CAPS
Child Advocacy & Parenting Services, Inc.

Respite Childcare Checklist

Please make sure you bring all the following information on your child's first day. Thank you!

- ☐ **Authorization for Emergency Medical Care** (white sheet)
  Note: **This needs to be notarized.** (Please sign form in presence of notary) A notary is available on staff at CAPS.
- ☐ **Enrollment Packet**
- ☐ **Current Physical (dated within last 11 months)** CAPS FAX# 785-825-4736
- ☐ **Copy of Medical Insurance card / Information**
- ☐ **Copy of up-to-date immunizations records**
- ☐ **Current picture ID of Parent/Guardian**
- ☐ **Any items your child will need**
  Tot Spot Room
  -Toddler MUST be 1yr. of age **AND** walking.:
  -diapers, wipes & diaper rash ointment as needed (if your child is NOT potty-trained)
  --extra change(s) of clothing (at least 1 complete set-- ***must always be kept here*** !)
  -**MUST** wear shoes! We go outside daily...weather permitting

  Kid Zone Room:
  - Wear weather-appropriate clothing for outside play (tennis shoes preferred over flip-flops, sandals, or crocs)
  - **One complete set of clothing needs to be left here in a marked baggie for children under 3yrs. old.**
  - Diapers, wipes; (extra pull-ups, wipes, underwear, & clothing if your child is potty training.)

Respite Childcare Attendance Policy

Future funding for this program is based on current attendance (how many children and families we serve). We have a waiting list of people wanting to participate in any CAPS respite childcare program. Therefore, we are watching attendance closely. It is important that you bring your children to the scheduled childcare each week. Failure to do so will put your enrollment spot in jeopardy. We realize there may be valid reasons for not attending a session of scheduled childcare. ***The important thing to remember is to call us as early as possible by calling this number: Child Advocacy & Parenting Services, Inc. (CAPS) 785-825-4493 or Childcare direct line is 785-833-6187.***

Respite Hours are: 9-12pm & 2-5pm(M-F). **Please have your child picked up by the end of respite time or a late fee will be accessed.**

In case of bad weather; if USD 305 is closed/ late start due to bad weather, Respite Childcare will be **CLOSED.**

We hope to continue with this program for many years to come, but your cooperation is needed for us to do so. Follow the tips below for illnesses.

I NEED TO STAY HOME IF...

I've had a FEVER over 100.1 in the last 24 hrs. Without Tylenol or Motrin

I've vomited in the last 24 hours

I've had DIARRHEA in the last 24 hours

I have any kind of RASH on my body

I have LICE or NITS in my hair.

I have RED, ITCHY or CRUSTY eyes or drainage from my eyes.

We are proud of our childare staff who have excellent educational and early childhood development backgrounds.
Teachers: Valeria Gonzalez Michele Hays Jakyma Roughton Childcare Director: Necol Agugba

Our priority is to keep your child(ren) & family safe, healthy and strong! Please contact Necol Agugba at the office number above or by email at necol@capsofsalina.org with any concerns related to your child's care. CAPS also provides other services for your families who want more support or information.

CAPS
Child Advocacy and Parenting Services, Inc.
155 N. Oakdale Ave., Suite 200, Salina, Ks 67401 • (785) 825-4483
www.capsofsalina.org

Respite Child Care

Family Enrollment & Income Information

Child's Name _____

Date of Birth: ___/___/_____ Race: _____ Gender: ___F ___M

Family First: ___Yes ___No Interested in Mentoring Services? ___Yes ___No

Does your child have an IEP or IFSP? If yes, which one: ☐ IEP ☐ IFSP ☐ None

Parent / Guardian Information: *List both parents/guardians or provide any necessary custodial court paperwork*

Parent/Guardian's Name: _____ Date of Birth: ____/____/_____

Address _____ City: _____ State: _____ Zip: _____

Race: _____ Gender: ____F ____M Marital Status: _____

Cell Phone ( ) _____-_____ Alt. Phone ( ) _____-_____

Education:(circle) less than HS diploma GED HS Diploma Some College/Tech training Degree or higher

Insurance status: Medicaid/State No Insurance Private Tricare Other _____

Employer: _____ FT PT Not employed

Income Sources (circle all) Wages Unemployment Alimony Soc, Security Workers Comp.

Agricultural SSI TANF Other: _____

Military Status: Current Former N/A Branch:_____

If Referred, by whom: _____

Parent/Guardian's Name: _____ Date of Birth: ____/____/_____

Address _____ City: _____ State: _____ Zip: _____

Race: _____ Gender: ____F ____M Marital Status: _____

Cell Phone ( ) _____-_____ Alt. Phone ( ) _____-_____

Education:(circle) less than HS diploma GED HS Diploma Some College/Tech training Degree or higher

Insurance status: Medicaid/State No Insurance Private Tricare Other _____

Employer: _____ FT PT Not employed

Income Sources (circle all) Wages Unemployment Alimony Soc, Security Workers Comp.

Agricultural SSI TANF Other: _____

Military Status: Current Former N/A Branch:_____

If Referred, by whom: _____

Annual Total household Income: $ _____

Name of <u>all</u> children(s) in the household:

1) First & Last Name: _____ DOB: ___/___/_____ M / F Race: _____

Ethnicity: Hispanic / Non-Hispanic Relationship to Parent/guardian: _____

Child's Insurance Status: Medicaid/CHIP No Insurance Private Tricare Other_____

2) First & Last Name: _____ DOB: ___/___/_____ M / F Race: _____

Ethnicity: Hispanic / Non-Hispanic Relationship to Parent/guardian: _____

Child's Insurance Status: Medicaid/CHIP No Insurance Private Tricare Other_____

3) First & Last Name: _____ DOB: ___/___/_____ M / F Race: _____

Ethnicity: Hispanic / Non-Hispanic Relationship to Parent/guardian: _____

Child's Insurance Status: Medicaid/CHIP No Insurance Private Tricare Other_____

4) First & Last Name: _____ DOB: ___/___/_____ M / F Race: _____

Ethnicity: Hispanic / Non-Hispanic Relationship to Parent/guardian: _____

Child's Insurance Status: Medicaid/CHIP No Insurance Private Tricare Other_____

<u>Family Information</u>:

Number of people living in the household: _____

Number of children under the age of 18 years in household: _____

Housing arrangements (circle one) Stable Temporary Homeless/living in a shelter

Parent/Guardian's Signature: _____ Date: _____

<u>Uso de la Oficina Unicamente</u>---Office Use Only

M(AM) M(PM) TU(AM) TU(PM) W(AM) W(PM) TH(AM) TH(PM) F(AM) F(PM)

Time slot: _____ Start Date: _____ Time slot: _____ Start Date: _____ End Date: _____

Annual Family Income: (please circle one) Below $17,000 $17,000 to $49,999 Above $50,000

In Database _____ Staff Initial _____ Family Share $_____

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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 Advocacy & Parenting Services, Inc

Child's Name _____ (First Last)

Date of Birth _____ (MM/DD/YYYY) Gender _____ (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): Salina Regional Health Center 400 S. Santa Fe 785-452-7000

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: _____

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Kansas Department of Health and Environment
Curtis State Office Building
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/280/Child-Care-Licensing

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 another outlined acceptable form, is required for all children including children of the provider or staff in Family Child Care Homes, Child Care Centers and Preschools. Acceptable forms include: A Kan-Be-Healthy Assessment Form (KDHE Form), a Physician Health Assessment Form and a School Health Assessment Form 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

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

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:_____

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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
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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 #**
Child Advocacy & Parenting Services	0077896-008

I authorize Necol Agugba and/or CAPS 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

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**

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

_____
Title (and Rank)

My appointment expires: _____

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.

CAPS Press Release Form

Pictures of your child may be taken while at CAPS. These photos can be posted in childcare classrooms. Some photos, however, may be posted in CAPS publications or online websites.

_____ I give the childcare staff permission to take and use my child's photo for classroom activities.
(Initial)

_____ My child's photo may be used for childcare advertising and/or CAPS publications.
(Initial)

_____ I do NOT want my child to be photographed while at CAPS Respite Childcare.
(Initial)

_____ _____
Parent/ Guardian's signature Date

CHILDCARE ILLNESS POLICY

Fever over 100.1 excludes your child from childcare for 24 hours and may not return until fever free without medication*

If I have vomited in the last 24 hours*

Diarrhea in the last 24 hours*

Any unexplained body rash must be seen by a physician and a doctors provided to attend

If you have lice or nits children must be treated, and nits picked. Hair will be checked upon arrival and nits seen child will be sent home

If red, itchy or crusty eyes with drainage. Must be seen a doctor and provide a doctor's note to attend childcare

Parents will be called if the child exhibits any of these symptoms and the child must be picked up within 30 minutes.

***Child can return once fever is normal WITHOUT the use of medication. Vomiting and diarrhea may attend childcare after 24 hours WITHOUT the use of medication.**

Parent Signature: _____ **Date:** _____

Respite Child Care Schedule

Monday AM Relay 9-12pm	Monday PM Relay 2-5pm
Tuesday AM Relay 9-12pm	Tuesday PM Relay 2-5pm
Wednesday AM Break 9-12pm	Wednesday PM Break 2-5pm
Thursday AM Relay 9-12pm	Thursday PM Relay 2-5pm
Friday AM Relay 9-12pm	Friday PM Relay 2-5pm

Please check the first and second options!

Doors open @ 8:45 a.m., and children **must be** picked up by 12:15 p.m. for morning sessions; and doors open @1:45 p.m. and children **must be** picked up by 5:15 p.m. for afternoon sessions. If you are going to be late, *CALL* and let us know.

Childcare 785-633-6236 CAPS 785-825-4493

Respite Staff