SUSANNA WESLEY UNITED METHODIST CHURCH

School Age

Student Full Name: _____
Student DOB: ____/____/_____ Grade: _____
Required Parent/Guardian Information:
Name:_____
Address:_____
City,State/Zip:_____
Phone#:_____
Required Emergency Contact Information:
Name:_____
Phone#: _____
Days Attending: M T W T F
Drop Off Time AM: _____
Pick Up Time PM: _____

E-Mail Address
Please list an e-mail address(s) that you would like us to use for correspondence:

_____

- YOUR CHILD'S DOCTOR IS_____PHONE #_____
- Preferred Hospital_____
- DOES YOUR CHILD TAKE ANY MEDICATIONS CURRENTLY? IF YES, PLEASE LIST THE MEDICATION AND DOSAGES: (IF NONE, WRITE NONE)

_____
_____

- LIST ANY ALLERGIES, INCLUDING FOOD ALLERGIES: (IF NONE, WRITE NONE)

_____
_____

- DOES THIS STUDENT HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS? (CHECK ALL THAT APPLY)

ADD/ADHD	
Anxiety/ Depression	
Asthma (If yes, please provide inhaler)	
Autism Spectrum Disorder	
Behavior Defiance	
Bipolar	
Seizures	
Developmental Delay	

Diabetes	
Eating Disorder	
GI Disorder	
Gifted	
Headaches	
ODD (Oppositional Defiance Disorder)	
Obsessive Compulsive Disorder	
Self-Harm	

OTHER: (PLEASE EXPLAIN ANY OF THE ABOVE CHECKED BOXES OR ANY OTHER HEALTH CONCERNS):

_____
_____
_____

INSURANCE NAME_____
ADDRESS_____

POLICY #_____

GROUP # _____

INSURANCE EMPLOYER_____

I certify that all information on this enrollment form is correct:

Parent Signature: _____Date: _____

CCL 010
Rev. 5/2020

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

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. 28-4582(e)(2).

Name of facility exactly as stated on the license.	**License #**
Susanna Wesley School Age South	0057315

I authorize Susanna Wesley School Age Program Staff (caregiver/staff) 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 _____ (child's first and last name) while child or youth is in the facility's custody between _____ and _____.
MM/DD/YYYY MM/DD/YYYY

If known, date of last Tetanus inoculation: _____
MM/DD/YYYY

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

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**

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: _____

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

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. 358
Rev. 5/2020

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Kansas Department of Health and Environment

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28- 4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1- 20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address City	City	Zip Code	Home Phone #

Mother/Guardian's Workplace Name & Street Address City	City	Zip Code	Work Phone #

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone #

Father/Guardian's Workplace Name & Street Address	City	Zip Code	Work Phone #

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
☐	☐	☐	Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
☐	☐	☐	If yes above, is there signed permission on file?

Select any of the following conditions or difficulties that affect this child or youth.			
☐ Allergies	☐ Frequent sore throats/ Colds	☐ Ear Infections or Aches	☐ Heart or Lung Conditions
☐ Skin Problems	☐ Asthma	☐ Headaches	☐ Diabetes
☐ Vision	☐ Speech/Communication	☐ Hearing	☐ Emotion/Behavior
Other: Please describe.			

If you selected any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
	☐	Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
☐	☐	If yes, are this child's or youth's immunizations current?
☒	☒	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

Susanna Wesley School-Age Program

School year Contract and Permissions Effective
for School Year 2025-2026

I,_____, contract for services of the SW School Age Program for my
(Parent Name)
Student as specified below:

Student Name: _____ Grade (Fall 2025): _____ T-Shirt Size: _____

Photographs and Social Media:

I give my consent for my child to be photographed during the Susanna Wesley School Age Program and for their first name to be used for general public purposes. Yes ☐ No ☐

Furthermore, I authorize my child's photo and first name to be used for social media purposes including but not limited to Susanna Wesley UMC social media. Yes ☐ No ☐

Supply Fee $75 per child and covers all supplies for the entire School Year.
This is non-refundable. This year we will be billing weekly, and it is due the following Monday.
AM and PM - $80
AM Only- $45 per week
PM Only- $55 per week
Drop In Care- $30 per day
Days Out Care- $40 per day

Please read carefully:
Additional Fee Information:
Late Departure Fees: It is the policy to charge an additional fee for late pick up. Charges are $15 first ten minutes then a $1 every minute after that with no grace period. This fee is payable the night of the occurrence or the following morning. If fee is not paid the student will not be allowed to return until it is paid.
Late Payment: Payments are due by the end of the month payment is considered late and a $10 late fee will be assessed. Unless there is special permission, your child will not be able to attend that week unit it is paid for.
Weather Closures: Susanna Wesley School Age Program will close for weather if USD 437 is closed unless we determine we are able to be open. A discount for weather related closures will be determined by the school age director.

By signing this contract,

- ☐ I acknowledge that I have read the SW School Year Handbook posted on the Susanna Wesley United Methodist Church's website. (www.swumc.org) and agree to be bound by its policies.
- ☐ I agree that my student can go on to the Indian Hills Playground and grass play area around Susanna Wesley.
- ☐ I have read this contract and agree to pay the above stated tuition and any other fees that I may incur.
- ☐ I agree to complete the enrollment form on Brightwheel and pay the registration fee there and return contract to the office no later than the first day of care with the understanding that until the information is filled out on Brightwheel and supply payment of $75 are turned in my child is not enrolled in the program. Remember children are enrolled on a first come first served basis.
- ☐ I understand that I am to keep Susanna Wesley updated on any changes to my enrollment application and/or my contract.

Parent Signature:_____**Date** _____

Additional Parent signature_____**Date** _____