As of 01/13/2025

Registration Packet

Carter Children's Cottage

6725 W. 76th Street
Overland Park, Kansas 66204
Phone: (913) 649-1143 Fax: (913) 649-0608
Email: carterchildrenscottage@gmail.com
Director's Email: cccdirector.kriley@gmail.com

As of 01/13/2025

Carter Children's Cottage

6725 W 76th Street, Overland Park, KS. 66204
(913) 649-1143

Registration form

Child's Name:_____**Birth Date:**_____/__/_____

Address:_____

City:_____**State:**_____**Zip:**_____

Mother's Name:_____**Email Address:**_____

Cell Phone:_____**Work Phone:**_____

Father's Name:_____**Email Address:**_____

Cell Phone:_____**Work Phone:**_____

Marital Status: ( ) Married ( )Divorced ( )Separated ( )Single

Child in custody of:_____

Other household members	Relation	Age
1.		
2.		
3.		

Authorized pick-up
(If you cannot be contacted, we will contact the people listed)

Name	Relation	Phone Number
1.		
2.		
3.		

As of 01/13/2025

Carter Children's Cottage
6725 W 76th Street, Overland Park, KS 66204
Hours of Operation: Monday through Friday, 6 a.m. to 6 p.m.

Provider/Family Contract

Child's Name:_____

Hours your child will attend: From _____am/pm to _____am/pm

Payment Frequency (select one): Weekly Monthly

Effective Date: _____

Payments are due Monday morning. Payments must be made before enrolling your child in the care center.

NO EXCEPTIONS. NO PART-TIME

INFANTS (under 12 m)	TODDLER 1 (13-30m) (Must be walking)	TODDLER 2 (2-1/2-3 years)	3-year-olds (Not potty trained)	Children from 3 to 5 years old (Potty trained)
$300/Weekly	$275/Weekly	$250/Weekly	$240/Weekly	$225/Weekly
Care exceeding 55 hours will incur an hourly surcharge of $10/hour				

_____ Your pay will remain the same until your child's age changes.

_____ All child care payments must be made weekly by Friday or monthly on the first day of the month.

_____ Payments will be mandatory and will remain the same even if your child does not attend due to illness, a holiday, or a vacation. Payments are made based on registration, not attendance.

_____ One week of free vacation after 1 year of enrollment. (If your child does not attend, no payment is required. Vacation weeks cannot be split.)

_____ Late pickup fee of $1 per minute per child after 6 p.m.

_____ If your child will be late, you must call 913-649-1143 or send a message through brightwheel© before 9 a.m. If we are not notified, your child will not be able to attend. Drop-off after 11am not permitted unless accompanied by doctors note.

_____ At least 2 weeks' notice (verbal or written) is required prior to termination of care.

Please note that by signing below, you agree to the terms of this agreement. Please refer to the CCC Family Handbook provided for our policy on discipline and other information.

Parent/Guardian Signature_____Date:_____

Provider Signature_____ Date:_____

CCL.010
Rev. 07/2024

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

Kansas Department of Health and Environment

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 #**
Carter Children's Cottage	0079509

I authorize Staff Members of Carter Children's Cottage (*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 Until Terminated.
MM/DD/YYYY 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**

- -

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 off premised from the facility.

CARTER CHILDREN'S COTTAGE
PHOTO RELEASE FORM

I, _____, the parent of a child/children at Carter Children's Cottage (Hereinafter known as the “Daycare), agree to the following:

I understand that my child(ren) whose name(s) are listed below may be photographed at the Daycare during normal daycare hours, field trips, or activities. I understand that these photographs may be used in promoting child care services, either in print or on the Internet.

The child(ren) are known as: _____.

With my signature below I grant permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting the Daycare’s services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child’s enrollment. I understand that there will be no payment for me or my child’s participation in this release.

Parent/Guardian Signature _____ Date_____

Relationship To Child _____

CCL. 029
Rev. 08/2024

Child Care Licensing Program
Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

Kansas Department of Health and Environment

Medical Record

Medical History

In accordance with K.A.R. 28-4-117 and K.A.R. 28-4-430, a completed medical record shall be on file for all children in care. For a Family Child Care Home, children under 10 years of age and all children living in the home under 16 years of age, a medical record shall be completed. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment. The Medical Record is 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/Cell Phone Number _____

Work Phone Number _____

E-mail Address _____

Best way to contact _____

Parent/Guardian Information

Name _____

Home Address _____
Street City Zip Code

Home/Cell Phone Number _____

Work Phone Number _____

E-mail Address _____

Best way to contact _____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____

Address _____

Phone Number _____

Name _____

Address _____

Phone Number _____

Child's Physician _____ Phone Number _____

Hospital Preference (for emergencies): _____

Known allergies or medical conditions: _____

Major changes at home that might affect your child in care: _____

Additional information or special instructions that will help the person caring for your child: _____

Parent/Guardian Signature: _____ **Date:** _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Medical Record:

Medical History Cont. - 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.; not required						
Influenza (Flu) *Recommended annually >6 mo.; not required						

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

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 ☐ Hep A ☐ Hep B
☐ Hib ☐ PCV ☐ Varicella ☐ Other (describe): _____

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. 08/2024

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Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
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Kansas Department of Health and Environment

Medical Record:
Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

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 Family Child 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.

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 pages if necessary)

☐ None

Signature of Licensed Physician or Nurse approved for Child Health Assessment	**Date**
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code

Carter Children's Cottage

Sick/Illness Policy

I, _____ acknowledge that I have received and read the daycare's sick policy in the handbook provided. I understand and agree to abide by the following guidelines:

1. If my child is experiencing any of the following symptoms, I will not bring them to daycare:
   - Fever of 100 degrees Fahrenheit or higher
   - Vomiting or diarrhea within the last 24 hours
   - Severe coughing or difficulty breathing
   - Rash with fever
   - Pink eye or other contagious eye infections
   - Severe sore throat
   - Contagious illnesses such as, but not limited to, strep throat, flu, or chickenpox

2. If my child displays any symptoms described in paragraph 1, I will promptly pick them up as soon as I am notified by the daycare staff.

3. I understand that my child must be symptom and/or fever free for at least 24 hours (without the aid of fever-reducing medication) before returning to daycare.

4. I will inform the daycare staff of any contagious illnesses my child may have been exposed to or diagnosed with.

5. I will keep the daycare updated on any changes to my child's health status.

6. If antibiotics are needed then your child must be on the medication for 24hrs before returning to care.

7. I understand that failure to follow this sick/illness policy can result in termination of care.

Parent Signature _____Date_____

Name(s) of Child Enrolling. _____. _____.

Director Signature _____.