JOHNSON COUNTY
Park & Recreation
District

2020-2021 JCPRD PRE-K ENRICHMENT REGISTRATION (Shawnee Mission)

Participant's Name	Date of Birth
School Location	**Start Date**
Payment Options (Check One)	**Barcode**
Charge Full ☐ Charge Weekly ☐	Office Use Only

Days of Attendance (Check Days) *Days must be consistent*										
Mon	☐	Tues	☐	Wed	☐	Thurs	☐	Fri	☐	
PROGRAM OPTIONS										
Before School	☐	Pre-K AM	☐	Pre-K PM	☐	After School	☐			
Eligible for Multiple Child Discount?										
No	☐	Yes	☐	*Name of Other Sibling(s) Enrolled:* _____						

Enrollment Instructions

Enrollment Accepted by JCPRD
Signature_____
Date_____

1. ***Submit Signed and Completed Forms*** **(6 pages) to JCPRD prior to start date:**
   - **Scan & E-mail to Lisa.hughes@jocogov.org , OR…**
   - **Mail or Walk-in to Antioch Park: 6501 Antioch Road, Merriam, Kansas 66202**
2. **You will receive a confirmation email within 2-3 business days, stating that your registration has been processed. If you have not received an email after 3 business days, and have verified that the email did not go to your spam folder, please call our Registration office (913-831-3359) to verify enrollment.**
3. **Your registration fee will be collected at a later date. You will receive an email prior to August 1st with additional instructions for payment.**

2020-21 Pre-K Enrichment Fee Installments

(paid weekly, in advance of programming)

Program Options	Full Time (4-5 Days/Week)		Part Time (2-3 Days/Week)		Registration Fee (Due upon Step 3 Above)
	1st Child	10%discount for 2nd child	1st Child	10% discount for 2nd child	
Before School Only	$38.00		$35.00		$30.00
After School Only	$71.00		$61.00		$30.00
Pre-K Only	$80.00		$63.00		$30.00
Pre-K & Before School	$100.00		$80.00		$30.00
Pre-K & After School	$105.00		$92.00		$30.00
Before/Pre-K/After	$110.00		$109.00		$30.00

• All fees are non-refundable and non-transferrable. • ALL required forms must be submitted prior to start date. • Fees are not prorated. •Part Time days must be consistent • 2nd Child Discount applies to sibling with lowest fee. • $25 Registration Fee is due upon completion of Registration. •A $15 Fee will be assessed for changes in program options •Families are responsible for reviewing the Pre-K Program Handbook at for additional policies, procedures, and terms of enrollment.

JCPRD Authorization Form for Recurring Children's Services Program Payments

JCPRD Authorization Form for Recurring Children's Services Program Payments

I understand that I must call the JCPRD Registration office at the phone number listed below and provide my debit or credit card information to complete this authorization for recurring payments within two business days of receiving confirmation of my registration. Completion of this form will authorize regularly scheduled charges to your Visa, Mastercard, Discover, ***or bank account (via ACH)***. Your account will be charged per the payment schedule provided by the JCPRD Registration Office. Proof of payment will be available to you through your CLASS registration account. The authority you give to charge your account will remain in effect until JCPRD Registration is notified in writing to terminate this authorization and a new account number is provided to complete your payment schedule, or until fees are paid in full and/or care is terminated. To grant authorization for recurring program payments, complete this form and return it with the remaining registration forms to registration@jocogov.org. For ACH payments, please submit a voided check with this form.

I,_____authorize JCPRD to charge my account for payment of the JCPRD Program for my child(ren) listed below. I agree to notify JCPRD in writing of any changes in my account information 15 days prior to the next due date of the charges and will not dispute merchant recurring billing with my credit card company, so long as the amount corresponds to the terms indicated in the payment schedule. If my account does not accept the scheduled charges, I am aware that I will be assessed a $30 reconciliation fee, with a maximum non-resolution period of 10 days at which time my child care will be terminated.

X Signature_____ Date_____

Printed Name_____ Email Address_____

Names of All Children Enrolled:_____

***JCPRD** is committed to making reasonable accommodations as required by the **Americans With Disabilities Act.** Requests must be made two weeks or ten working days prior to the start of the program. Please indicate what accommodations are needed:_____*

JCPRD WAIVER STATEMENT: "The undersigned states that he/she understands that the Johnson County Park & Recreation District is not and shall not be responsible for or liable for any illness, injury, or death to person or damage to property, including but not limited to illness, injury, or death arising from exposure to the Novel Coronavirus (COVID-19), resulting from the program in which the undersigned is enrolling or being enrolled or from his/her participating in said program, and the participant and the undersigned, if the participant is a minor or under other legal disability, hereby forever releases and holds harmless the said Johnson County Park & Recreation District, it's employees, agents and representatives from any and all claims of any kind, including but not limited to claims arising from exposure to the Novel Coronavirus (COVID-19), that the participant, or the undersigned or their respective heirs, executors, administrators, or assigns may have or claim to have resulting from participation in said program. **NOTICE:** By enrolling in this program you hereby acknowledge the Johnson County Park & Recreation District can and may photograph and/or video tape program participants and then use such images without payment or any other consideration, for purposes of publicizing District parks, facilities, programs or services, or for any other lawful purpose. **I HAVE READ & UNDERSTAND THE WAIVER STATEMENT & CANCELLATION POLICIES :**

X Parent/Guardian Signature **Date**

_____ _____

***REGISTRATION IS INVALID WITHOUT SIGNATURE**

SCHOOL DISTRICT WAIVER: We, the undersigned, parents of _____, acknowledge that the School Age Child Care Program operated by Johnson County Park and Recreation District ("Park District") is not a program operated or controlled by Shawnee Mission School District, Johnson County, State of Kansas (the "School District"); that the School District is only a lessor of space and has no responsibility whatsoever for the administration or operation of the program, for the selection of any employees to operate the program by the provider thereof, or for any act or omission which may occur while any child is going to, participating in, or going from the program. We, further, acknowledge that the program has not been approved by the School District and will not be supervised by the School District. We agree that the School District shall not be liable for any act or failure to act on the part of the Park District, its agents or employees, and we do waive any liability of the School District with reference thereto and promise and agree to save, and hold the School District free and harmless from any and all loss, of any and all nature or kind whatsoever, as the same may relate to any injury suffered or damage sustained by our child(ren) participating in the program or by us.

I HAVE READ & UNDERSTAND THE WAIVER STATEMENT:

Signature

X Parent/Guardian **Date**

_____ _____

***REGISTRATION IS INVALID WITHOUT SIGNATURE**

Parent/Guardian Name:_____( )_____( )_____

PLEASE PRINT Day Phone # Evening Phone #

Address:_____

Street (Apt. #) City State Zip (Required)

Please print or type and complete one Personal Data Form for each child enrolled

JOHNSON COUNTY PARK AND RECREATION DISTRICT
JCPRD PRE-K ENRICHMENT PROGRAM
2020-2021 PERSONAL DATA FORM
NAME OF SCHOOL: _____

Child's Full Name:_____ Start Date:_____

Child's Age:_____ Child's Birth Date:_____

Address:_____ Home Phone:_____
(Street) (City) (State/Zip)

Parent/Guardian:_____ Home #:_____

Home Address:_____ Cell #:_____

Employer:_____ Work # & Ext._____

Email:_____

Parent/Guardian:_____ Home #:_____

Home Address:_____ Cell #: _____

Employer:_____ Work # & Ext._____

Email:_____

Siblings Name:_____ Siblings Age:_____

Emergency contact:_____ Phone #:_____

Relationship:_____

_____ Phone #:_____

Relationship:_____

Child's Doctor:_____ Phone Number:_____

Child's Dentist:_____ Phone Number:_____

List Food/Substance Allergies:_____

_____

_____

The Pre-K Enrichment program is authorized to release my child to the following individuals without advance written or verbal permission (in addition to parents and/or ER contacts).

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

(MUST HAVE PHOTO ID TO PICK UP CHILDREN)

Specifically state any physical limitations:_____

_____

Signature of Parent/Guardian:_____ Date:_____

CCL. 029
Rev. 8/2013

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) 296-0803
Website: www.kdheks.gov/kidsnet

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:**_____

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. 8/2013

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/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

CCL 010
Rev. 8/2013

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) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
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. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	**License #**

I hereby authorize JCPRD Staff (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 until care is terminated .
MM/DD/YYYY 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 _____ by _____.
MM/DD/YYYY Name of Person

(Seal, if any.)

_____
Signature of notarial officer

Notary Not Required

_____
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.