

**Care Quest
Enrollment/Information Form**

For
2009-2010
TONGANOXIE UNITED METHODIST CHURCH

Child's Name: _____ Boy ___ Girl ___ DOB: _____
Child's Home Address: _____
City/State/Zip: _____
Child's Home Phone#: _____

Name of mother: _____ Home : _____ Work#: _____
Address: _____
E-mail: _____ Cell/Pager #: _____

Name of father: _____ Home : _____ Work#: _____
Address: _____
E-mail: _____ Cell/Pager #: _____

Please check the parent who should be contacted first concerning questions, etc.

List two other local persons who can be contacted in case of emergency and may pick up the above named child.

1. _____ Relationship to the child: _____
Address: _____
Home # _____ Work # _____ Cell # _____

2. _____ Relationship to the child: _____
Address: _____
Home # _____ Work # _____ Cell # _____

Other persons authorized to pick up your child. Attach an additional sheet if necessary.

1. Name _____ Relationship to child _____
Home# _____ Work# _____ Cell# _____

2. Name _____ Relationship to child _____
Home# _____ Work# _____ Cell# _____

Please include a recent photo of the child with this form.

I have read the handbook and agree to abide by the policies. I agree to honor this enrollment as described above. In case I do need to remove my child from the program, I will give two weeks notice or pay for that time.

Signature of parent/guardian

Date

KANSAS CERTIFICATE OF IMMUNIZATIONS (KCI)

This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)

Student Name: _____ Address: _____
 Parent or Guardian Name: _____
 Phone: _____
 Birthdate (MM/DD/YYYY): _____ SEX: [] MALE [] FEMALE Race: _____ Ethnicity: _____ County: _____

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED						
	1st	2nd	3rd	4th	5th	6th	7th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis) Required for school entry. <div style="text-align: right; font-weight: bold;">State Type</div>	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap	DT DTaP Td Tdap
Polio Required for school entry.						If additional doses are added, please initial the dose and sign below: _____ _____ _____	
HEP B (Hepatitis B) Required for school entry through Grade 9 for 2009-2010 school year. Recommended for all children.							
Varicella (Chickenpox) Required for school entry through Grade 9 for 2009-2010 school year. Recommended for all children.			Hx of Disease: _____ Date of Illness: _____ Physician Signature: _____				
MMR (Measles, Mumps, and Rubella combined) Required for school entry.	MMR Me/Mu/Ru	MMR Me/Mu/Ru					
Influenza (Flu) Recommended annually for ages 6mo - 18 yrs. Not required for school entry.							
HIB (Haemophilus influenzae Type B) Required < 5 years of age for preschool or child care operated by a school.							
PCV7 (Pneumococcal Conjugate) Required < 5 years of age for preschool or child care operated by a school.							
HEP A (Hepatitis A) Required < 5 years of age for preschool or child care operated by a school.							
MCV4 (Meningococcal) Recommended ≥ 11 yrs. Not required for school entry.							
HPV (Human Papillomavirus) Recommended for females ≥ 11 yrs. Not required for school entry.							
Rotavirus Recommended < 8 mo. Not required for school entry.							

<p style="text-align: center;">DOCUMENTATION</p> <p>KCI MAY ONLY BE SIGNED BY A PHYSICIAN (MD/DO), HEALTH DEPT, OR SCHOOL.</p> <p><input type="checkbox"/> I certify I reviewed this student's vaccination record and transcribed it accurately</p> <p>Agency Name: _____ Authorized Representative: _____ Address: _____</p> <p>The record presented was: _____ Date: _____</p> <p><input type="checkbox"/> Kansas Immunization Record <input type="checkbox"/> Other Immunization Record (Specify) _____</p>	<p style="text-align: center;">LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS "KSA 72-5209"</p> <p>1. "Annual written statement signed by a licensed physician (Medical Doctor/M.D. or Doctor of Osteopathy/D.O.) stating the physical condition of the child to be such that the tests or inoculations would seriously endanger the life or health of the child." Medical exemption shall be validated annually by physician completion of KCI Form B and attachment to the KCI.</p> <p style="text-align: center;">KCI FORM B - MEDICAL EXEMPTION is located at http://www.kdheks.gov/immunize/imm_manual_pdf/KCI_formB.pdf</p> <p>2. "Written statement signed by one parent or guardian that the child is an adherent of a religious denomination whose religious teachings are opposed to such tests or inoculations."</p>
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KANSAS IMMUNIZATION PROGRAM
 1000 SW Jackson, Suite 210, Topeka, KS 66612-1274
 PHONE 785-296-5591 FAX 785-296-6510
 WEB SITE www.kdheks.gov/immunize

I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

 Parent/Legal Guardian's Signature _____ Date Rev. 05/20/2009

KANSAS IMMUNIZATION REQUIREMENTS: Based on age of child as of September 1 of current school year.

As per Kansas Statute 72-5209, all children upon entry to school must be appropriately vaccinated. In each column below, vaccines are required for all ages listed in that column.

Ages 0-4	Ages 5-6	Ages 7 and Older
<p>Recommended Schedule</p> <p>Birth HEP B</p> <p>2 Months DTaP/DT POLIO HEP B HIB PCV7 ROTAVIRUS</p> <p>4 Months DTaP/DT POLIO HIB PCV7 ROTAVIRUS</p> <p>6 Months DTaP/DT POLIO HEP B HIB PCV7 ROTAVIRUS</p> <p>12-15 Months DTaP/DT MMR VAR HIB PCV7 HEP A</p> <p>Recommendations are based on the ACIP recommended schedule.†</p>	<p>DTaP/DT: 5 doses</p> <p>a) 4 week minimum interval between doses, with at least 6 months between dose 3 and dose 4.</p> <p>b) 4 doses acceptable if dose 4 given on or after the 4th birthday.</p> <p>c) If dose 4 is administered before the 4th birthday, a 5th dose must be given at 4-6 years of age.</p> <p>* If 1st DT dose given at <12 months of age, 4 doses recommended; acceptable only when Pertussis component is contraindicated by the physician.</p> <p>* If 1st DT dose given at 12 months or older, 3 doses complete primary series; acceptable only when Pertussis component is contraindicated by the physician.</p> <p>The limit for DTaP vaccine is 6 doses, regardless of schedule.</p> <p>POLIO:</p> <p>4 doses of POLIO are acceptable IF:</p> <p>a) 4 week minimum interval between doses, regardless of age given.</p> <p>3 doses of POLIO (all IPV) are acceptable IF:</p> <p>a) 4 week minimum interval between each dose, with 1 dose given on or after the 4th birthday.</p> <p>The limit for POLIO vaccine is 5 doses, regardless of schedule.</p> <p>MMR: 2 doses</p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) 4 week minimum interval between doses.</p> <p>Single antigen measles vaccine will not meet requirements without the addition of mumps and rubella vaccine.</p> <p>VARICELLA: 2 doses required for Kindergarten for 2009-10 school year 1 dose required for Grades 1-9 for 2009-10 school year</p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) None required if prior varicella disease verified.</p> <p>c) Two doses are <i>recommended</i> for all children.</p> <p>HEPATITIS B: 3 doses required through Grade 9 for 2009-10 school year</p> <p>a) 4 week minimum interval between dose 1 and dose 2.</p> <p>b) 8 week minimum interval between dose 2 and dose 3.</p> <p>c) 16 week minimum interval between dose 1 and dose 3.</p> <p>Dose 3 must be given after 24 wks of age.</p>	<p>Tdap/Td: 3 doses if DTaP/DT series not completed previously† Must have Tdap as one of the 3 doses</p> <p>a) 4 week minimum interval between dose 1 and 2.</p> <p>b) 6 month interval between dose 2 and dose 3.</p> <p>Booster dose of Tdap is required at 11 years of age if more than 2 yrs since previous dose. For adolescents older than 11 years of age, Tdap booster required 10 years after the completion of the primary series or previous dose. If pertussis is contraindicated, KCI Form B Medical Exemption should be completed by a physician.</p> <p>POLIO - All IPV or OPV Schedule</p> <p>4 doses of POLIO are acceptable IF:</p> <p>a) 4 week minimum interval between doses, regardless of age given.</p> <p>3 doses of POLIO are acceptable IF:</p> <p>a) 4 week minimum interval between each dose, with 1 dose given on or after the 4th birthday.</p> <p>POLIO - IPV/OPV Combination Schedule</p> <p>4 doses of POLIO are acceptable IF:</p> <p>a) 4 week minimum interval between each dose, regardless of age given. Three doses of a combination schedule are NOT acceptable.</p> <p>The limit for POLIO vaccine is 5 doses, regardless of schedule.</p> <p>MMR: 2 doses</p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) 4 week minimum interval between doses.</p> <p>VARICELLA: 1 dose required through Grade 9 for 2009-10 school year</p> <p>a) First dose must be on or after the 1st birthday.</p> <p>b) None required if prior varicella disease verified.</p> <p>c) Two doses are <i>recommended</i> for all children.</p> <p>HEPATITIS B: 3 doses required through Grade 9 for 2009-10 school year</p> <p>a) 4 week minimum interval between dose 1 and dose 2.</p> <p>b) 8 week minimum interval between dose 2 and dose 3.</p> <p>c) 16 week minimum interval between dose 1 and dose 3.</p> <p>d) Dose 3 must be given after 24 wks of age.</p>

† - The ACIP Schedules may be accessed at: <http://www.cdc.gov/vaccines/recs/schedules>

Vaccine doses given up to 4 days before the minimum interval or age may be considered valid.
With the exception of Hepatitis B vaccine, immunizations given before 6 weeks of age are not considered valid.
Half doses or reduced doses of vaccine are not considered valid.

PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORMS.

KCI FORM B - MEDICAL EXEMPTION is located at http://www.kdheks.gov/immunize/imm_manual_pdf/KCI_formB.pdf

BLANK VERSION OF KCI FORM is available at http://www.kdheks.gov/immunize/download/KCI_Form.pdf

A ROSTER WITH THE NAMES OF ALL EXEMPT STUDENTS SHOULD BE MAINTAINED. PARENTS OR GUARDIANS OF EXEMPT CHILDREN SHOULD BE INFORMED THAT THEIR CHILDREN SHALL BE EXCLUDED FROM SCHOOL IN THE EVENT OF AN OUTBREAK OR SUSPECTED CASE OF A VACCINE-PREVENTABLE DISEASE.

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 Child Health Assessment is optional for children in Registered Family Day Care Homes. 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. Any Health Assessment Form should be attached to the KDHE Medical Record Form.

Child's Name _____ Date of Birth _____

Past Health History (Developmental – Illness – Hospitalization) _____

Allergies _____

Current Medications _____

Nutritional Status _____

Physical Examination

Height _____

Weight _____

Head _____

Abdomen _____

EENT _____

GU _____

Teeth _____

GYN _____

Heart _____

Skeletal _____

Lungs _____

Neurological _____

Screening Tests (Dates Done and Results)

Vision _____

TBC. Test _____

Hearing _____

Sickle Cell _____

Speech _____

HGB. _____

DDST _____

U.A. _____

Lead _____

Other _____

Diagnosis:

Recommendation:

Do you see this child for regular health supervision: Yes _____ No _____

Signature of Licensed Physician or Nurse Approved for Child Health Assessments

Date (MM/DD/YYYY)

Print the Name of the Individual Signing Above

Phone number

Address of Physician or Nurse

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

Name of facility exactly as stated on the license/certificate.	License or Certificate #
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I hereby authorize _____ (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
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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 only if required by local hospital or clinic.

<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.

**2009-2010
Photography Release Form
For
Care Quest**

Child's Name

I authorize and give consent to Tonganoxie United Methodist Church to:

Use my child's photograph, videotape coverage and/or student work in promotional or information pieces.

Have my child interviewed by the newspaper.

Use my child's pictures on the church web site.

I waive the right to inspect or approve the finished media prior to publication or use.

I DO NOT give my consent.

Parent/Guardian's signature

Date