Dear Parents,

I am looking forward to a wonderful year with you and your child. It will be a blessing to have your family as a part of our school. The purpose of the program is to provide a safe, nurturing, and developmentally appropriate environment. Little Builders has a child-center and family-focused atmosphere. Daily routines, curriculum, and learning activities are centered on meeting your child's needs. At Little Builders we believe:

- Children must be treated with respect
- Children are individuals and have special gifts and talents
- Children learn best through play
- Learning experiences should be developmentally appropriate
- Parents/guardians/families have a critical role in their child's education
- The role of the teacher is to provide/encourage
    1. Learning through hands-on exploration
    2. Responsibility
    3. Respect for self and others (as well as material possessions)

Please remember that the best way for your child to have successful experiences throughout school, is to play an active part in the process. You are invited to the school any day at any time. The bond between home and school must be strong in order for us to provide the environment that best meets your child's needs.

Included in this packet are any documents that need to be filled out and returned to the SC Learning Center. The Emergency Medical Release form must be notarized. Please remember to bring a change of clothes and a blanket for naptime.

Sincerely,

Alexis Miers

Director/ Lead Teacher

SC Learning Center

120 W. 12th

Winfield, KS 67156

620-402-6470

SC Learning Center
Southwestern College
Enrollment Application

Date of Application: _____ Birth Date:_____

Child's Name: _____ Nickname: _____

Gender: Male / Female Age: _____

(Preschool Students) Type of Care Desired: Full Day ___ ½ AM ___½ PM___
Days of the week: _____

(School Age Students) Days Child Will Attend:_____
School Child Attends:_____

Parent/Guardian Information:

_____	_____
Mother/Guardian's Name	Father/Guardian's Name
_____	_____
Street Address	Street Address
_____	_____
City State/Zip	City State/Zip
_____	_____
Home Phone	Home Phone
_____	_____
Cell Phone	Cell Phone
_____	_____
Work Phone	Work Phone

CCL 010
Rev. 3/2017

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) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas

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 #
SC Learning Center	36168

I hereby authorize Alexis Miers (Name of individual/staff member) and/or SC Learning Center 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 _____ (MM/DD/YYYY) and end of care (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 _____ (MM/DD/YYYY) by _____ (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. 029
Rev. 3/2018

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) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas
Department of Health and Environment

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

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
_____Asthma
_____Epilepsy/Seizures
_____Frequent sore throats/colds
_____Speech, Visual, Hearing
_____Other_____
_____Ear Aches
_____Diabetes

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					
	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. 029a
Rev. 3/2017

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/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)
☐ 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

Your Child

Answers to the following questions will help us provide your child with a comfortable safe environment that will allow him or her to have a happy experience at our school.

Is this your child's first separation from home? _____

Has your child had any kind of group experience before? _____
Where: _____

Does your child make new friends easily? _____

Is he/she used to playing alone or with others? _____

What are his/her favorite toys or activities at home? _____

Are there other languages spoken in the home? _____
(Name Languages)

What is your child's race? _____
What is your religious preference? _____
Are there any cultural routines that we should be aware of? _____
_____
Does your child have to be reminded to go to the restroom? _____

Does your child take a mid-day nap or rest? _____
Time of Day _____ For How Long? _____
Special feeding instructions: (Food likes and dislikes, etc.) _____
_____

What fears does your child have (such as animals, storms, etc.)? _____
_____
How do you handle these fears? _____

To what behavior management practices or methods of discipline is your child accustomed? _____
_____
What other information could you provide to assist us in caring for your child? _____

PERMISSION TO PARTICIPATE IN THE SC LEARNING CENTER

1. I hereby grant permission for my child to use all play equipment and participate in all activities.
   _____Yes _____No

2. I hereby grant permission for my child to participate in supervised walks, outside play/activities and activities involving various college programs.
   _____Yes _____No

3. I hereby grant permission for my child to be included in photographs and video tapings for instructional, publicity, and portfolio use. I grant permission for my child's information to be shared with other relevant providers, agencies, or other programs.
   _____Yes _____No

4. I will pick up my child promptly. I agree to pay an extra $5.00 for each five (5) minute block (or any portion thereof) after the 6:00 PM closing, beginning at 6:05 PM (11:20 AM for half-day kids) as shown on the preschool clock.
   _____Yes _____No

5. I will provide the required birth, health, and immunization records for my child BEFORE he/she may begin school.
   _____Yes _____No

I hereby attest that I will pay all fees when due. I understand that this is a laboratory school and that university students and high school students will be observers and aids. Southwestern College students under the supervision of the Lead Teacher and the Director will be involved with my child on a daily basis.

_____ _____

Signature of Father/Guardian Date

_____ _____

Signature of Mother/Guardian Date

CCL. 034
Rev. 3/2017

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: 785-559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #
SC Learning Center			36168
Street Address of the Facility	**City**	**Zip Code**	**County**
120 W. 12th Ave.	Winfield	67156	Cowley

_____ may go to the following locations off the premises **with** adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Public Library	605 College	Winfield	(By Vehicle)	
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Southwestern College	100 College	Winfield	(By Vehicle)	
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Rec Center	624 College	Winfield	(By Vehicle)	
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Arts & Humanities Center	700 Gary	Winfield	(By Vehicle)	
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Cochran Park	16th & Manning	Winfield		(Walk/Bike)
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Island Park	N. end of Main	Winfiad	(By Vehicle)	(Walk/Bike)
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Winfield Aquatic Center	300 Main St.	Winfiad	(By Vehicle)	(Walk/Bike)
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Sedgwick County 200	5555 200 Buld.	Wichita	(circled)	
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Tanganyika Wildlife Park	1000 S. Hawkins Ln.	Goddard	(circled)	
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	

FOR SCHOOL AGE CHILDREN OR YOUTH ONLY

I hereby authorize my **school age child** ____

First and Last Name of Child or Youth **Birth Date MM/DD/YYYY**

To walk/bike to and from the following location(s) **without** adult supervision:

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	

SC | LEARNING CENTER

Building Bright Futures Step By Step

Photographing, Videotaping, Audiotape, and Observation Release Form

I understand that the faculty, staff, and students of Southwestern College and SC learning Center will be taking digital images, photographs, and or/video tapes for decoration (e.g. posting pictures on bulletin boards, on cubbies, ect.) and/or security purposes.

I understand that parents are also allowed to come in the center and observe, photograph, video tape, and/or audiotape children.

I, hereby, consent that all digital images, photographs, videos, or other images taken of my child, _____, and/or recordings of his/her voice made by Southwestern College or SC Learning Center students and staff may be used by Southwestern College or SC Learning Center, and/or other with its consent, for education, decoration, illustration, advertising, publication, or security purposes in an manner.

I, also, understand that since my child _____ is enrolled at SC Learning Center, which is a campus based facility, he/she may be observed, video taped, recorded, digitally imaged, or photographed by the Southwestern College faculty, staff, and students to use in classroom assignments only. This will be supervised by the teachers and staff at SC learning Center. No child will be observed, video taped, or recorded, or photographed without supervision of a teacher and the authorization of the administration of the SC Learning Center.

Parent/Guardian Signature_____ Date_____

Parent Payment Contract

I _____ intend to pay the

SC Learning Center $_____ (circle one)

WEEKLY BI-WEEKLY MONTHLY OTHER

On (insert day of the month) _____

I understand my account must be maintained in order for my child to attend. If failure to make payment within 90 days, I understand my account will be charged 10% of my current balance monthly until payment is made. **Students will be discharged immediately until account is current.**

PLEASE CIRCLE ONE OF THE FOLLOWING TYPES OF PAYMENT:

DCF PRIVATE PAY FLEX PAY

The definitions are as follows: DCF means the family receives a supplement for childcare once a month. Private pay means the family pays from their own funds. Flex pay means the family participates in a program at work.

_____ _____

Parent's signature Date

_____ _____

Director's Signature Date

Behavior Management and Discipline Policy

The general goals of guidance and discipline at SC Learning Center are to help the individual child to become increasingly responsible for his or her own behavior.

We believe that children learn best within a safe and nurturing environment. The staff will provide positive support and reinforcement for appropriate behaviors, as well as any necessary guidance toward those appropriate behaviors. We encourage children to develop and use potentialities as fully as possible to manage his or her own affairs with due consideration for others. We want children to solve problems intelligently and think for him or herself. We will help children manage feelings and emotions in an appropriate, constructive manner and will provide developmentally appropriate consequences when inappropriate, hurtful or harmful behaviors occur.

If determined by the director, teachers of the children, and parents/guardians and early childhood specialist from Winfield School District or other agency may be recommended. When a discipline plan has been developed for the child the center personnel will work with the agency. Ongoing communication will occur with parents/guardians, teaching staff, and the agency.

Discipline

The classroom rules at the SC Learning Center are generated from student input along with teacher guidance. When children choose inappropriate behavior the following actions will be taken by the staff members: (All situations will be documented and notes will be sent home to inform parents of the behavior.)

-The problem will be discussed in a quiet voice.

-The child will be given an opportunity to come up with a solution to resolve the problem thus preventing a recurrence of behavior.

-A safe place is provided in each classroom for children to calm down. If needed the child will sent there to think about their behavior and how it can be fixed.

-Parent will be called to discuss further disciplinary actions if needed.

-Termination of class membership—if problem behavior continues—as determined by Director.

I, the parent or guardian of _____(Child's full name), do herby state that I have read and received a copy of the Behavior Management and Discipline Policy and that the SC Learning Center (or other designated staff member) has discussed the Behavior Management and Discipline Policy with me.

Parent/Guardian Signature _____Date_____

I have read and understand the contents of the parent handbook. I understand that if I have any questions I may ask the director to explain. I also understand that after signing this form a copy will be put in my child's file.

Signature _____ Date _____