 647-7285 • Synagogue (913) 647-7279 • Fax (913) 647-7278



EMERGENCY INFORMATION
(Please fill out as completely as possible)

TODAYS DATE: _____

CHILD'S NAME _____

DATE OF BIRTH _____ WEIGHT _____

HEBREW NAME _____

NICKNAME _____

NAME FOR CUBBIES _____

ALLERGIES _____

WHAT IS THE REACTION? _____

PARENT 1 NAME _____

PARENT 2 NAME _____

HEBREW NAME _____

HEBREW NAME _____

HOME ADDRESS _____

HOME ADDRESS _____

HOME PHONE _____

HOME PHONE _____

CELL PHONE _____

CELL PHONE _____

E-MAIL ADDRESS _____

E-MAIL ADDRESS _____

PLACE OF EMPLOYMENT _____

PLACE OF EMPLOYMENT _____

PHONE _____

PHONE _____

OCCUPATION/TITLE _____

OCCUPATION/TITLE _____

PEDIATRICIAN'S NAME _____ PHONE _____

ADDRESS _____

HOSPITAL PREFERENCE _____

IN CASE OF AN EMERGENCY (PARENTS WILL BE NOTIFIED FIRST), PLEASE LIST EMERGENCY CONTACTS WE CAN REACH BESIDE YOURSELVES (PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY WITH ANY CHANGES):

1) _____ HOME PHONE _____

RELATIONSHIP _____ CELL PHONE # _____

2) _____ HOME PHONE _____

RELATIONSHIP _____ CELL PHONE # _____

3) _____ HOME PHONE _____

RELATIONSHIP _____ CELL PHONE # _____

INITIAL _____



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STUDENT INFORMATION SHEET

CHILD'S NAME _____

ARE THERE ANY PHYSICAL PROBLEMS OR LIMITATIONS WE SHOULD KNOW ABOUT? _____

DOES YOUR CHILD TAKE ANY MEDICATIONS REGULARLY? IF SO, PLEASE LIST THE NAME(S), THE DOSE, AND THE REASON FOR THE MEDICATION.

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES IN THE PAST? _____

PLEASE LIST CONTAGIOUS DISEASES AND DATES _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? WHEN? FOR HOW LONG? FOR WHAT? _____

BROTHERS AND SISTERS:

<u>NAME</u>	<u>BIRTHDATE</u>	<u>SCHOOL ATTENDING</u>
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WHAT WOULD YOU LIKE YOUR CHILD TO GET OUT OF THIS YEAR'S SCHOOL EXPERIENCE?

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SCHOOL EXPERIENCE? _____

WHAT ARE YOUR CHILD'S FEARS? _____ HOW DOES HE/SHE REACT TO THEM? _____

HOW DO YOU COMFORT YOUR CHILD? _____

HOW DO YOU DISCIPLINE YOUR CHILD? _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SPEECH AND LANGUAGE DEVELOPMENT? _____

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S MOTOR DEVELOPMENT? _____

HAS YOUR CHILD EVER HAD A SPEECH & LANGUAGE, MOTOR OR BEHAVIORAL EVALUATION? YES _____ NO _____
IF ANSWER IS YES, BY WHAT AGENCY AND DOES YOUR CHILD RECEIVE THERAPY? _____

IS THERE ANY INFORMATION THAT WE SHOULD HAVE TO BE MORE EFFECTIVE WITH
YOUR CHILD? HOW CAN WE BE OF THE MOST HELP TO YOU? _____

ANY OTHER ADDITIONAL CONCERNS? _____



PARENTAL PERMISSION FORM FOR OFF-PREMISE TRIPS
GROUP OF CHILDREN TO ONE LOCATION

Name of the facility exactly as stated on the license or certificate <u>Beth Shalom Early Childhood Education Center</u>		License/Certificate # <u>0057829-003</u>	
Street Address of the Facility <u>14200 Lamar Ave.</u>	City <u>Overland Park</u>	Zip Code <u>66223</u>	County <u>Johnson</u>

Children or Youth listed below may go on an off-premise trip to: Freedom Bank
 Located at: 6640 W. 143rd St. Overland Park, KS Johnson
Street City County
 on as needed in case of emergency evacuation for any reason
we feel is necessary.
 Time of Departure: I.C.E. Estimated Time of Return: I.C.E.

Children or Youth will be traveling by: Car Walking

Children or Youth will be supervised at all times by the following staff:
 Judy Jacks Berman, Debbie Beznovsky, Mindi Squire, Susie Blackman, Cathy Newman, Kerry Kuluva,
 Estelle Edelbaum, Staci Kahn, Michele Frumkin, Kristy Schaefer, Sunni Rosenbloom, Meredith Nye, Vicki
 Diamond, Sharon Rosenthal, Laura Galler, Connie Simon, Stephanie Kolb, Jana Kirke, Sharon Waxman,
 Heather Wipperman, Linda Gibian

Child's First and Last Name

Parent/Guardian First and Last Name – printed

Parent/Guardian Signature **Date**

CCL.035
Rev. 9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 296-0803
Website: www.kdhe.state.ks.us/kidsnet/



PARENTAL PERMISSION FORM FOR OFF-PREMISE TRIPS
GROUP OF CHILDREN TO ONE LOCATION

Name of the facility exactly as stated on the license or certificate <u>Rose Family Early Childhood Education Center</u>		License/Certificate # <u>0057829-001</u>	
Street Address of the Facility <u>14200 Lamar Ave.</u>	City <u>Overland Park</u>	Zip Code <u>66223</u>	County <u>Johnson</u>

Children or Youth listed below may go on an off-premise trip to: Goldsmith Haller Computer Room

Located at: Beth Shalom ^{Street} Other side of building or downstairs ^{City}
on Various times and days ^{County}
~~(ATTN:DBA*****)~~

Time of Departure: VARIES Estimated Time of Return: VARIES

Children or Youth will be traveling by: _____ Car Walking

Children or Youth will be supervised at all times by the following staff:

Judy Jacks Berman, Susie Blackman, Vicki Diamond, Michele Frumkin, Laura
Galler, Dayna Gershon, Barb Jacobs, Amy Jacobson, Julie Kadosh, Jana
Kirke, Tanya Kramarovsky, Jennifer Levy-Mackay, Meredith Nye, Ellen
Polisky, Sunni Rosenbloom, Norine Rosenblum, Sharon Rosenthal, Deah Rubin,
Connie Simon and Rachel Warner.

Child's Name

Parent's Signature

Date



MEDIA & PERSONAL INFO WAIVER

1. I hereby give my consent to the school to publish my personal contact information on (but not limited to) class and school rosters.

_____ Yes _____ No

2. I hereby give my consent to the school to post pictures of my child on Facebook.

_____ Yes _____ No

3. I hereby give my consent to the school to have my child's picture in the school's Shutterfly album. This is sent weekly in email form to parents of the children in the school only.

_____ Yes _____ No

4. I hereby give my consent to the school to publish my child's picture in the school yearbook.

_____ Yes _____ No

Student's Name

Date

Signature of Parent/Guardian

Print Parent/Guardian Name



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) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate. <u>Beth Shalom Early Childhood Education Center</u>	License or Certificate # <u>005-7829-003</u>
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I hereby authorize Beth Shalom (Name of individual/staff member) and/or
Director / Staff (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 beginning of care and care terminated
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	Date Signed
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Notarization of Parent's or Guardian's signature ~~_____~~

<u>State of Kansas</u>
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: _____

Complete information regarding health care insurance, if applicable.

Health Insurance Policy Name: _____ Policy Number _____
Medical Assistance Program _____ Card Number _____
Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

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

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.



Over The Counter Medication Permission Form

We, _____,
give permission to the Nursery School administration and staff
to administer the following OTC medications to our child, _____
_____, as deemed necessary by
the Director or her assistant and after phone approval from one
of us.

_____ **Children's Tylenol** _____ **Dosage**
 (Acetaminophen)

_____ **Benadryl** _____ **Dosage**

_____ **Children's Advil (Ibuprofen)** _____ **Dosage**

_____ **Antibiotic First Aid Cream/Spray**

_____ **Calamine Lotion**

_____ **Sunscreen**

Signature

Date



PICK UP AUTHORIZATION 2016-2017

No child will be turned over to an adult other than a parent unless we have written authorization from you. Please complete the following authorization, affix your signature and return it to the school as soon as possible. Please make sure this is updated as your arrangements change.

My child _____ is to go home **ONLY** with the following family members, friends or other care givers:

_____	Phone Number _____	Relationship _____
_____	Phone Number _____	Relationship _____
_____	Phone Number _____	Relationship _____
_____	Phone Number _____	Relationship _____
_____	Phone Number _____	Relationship _____
_____	Phone Number _____	Relationship _____

ADDITIONAL COMMENTS:

(Parent's Signature) (Date)

****Remember: Please send a note if anyone other than your carpool will be taking your child home****

PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY IF THERE IS ANY CHANGE IN CARPOOL AUTHORIZATION.