



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 _____

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 _____



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.



**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: _____

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	✓ 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	

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: _____



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? _____

What language do you speak at home? _____

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? _____



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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>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? _____



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

Can your child have cucumbers? _____ 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 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.



PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #	
Beth Shalom Early Childhood Center			0057829-012	
Street Address of the Facility	City	Zip Code	County	
14200 Lamar Ave.	Overland Park	66223	Johnson	

_____ may go to the following locations off the premises with adult supervision:

First and Last Name of Child or Youth

Place Goldsmith Hall	Street Address 14200 Lamar Ave.	City O.P.	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place Downstairs Library	Street Address 14200 Lamar Ave.	City O.P.	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place Playroom	Street Address 14200 Lamar Ave	City O.P.	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	



Over The Counter Medication Permission

We, _____,
(names of parents)

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. The staff will attempt to call for your approval.

Child's Weight: _____

_____ Children's Tylenol _____ Dosage
(Acetaminophen)

_____ Benadryl _____ Dosage

_____ Children's Advil (Ibuprofen) _____ Dosage

_____ Calamine Lotion

_____ Sunscreen

Signature

Date

Personal Information Waiver

I hereby give my consent to the school to share my personal contact information to school and class rosters.

_____ Yes _____ No

Student's Name _____ Date _____

Signature of Parent/Guardian _____

Print Parent/Guardian Name _____



David M. Glickman
Senior Rabbi

Hazzan Tahl Ben-Yehuda
Director of Congregational Learning

Bernard A. Fried
Executive Director

Stefanie Williams
Associate Executive Director

Judy Jacks Berman
Director of Early Childhood
Education

Alan L. Cohen
Rabbi Emeritus

Art Federman
President

Jason Krakow
Executive Vice President
& Vice President, Ritual

Victor Wishna
Vice President, Education

Dr. Ann Karty
Vice President, Programming

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Linda Lessner
Adam Matsil
Ed Meltzer
Cathy Newman
Eric Schultz
Larry Silver
Josh Sosland

Photo Permission

_____ I give permission for my child's photo to be used on Congregation Beth Shalom's website, Beth Shalom's monthly Scroll, and/or the Jewish Chronicle. I realize my child's name will NOT be mentioned, just the photo.

_____ I do NOT give permission for my child's photo to be used on Congregation Beth Shalom's website, Beth Shalom's monthly Scroll, and/or the Jewish Chronicle.

Child's Name (please print) _____

Parent's Name (please print) _____

Date _____



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PICK UP AUTHORIZATION 2020-21

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: Please provide cell phone numbers below.

_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell Number _____	Relationship _____
_____	Cell 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.



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Dear Parents,

These times are so unlike any times I have ever experienced. The threat of COVID19 and all of the unknown information is very difficult. When creating the following policies and protocols we followed the guidance of KDHE and the CDC.

These are the proactive measures we will be taking to keep staff and children safe and healthy:

- Classes and pods will not interact.
- Teachers will always be masked and children 3 and over will be masked anytime they are indoors.
- We will encourage “airplane arms” to teach the children about social distancing and personal space.
- Children will have their own art supplies to limit touch zones.
- All shared toys will be sanitized after use.
- Children will bring their own water bottles and a snack to limit who is touching their food.
- Parents will fill out a health questionnaire daily before coming to school.
- Playground Surfaces will be cleaned in between classes.

When the pods and in school classes open, we need a commitment that you will do the following:

Keep your child home if they have any of the following symptoms:

- Runny nose
- Fever
- Cough
- Diarrhea or vomiting
- Shortness of breath
- Chills
- Sore throat
- Headache
- Loss of taste or smell
- Muscle pain
- Contact with someone who has tested positive for COVID19 or someone who is ill with a respiratory illness.

Please sign below to confirm your commitment to help keep all of our children, families and staff healthy by keeping your child home if they have any of the above symptoms.

Parents name _____ (please print)
Parent's signature _____ Date _____