

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
Curtis State Office Building
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax: (785) 296-0803
Website: www.kdheks.gov/kidsnet



**INSTRUCTIONS FOR COMPLETING THE APPLICATION
FOR A LICENSED SCHOOL AGE PROGRAM**

- NEW APPLICANTS:** This includes all facilities required to be licensed, currently licensed programs that are moving, ownership changes, and programs changing from one category to another. **PROGRAMS THAT ARE APPLYING FOR A NEW LICENSE MUST COMPLETE ITEMS 1 THROUGH 4 AND 6 THROUGH 10.** If you are applying for a NEW licensed School Age Program, return the required forms and fees to your local child care facility surveyor.
- INTENT TO CONTINUE: (ANNUAL RENEWAL):** COMPLETE THE FORMS LISTED UNDER 1 THROUGH 5 BELOW. If you are renewing your current license, return the required forms and the annual state fee to the Kansas Department of Health and Environment at the above address. Send the local fee, if any, to your local child care facility surveyor.
- CLOSURE:** If you are no longer operating your School Age Program, you must notify KDHE of your intent to close. Complete the information requested on the form by checking the Closure box and provide the date you closed. Complete Section II & VI of the application and send to KDHE at the above address.

1. APPLICATION FOR LICENSE.

Applications for a new license are to be **submitted a minimum of 90 days prior to the anticipated opening** of the facility. Applications are processed in the order received. The facility is not authorized to provide services to children or youth prior to receiving a temporary permit or license.

CLEARLY PRINT OR TYPE using black ink. Complete all statements carefully and include all requested information as attachments. Please carefully review the complete application prior to mailing to the local child care facility surveyor or the Kansas Department of Health and Environment to be sure that all items as listed on the application are included. **Incomplete applications may be returned.**

TOTAL LICENSE CAPACITY OF THE FACILITY. Provide the requested capacity for the facility. Total capacity of a facility will be determined by KDHE at the time of licensure. The maximum capacity of a facility is determined by program director qualifications, available indoor and outdoor space for children, and fire approval.

SHOW FACILITY ADDRESS ON WEBSITE. Checking "yes" to this question authorizes KDHE to publish the facility address and phone number on a compliance report made available to the public through the online compliance information system.

ORIENTATION. If you currently have a license, you do not need to complete this section. If you are applying for a new license, please complete the date of your orientation. If you have not attended an orientation session, please contact the local child care facility surveyor **prior to submitting an application.**

- 2. STATE FEE.** Payment of the \$20.00 fee may be made with a check or money order made payable to the Kansas Department of Health and Environment or with a credit card by completing the necessary information on the application.

LOCAL FEE. KDHE contracts with local health departments or private contractors for local regulatory services. Local contractors may charge a local fee. Please contact your local child care facility surveyor to determine the amount of the local fee and submit that fee directly to the local contractor per their instructions.

3. FIRE SAFETY as required by K.S.A. 65-508.

NEW APPLICANTS: You must contact the Office of the State Fire Marshal (785-296-3401) and obtain fire safety acceptance/approval. Documentation of approval must be submitted with the application.

INTENT TO CONTINUE/ANNUAL RENEWAL: The school age program must comply with all applicable rules and regulations of the Kansas State Fire Marshal. An annual fire safety inspection will be conducted. A copy of the fire safety inspection is to be available for review by the local child care facility surveyor. If the school age program is located in a public school or public recreation facility, the current fire safety inspection for the facility is accepted as the current fire safety inspection for the school age program. If you have questions about the fire safety inspection, contact the State Fire Marshal at 785-296-3401.

4. **KBI/DCF SCREENING FORM as required by K.A.R. 28-4-125.**

CLEARLY PRINT OR TYPE IN ALL INFORMATION REQUESTED FOR EACH PERSON USING BLACK INK. All blanks must be completed. The Social Security Number is optional. If a section is not applicable, write NA in that space. Incomplete applications will be returned.

CAREFULLY CHECK the accuracy of the information you are submitting. All of the information requested ensures the accuracy of the background screening process. **EVERY PERSON LIVING, WORKING OR REGULARLY VOLUNTEERING AT THE FACILITY IS TO BE SUBMITTED AT THE TIME OF ANNUAL RENEWAL. THROUGHOUT THE RENEWAL YEAR, NEW PERSONS ARE TO BE SUBMITTED WITHIN ONE WEEK. Keep a copy** of the completed request form on file. Please see K.A.R. 28-4-125 for more information.

APPLICANTS TO CONTINUE A CURRENT LICENSE MUST ALSO COMPLETE AND SUBMIT THE FOLLOWING INFORMATION.

5. **PROGRAM DIRECTOR'S ANNUAL REPORT FORM.** Complete all information carefully. The license capacity is to reflect the total license capacity as stated on the most current license. **Complete and sign the form.**

APPLICANTS FOR A NEW LICENSE MUST ALSO COMPLETE AND SUBMIT THE FOLLOWING INFORMATION.

6. **VERIFICATION OF THE LEGAL OWNER OR OPERATOR.**

Private Owner or Partnership that is not Incorporated.

Submit a copy of the lease or deed for the property and, pursuant to K.S.A. 1991 Supp. 74-139, a copy of the Social Security Card or Driver's License or Birth Certificate for each owner or partner. If located in a church, school, or other building not owned by the individual or partnership, include authorization signed by the owner of the property granting permission for the operation of the program on their premises.

Corporate and LLC Owners.

Submit the Federal Identification Number and the Kansas Secretary of State's Business Entity ID Number. If located in a church, school, or other building not owned by the corporation, include authorization signed by the owner of the property granting permission for operation of the program on their premises.

Governmental Agency including School District.

Submit the Federal Identification Number assigned to the legal owner. If located in a church, school, or other building not owned by the government agency, include authorization signed by the owner of the property granting permission for the operation of the program on their premises.

7. **PROGRAM INFORMATION.**

- a. **Description of Program Activities and Services to be provided** including a statement of the program's purpose and goals including description of services provided such as educational activities, any high-risk activities, transportation, etc., the number and ages of children and youth for whom the program is designed and anticipated opening date.
- b. **Qualified Program Director.** Submit a KDHE Program Director Approval letter if available. If not available, complete and return the enclosed Program Director's Application included in this packet.

8. **PHYSICAL PLANT INFORMATION.**

A. **Floor plan.**

- a) Submit a floor plan showing how the rooms used by the program fit into the overall building design and what level the program is on.
- b) Specify the linear dimensions for each room to be used by the children and youth and mark the entrances and exits from each room.
- c) Identify the interest areas in each room.
- d) Indicate the number of toilets and hand sinks in the restrooms.
- e) Mark all of the exit paths used by the children/youth to the outside of the building.
- f) Indicate on the floor plan which direction is north.

- B. **Outdoor activity area on the premises. (Outdoor activity area on the premises is not required for school age programs unless the school age program includes outdoor activities as part of its program.) OUTDOOR ACTIVITY SPACE MAY NOT BE SHARED WITH ANOTHER LICENSED CHILD CARE FACILITY.**
- a) Specify the location and linear dimensions of the outdoor activity area and include information about its location relative to the indoor activity area. Please indicate if the outdoor area is fenced or not and indicate the location of any hazards adjacent to the area such as heavily traveled streets, railroad tracks and bodies of water.
 - b) Show the route children will take to enter the outdoor activity area.
 - c) Indicate the location of drinking water and of restrooms, and how accessed by the children/youth.
 - d) Mark the location of pieces of stationary play equipment (swings, climbers, slides, etc.) and indicate the distance between them.
 - e) Specify the type of impact-absorbing material under and around the climbing equipment, and the outdoor surface material on the remaining playground.
9. **SANITARIAN'S APPROVAL.** If connected to private water or sewage disposal system a sanitarian's approval is necessary.
10. **LOCAL CODE APPROVAL.** Local codes and ordinances may prescribe other requirements for the legal operation of a school age program. Applicant must submit written approval from the appropriate local agencies indicating that all local codes are met or that there are none which apply.

FOR YOUR INFORMATION AND USE

KDHE INSPECTION.

K.S.A. 65-512 requires that all licensed facilities be inspected at least once every twelve months. An initial announced inspection will be requested by KDHE when a **complete and reviewed** application is received and the facility is ready for occupancy. Your local child care facility surveyor will make an **ANNOUNCED** initial inspection of the facility and the surrounding outdoor area. However, all future inspections including compliance checks, complaint investigations and annual reviews are **UNANNOUNCED**. The annual review inspection will not necessarily occur at the time of your annual renewal date for your Intent to Continue Licensure. KDHE provides dates for inspection to the local child care facility surveyor. Inspection dates may change from time to time. If you have questions or comments about your inspection, please contact the Kansas Department of Health and Environment.

KDHE REQUIRED FORMS.

Current KDHE forms are enclosed for your use. **Please make copies of these forms for future program use.** Destroy all unused copies of out-of-date forms, if you have any. Forms may also be downloaded from the KDHE website at www.kdheks.gov/kidsnet

REGULATORY QUESTIONS.

The local child care facility surveyor is your first and primary person of contact for questions about school age program regulations and laws. Surveyors have a supply of Laws and Regulation books. If you need a law or regulation book, contact your local surveyor or download from the KDHE website at www.kdheks.gov/kidsnet. Surveyors are also a good source of information about other local services including local education opportunities that may be available to school age program facility staff.

OTHER INFORMATION.

Once you have obtained a temporary permit or license, you may be eligible for services provided by other agencies. Please contact your local child care facility surveyor, local area Department of Social and Rehabilitation Service office, and your local child care resource and referral agency to find out what is available in your area.

Good Beginnings Last A Lifetime!



APPLICATION FOR A SCHOOL AGE PROGRAM

Good beginnings last a lifetime. The service you offer to children and youth is important to the community and will have a lasting impact on the children and youth in your program. Kansas child care laws and regulations are designed to reduce the predictable risk of harm to children and youth. By completing and submitting this application you are: 1) requesting a license to operate a school age program; and 2) affirming that you have read and agree to comply with all laws and regulations for licensed school age programs.

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SECTION I: INTENT OF THE APPLICANT/OWNER. COMPLETE ONE OF THE FOLLOWING THREE BOXES BELOW.

NEW APPLICATION / MOVE / PROGRAM CHANGE	
_____ This application is for a new school age program that is not currently licensed or is currently licensed, but I/we are	
_____ moving to a new location	_____ anticipated date _____
_____ changing ownership	_____ anticipated date _____
_____ changing our program type (submit application for program type)	
I/We are applying for the following type of School Age Program:	
_____ Building Based	
_____ Outdoor Summer Camp	
_____ Mobile Summer Program	
_____ Day Reporting Program	
Requested License Capacity _____	

RENEWAL APPLICATION
_____ This application is notification to renew our existing license for another year.

NOTIFICATION OF CLOSURE
_____ This is notification that I/we no longer provide school age program services.
Close the school age program effective _____ (MM/DD/YYYY).
Please complete Sections II and VI.

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SECTION II: FACILITY INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

Name of the Facility to be stated (or as stated) on the license:		License #: (if renewing/closing)	
Name of Facility Contact Person:		Name of Qualified Program Director:	
Physical Address of the Facility: Street Address		City	Zip Code
County:	Phone Number: ()	Fax Number: ()	Email Address:
Show Facility Physical Address and Telephone Number on the Website? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Mailing Address of the Facility: Street Address	City	Zip Code
Year Facility Built:	Most Recent Fire Inspection Date:	
Public Water: <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Sewer: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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SECTION III: LEGAL OWNER/OPERATOR INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

Name of the Legal Owner/Operator:			
Physical Address of the Owner/Operator: Street Address		City	Zip Code
County:	Phone Number: ()	Fax Number: ()	Email Address:
Mailing Address of the Owner/Operator (if different from above): Street Address		City	Zip Code
Type of Ownership. The Legal Owner/Operator is a (check ONE of the following): <input type="checkbox"/> Individual or individuals that is/are not incorporated <input type="checkbox"/> Corporation, LLC, LLP <input type="checkbox"/> Government entity/agency or school district Federal ID No. _____ Business Entity ID No. _____			

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SECTION IV: FACILITY OPERATION INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

Indicate the months of the year, hours and days of the week you will be providing services to children and youth (check only one option for each schedule you complete):

_____ All Year (Jan through Dec) _____ Summer Only (June through Aug) _____ School Year Only (Sept through May)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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_____ All Year (Jan through Dec) _____ Summer Only (June through Aug) _____ School Year Only (Sept through May)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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Yes **No** Do you have or intend to have a Provider Agreement with the Department of Children and Families (DCF)?

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SECTION V: ADDITIONAL INFORMATION FOR NEW APPLICANTS ONLY. COMPLETE ALL INFORMATION. PLEASE PRINT.

<input type="checkbox"/> Yes <input type="checkbox"/> No I/we had a child care license/certificate in the past. If yes, complete the following: Name on the previous license or certificate: _____ License/Certificate Number : _____ Year(s) of operation: _____ Address on the previous license or certificate: _____ I/We attended an orientation session with my/our local child care facility surveyor on: _____ (Date)	
Signature of the Child Care Facility Surveyor:	Date Signed (MM/DD/YYYY):

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SECTION VI: AGREEMENTS AND AUTHORIZED SIGNATURE. READ EACH STATEMENT AND SIGN THE APPLICATION.

I/We the undersigned, am [are the person(s)] named as the Applicant or the person(s) authorized to represent the owner listed above.

I/We have read the laws and regulations governing the operation of this licensed facility and it is the intention of this applicant to comply. I/We understand that I/we are responsible for meeting and maintaining compliance with all applicable child care licensing laws and regulations at all times.

I/We understand that a **new** application may take up to **90 days for processing** by the Kansas Department of Health and Environment (KDHE), once KDHE receives a complete application. I/We understand that I/we are not authorized to provide services to children and youth prior to receiving a Temporary Permit or License from KDHE.

In accordance with K.S.A. 44-1009, I/we shall not exclude any child from care for reason of race, religion, color, sex, physical handicap, national origin, or ancestry.

I/We attest, under penalty of perjury, that to the best of my (our) knowledge, that the information provided in this application is true and correct.

Authorized Signature:	Date (MM/DD/YYYY):
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Authorized Signature, if more than one person:	Date (MM/DD/YYYY):
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FEE: IF PAYING THE STATE LICENSE FEE BY CREDIT CARD, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Credit Card Information - DISCOVER CARD ONLY	
Discover Card Account #: _____ (Please print clearly)	Expiration Date: _____
Amount of the state licensing fee: \$ _____	
Signature as it is written on the Card: _____ By my signature, I acknowledge my understanding that a 2.5% convenience fee will be included in the final total of this transaction.	

Kansas Department of Health and Environment contracts with local health departments or private contractors for local regulatory services. **Local contractors may charge a local fee.** Please contact your local child care facility surveyor to determine the amount of the local fee and submit that fee directly to the local contractor per their instructions.

Some local ordinances may apply to your school age program in addition to the state laws and regulations. Please contact your local child care facility surveyor to determine if there are local ordinances which may apply to the operation of a school age program.

For information about requirements of the Americans with Disabilities Act (ADA), contact: Great Plains Disability and Business Technical Assistance Center, University of Missouri at Columbia, 100 Corporate Lake Drive, Columbia, MO 65203, Phone: 1-800-949-4232.

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SECTION VII: MAILING INSTRUCTIONS. Return the completed and signed application along with the documents listed in one of the three boxes below, as applicable. Follow the mailing instructions provided.

NEW APPLICATION / MOVE / PROGRAM CHANGE

Return the following documents:

1. Completed and signed application.
2. Request for KBI/DCF Child Abuse Registry Check. (You must keep a copy on file.)
3. Fire Safety Approval. You must obtain Fire Safety Approval from the State Fire Marshal. Call the State Fire Marshal at (785) 296-3401. See Instructions.
4. State Licensing Fee (\$20.00) payable to the Kansas Department of Health and Environment or complete credit card information.
5. Verification of legal owner/operator according to the instructions.
6. Description of Program Activities and Services according to the instructions.
7. Physical Facility Information according to the instructions.
8. Local Code approval according to the instructions.
9. Sanitarian's approval, if applicable, according to the instructions.
10. Local Fee, if required by the local child care facility surveyor.

SEND THE ABOVE INFORMATION TO THE LOCAL CHILD CARE FACILITY SURVEYOR. IF YOU DO NOT HAVE THE ADDRESS OF THE LOCAL CHILD CARE FACILITY SURVEYOR, CONTACT KDHE AT 785-296-1270 TO OBTAIN THE INFORMATION OR VISIT THE KDHE WEBSITE www.kdheks.gov/kidsnet.

RENEWAL APPLICATION

Return the following documents:

1. Completed and signed application.
2. Request for KBI/DCF Child Abuse Registry Check. (You must keep a copy on file.)
3. Fire Safety Approval. See Instructions.
4. State License Fee (\$20.00) payable to the Kansas Department of Health and Environment or complete credit card information.
5. Program Director's Annual Report.

SEND THE ABOVE TO: Kansas Department of Health and Environment, Curtis State Office Building, Bureau of Family Health, Child Care Licensing Program, 1000 SW Jackson, Suite 200, Topeka, KS 66612-1274.

If the local child care facility contractor charges a local fee, the local fee is to be sent to the local contractor. Do NOT send the local fee to KDHE with the renewal application.

NOTIFICATION OF CLOSURE

Return the completed (Sections I, II and VI) and signed application to the Kansas Department of Health and Environment, Curtis State Office Building, Bureau of Family Health, Child Care Licensing Program, 1000 SW Jackson, Suite 200, Topeka, KS 66612-1274.



APPLICATION FOR A SCHOOL AGE PROGRAM

Good beginnings last a lifetime. The service you offer to children and youth is important to the community and will have a lasting impact on the children and youth in your program. Kansas child care laws and regulations are designed to reduce the predictable risk of harm to children and youth. By completing and submitting this application you are: 1) requesting a license to operate a school age program; and 2) affirming that you have read and agree to comply with all laws and regulations for licensed school age programs.

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SECTION I: INTENT OF THE APPLICANT/OWNER. COMPLETE ONE OF THE FOLLOWING THREE BOXES BELOW.

NEW APPLICATION / MOVE / PROGRAM CHANGE	
_____ This application is for a new school age program that is not currently licensed or is currently licensed, but I/we are	
_____ moving to a new location	_____ anticipated date _____
_____ changing ownership	_____ anticipated date _____
_____ changing our program type (submit application for program type)	
I/We are applying for the following type of School Age Program:	
_____ Building Based	
_____ Outdoor Summer Camp	
_____ Mobile Summer Program	
_____ Day Reporting Program	
Requested License Capacity _____	

RENEWAL APPLICATION
_____ This application is notification to renew our existing license for another year.

NOTIFICATION OF CLOSURE
_____ This is notification that I/we no longer provide school age program services.
Close the school age program effective _____ (MM/DD/YYYY).
Please complete Sections II and VI.

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SECTION II: FACILITY INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

Name of the Facility to be stated (or as stated) on the license:		License #: (if renewing/closing)	
Name of Facility Contact Person:		Name of Qualified Program Director:	
Physical Address of the Facility: Street Address		City	Zip Code
County:	Phone Number: ()	Fax Number: ()	Email Address:
Show Facility Physical Address and Telephone Number on the Website? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Mailing Address of the Facility: Street Address	City	Zip Code
Year Facility Built:	Most Recent Fire Inspection Date:	
Public Water: <input type="checkbox"/> Yes <input type="checkbox"/> No	Public Sewer: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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SECTION III: LEGAL OWNER/OPERATOR INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

Name of the Legal Owner/Operator:			
Physical Address of the Owner/Operator: Street Address		City	Zip Code
County:	Phone Number: ()	Fax Number: ()	Email Address:
Mailing Address of the Owner/Operator (if different from above): Street Address		City	Zip Code
Type of Ownership. The Legal Owner/Operator is a (check ONE of the following): <input type="checkbox"/> Individual or individuals that is/are not incorporated <input type="checkbox"/> Corporation, LLC, LLP <input type="checkbox"/> Government entity/agency or school district Federal ID No. _____ Business Entity ID No. _____			

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SECTION IV: FACILITY OPERATION INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

Indicate the months of the year, hours and days of the week you will be providing services to children and youth (check only one option for each schedule you complete):

_____ All Year (Jan through Dec) _____ Summer Only (June through Aug) _____ School Year Only (Sept through May)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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Yes No Do you have or intend to have a Provider Agreement with the Department of Children and Families (DCF)?

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SECTION V: ADDITIONAL INFORMATION FOR NEW APPLICANTS ONLY. COMPLETE ALL INFORMATION. PLEASE PRINT.

Yes No I/we had a child care license/certificate in the past. If yes, complete the following:

Name on the previous license or certificate: _____

License/Certificate Number : _____ Year(s) of operation: _____

Address on the previous license or certificate: _____

I/We attended an orientation session with my/our local child care facility surveyor on: _____ (Date)

Signature of the Child Care Facility Surveyor:

Date Signed (MM/DD/YYYY):

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SECTION VI: AGREEMENTS AND AUTHORIZED SIGNATURE. READ EACH STATEMENT AND SIGN THE APPLICATION.

I/We the undersigned, am [are the person(s)] named as the Applicant or the person(s) authorized to represent the owner listed above.

I/We have read the laws and regulations governing the operation of this licensed facility and it is the intention of this applicant to comply. I/We understand that I/we are responsible for meeting and maintaining compliance with all applicable child care licensing laws and regulations at all times.

I/We understand that a **new** application may take up to **90 days for processing** by the Kansas Department of Health and Environment (KDHE), once KDHE receives a complete application. I/We understand that I/we are not authorized to provide services to children and youth prior to receiving a Temporary Permit or License from KDHE.

In accordance with K.S.A. 44-1009, I/we shall not exclude any child from care for reason of race, religion, color, sex, physical handicap, national origin, or ancestry.

I/We attest, under penalty of perjury, that to the best of my (our) knowledge, that the information provided in this application is true and correct.

Authorized Signature:	Date (MM/DD/YYYY):
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Authorized Signature, if more than one person:	Date (MM/DD/YYYY):
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FEE: IF PAYING THE STATE LICENSE FEE BY CREDIT CARD, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Credit Card Information - DISCOVER CARD ONLY	
Discover Card Account #: _____ (Please print clearly)	Expiration Date: _____
Amount of the state licensing fee: \$ _____	
Signature as it is written on the Card: _____ By my signature, I acknowledge my understanding that a 2.5% convenience fee will be included in the final total of this transaction.	

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4. State Licensing Fee (\$20.00) payable to the Kansas Department of Health and Environment or complete credit card information.
5. Verification of legal owner/operator according to the instructions.
6. Description of Program Activities and Services according to the instructions.
7. Physical Facility Information according to the instructions.
8. Local Code approval according to the instructions.
9. Sanitarian's approval, if applicable, according to the instructions.
10. Local Fee, if required by the local child care facility surveyor.

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RENEWAL APPLICATION

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5. Program Director's Annual Report.

SEND THE ABOVE TO: Kansas Department of Health and Environment, Curtis State Office Building, Bureau of Family Health, Child Care Licensing Program, 1000 SW Jackson, Suite 200, Topeka, KS 66612-1274.

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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



REQUEST FOR KB/DCF CHILD ABUSE REGISTRY CHECK FOR CHILD CARE AND RESIDENTIAL CARE FACILITIES

Directions: COMPLETE BOTH SIDES OF THIS FORM. All blank spaces must be completed; however, social security number is optional. Incomplete forms will be returned. If a person does not have a Maiden or other name, write N/A. DO NOT include children or youth for whom you provide services. **K.A.R. 28-4-125(c) requires the facility to keep a copy of the completed form on file.**

Type of Facility: _____ Child Care Facility _____ Child Care Resource & Referral Agency _____ 24-Hour Residential Care _____ Child Placing Agency
Or School Age Programs _____ Including Family Foster Care

Name of Facility exactly AS STATED ON THE LICENSE		License #	Date (MM/DD/YYYY)
Street Address of Facility		City	Zip Code
First and Last Name of the Individual Completing This Form		Phone Number	E-mail address

I. This request for background check is being completed to meet the requirements (CHECK ONLY ONE of the THREE OPTIONS BELOW):
 _____ **Initial Application (New Facility, Move or Change of Ownership)**
 _____ **Renewal Application**
 _____ **Adding a New person(s) living, working or volunteering in the facility. The information provided on this form is to include only the identifying information for new individual(s).**

II. Check Yes or No for each question below with regard to the persons listed on this form. If yes, complete all the information in this section for the person.
The information provided on this form is to include: yourself; all other persons 10 years of age and older living in the facility and all persons working and/or volunteering in the facility; all substitutes and other caregivers and staff including relief and support staff.

Yes	No	Name of Person	Date	Court of Action County and State
		Had a misdemeanor or felony conviction of a crime against persons, a sexual offense or crimes affecting family relationships and children?		
		Had a felony conviction under the uniform controlled substances act?		
		Been adjudicated (found or determined in a court of law to be) a juvenile offender, delinquent, or miscreant?		
		Committed physical, mental or emotional abuse or neglect or sexual abuse as validated by DCF?		
		Had a child declared in a court order to be deprived or in need of care based on allegation of physical, mental or emotional abuse or neglect or sexual abuse?		
		Had parental rights terminated?		
		Signed a diversion agreement involving child abuse or a sexual offense?		
		Been found to be a disabled person in need of a guardian or conservator or both?		

Name of Facility exactly AS STATED ON THE LICENSE

License #

Date Completed (MM/DD/YYYY)

1.	Last	First	Middle	Maiden or Any Other Name Ever Used (Alias)	Social Security #	Date of Birth (MM/DD/YYYY)	Gender Male or Female	Race	Address - Street, City, Zip Code Phone
2.									Phone
3.									Phone
4.									Phone
5.									Phone
6.									Phone
7.									Phone
8.									Phone
9.									Phone
									Phone

FOLLOWING THIS PAGE ARE FORMS REQUIRED FOR
THE CONTINUATION OF A CURRENT LICENSE



PROGRAM DIRECTOR'S ANNUAL REPORT FOR SCHOOL AGE PROGRAM

Complete all information requested and return to the Kansas Department of Health and Environment within the next 30 days along with the renewal application. PLEASE PRINT CLEARLY.

License Number:		County:	
Official Name of the School Age Program exactly as stated on the license:			
Physical Address of the School Age Program: Street Address		City	Zip Code
First and Last Name of the on-site Program Director:		KDHE Program Director Number (as stated on the approval letter):	
Qualified as a Program Director for a total license capacity of:	Total License Capacity of the School Age Program:		

Within 10 calendar days after hiring a program director, a copy of the **approval letter issued by KDHE** that the program director is qualified for the license capacity is on file or a request has been submitted to KDHE for program director's approval as required by K.A.R. 28-4-587(b)(3).

The **program director** is at least 18 years of age or older and is at least three years older than the oldest youth in the program as required by K.A.R. 28-4-587(b)(1)(A) or for **day reporting programs** is 21 years of age or older as required by K.A.R. 28-4-596(g)(1).

The **program director** demonstrates knowledge of child and youth development, knowledge of licensing regulations applicable to the program, administrative and supervisory skills, the ability to communicate clearly and the competence to manage the program in compliance with program policies, the program plan and the school age regulations as required by K.A.R. 28-4-587(b)(1)(B).

The **program director for a day reporting program** must have knowledge and experience working with juvenile offenders, high-risk children and youth, community youth programs or social service programs serving children and youth as required by K.A.R. 28-4-596(g)(1)(C).

The operator delegates administrative **authority so that the program has a program director or a program director's designee** in charge during all hours of operation as required by K.A.R. 28-4-582(d). Each **program director designee** meets the requirements specified in K.A.R. 28-4-587(b)(1) and (2)(A).

First and Last Name of the Program Director Designee, if applicable.

If the program has a licensed capacity of 91 or more children, the program has an **administrator** that meets the qualifications as stated in K.A.R. 28-4-587(c).

Each **group leader** meets the qualifications as required in K.A.R. 28-4-587(d) or for **day reporting programs** must meet the qualifications as required in K.A.R. 28-4-596(g)(2).

Each **assistant group leader** meets the qualifications as required in K.A.R. 28-4-587(e) or for **day reporting programs** must meet the qualifications as required in K.A.R. 28-4-596(g)(3).

Each **substitute** used by the program meets the qualifications as required in K.A.R. 28-4-587(f).

Each **volunteer** used by the program meets the qualifications as required in K.A.R. 28-4-587(g).

Orientation training is provided to the program director and each staff member who is counted in the supervisory ratio before or within the first week of working with children or youth as required by K.A.R. 28-4-587(h).

Operator ensures that at least one staff member is on the premises, readily available to each child or youth at all times that has current certification in first aid and current certification in CPR appropriate to the age of children and youth attending the program as required in K.A.R. 28-4-592(c)(1). Record of certification is to be on file.

Ongoing professional development training:

The program director annually obtains 15 clock hours of professional development training as required by K.A.R. 28-4-587(h)(2)(A). Documentation must be on file and will be checked by a local child care facility surveyor.

The operator or program director assesses the **training needs of the staff members** and provides staff training as needed to maintain the program in compliance with license regulations as required by K.A.R. 28-4-587(h)(2)(B). Documentation of training is kept in the staff member's file and will be checked by a local child care facility surveyor.

Book reports and videos not part of a group discussion are not accepted. In assessing the professional development training needs of staff members, KDHE recommends that a professional development plan be developed and implemented for each staff member.

Professional development training means training approved by KDHE that is related to working with school-age children or youth as stated in K.A.R. 28-4-576(cc).

Relevant training includes instruction about the competency areas outlined in ***Core Competencies for Early Care and Education Professionals in Kansas and Missouri*** as applied to children and youth; child and adolescent growth and development; learning environment and curriculum; child and youth observation and assessment; families and communities; health, safety and nutrition; interactions with children and youth; program planning and development; and professional development and leadership. **For day reporting programs**, relevant training also includes training related to working with juvenile offenders, high-risk children and youth, community youth programs or social service programs serving children and youth.

Professional development training that has been KDHE approved for clock hours or academic credit hours is available in most communities on an on-going basis. Please contact your local child care resource and referral agency for information about training opportunities in your area.

Operator must notify KDHE in writing before closing the program or changing high risk sports or recreational activities offered by the program, program director, physical structure of the program site due to new construction or substantial remodeling that affects the license capacity, or the use of any part of the premises as required by K.A.R. 28-4-578(f).

I attest, under penalty of perjury, that the school age program complies with the above licensing regulations. I further agree to operate the program in compliance with all applicable child care licensing laws and regulations at all times, including staff qualifications, ongoing professional development training, and supervisory ratios.

Authorized Signature:	Date (MM/DD/YYYY):
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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



**APPLICATION FOR REVIEW OF PROGRAM DIRECTOR QUALIFICATIONS
FOR SCHOOL AGE PROGRAMS**

Complete all information requested and return to the Kansas Department of Health and Environment at the above address. **ATTACH COLLEGE TRANSCRIPT, IF APPLICABLE.** Any attachments should clearly state your current first and last name. Allow a minimum of 30 days for review. A Notice of Program Director Qualifications will be sent to the applicant. Incomplete applications will be returned without review.

This form is to be used for review of Program Director Qualifications according to K.A.R. 28-4-587. If you are wanting a review of qualifications for a Child Care Center, Preschool or Head Start Program according to K.A.R. 28-4-429, please use the "Application for Review of Program Director Qualifications for Child Care Centers, Preschools and Head Start Programs".

Check one of the following:

- I am requesting a first-time review of my education/experience for Program Director qualifications.
- My education and experience have been previously reviewed by KDHE. Attached is a copy of the current status of the last review. The information below is additional education and/or experience. I am requesting a review to update my Program Director qualifications.

I am requesting a review of my qualifications as follows:

- School Age Program for children and youth Kindergarten age and older.
- Day Reporting Program for children and youth 10 years of age and older.

Applicant Information: Please print clearly or type.

First and Last Name of Applicant				Date of Birth (MM/DD/YYYY)	
Physical Address of Applicant - Street		City	State	Zip Code + 4	County
Mailing Address of Applicant - Street		City	State	Zip Code + 4	County
Phone Number ()	Fax Number ()		Email Address		

Record of Education (Check One):

	<p>I am requesting review of my qualifications for a license capacity of 30 or fewer children/youth. I have graduated High School or completed a GED. I have (check one):</p> <p><input type="checkbox"/> completed at least three months of job-related experience as indicated on page 2 of this application.</p> <p><input type="checkbox"/> previously been approved as a program director as specified in K.A.R. 28-4-429(b) or (c). (Attach copy of approval.)</p>
	<p>I am requesting review of my qualification for a license capacity of 31 through 60 children/youth. I have (check one):</p> <p><input type="checkbox"/> completed a minimum of 15 academic credit hours. (Attach copy of transcripts.)</p> <p><input type="checkbox"/> completed at least six months of job-related experience as indicated on page 2 of this application.</p> <p><input type="checkbox"/> previously been approved as a program director as specified in K.A.R. 28-4-429(d) or (e). (Attach a copy of approval.)</p>

	<p>I am requesting review of my qualifications for a license capacity of 61 through 120 children/youth and have (check one):</p> <p>_____ completed a minimum of 60 academic credit hours. (Attach copy of transcripts.)</p> <p>_____ completed at least 12 months of job-related experience as indicated on page 2 of this application.</p> <p>_____ completed a combination of 30 academic credit hours (attach copy of transcripts) and at least six months of job-related experience as indicated on page 2 of this application.</p> <p>_____ previously been approved as a program director as specified in K.A.R. 28-4-429(e). (Attach a copy of approval.)</p>
	<p>I am requesting review of my qualifications for a license capacity of 121 or more children/youth and have:</p> <p>_____ a minimum of a four-year bachelor's degree from an accredited college or university (attach copy of transcripts) and job related experience as indicated on page 2 of this application.</p>
	<p>I am requesting review of my qualifications (check one):</p> <p>_____ the operator I work for is affiliated with a national organization or governmental entity with standards governing school age programs. I have participated in professional development training according to the standards established and the secretary of KDHE has deemed the standards to be equivalent. [(See K.A.R. 28-4-587(b)(2)(E)]. Attach copy of documentation showing completion of the organization's training program and print the name of the organization:</p>

Record of current and previous teaching experience working with children or youth. **Please list most current first.** (If more than space allows, please attach additional pages.)

Complete Name of Program			
Street Address		City	State
Title of Position Held	Beginning Date (MM/DD/YYYY)	Ending Date (MM/DD/YYYY)	Age of Children or Youth you worked with:

Complete Name of Program			
Street Address		City	State
Title of Position Held	Beginning Date (MM/DD/YYYY)	Ending Date (MM/DD/YYYY)	Age of Children or Youth you worked with:

Complete Name of Program			
Street Address		City	State
Title of Position Held	Beginning Date (MM/DD/YYYY)	Ending Date (MM/DD/YYYY)	Age of Children or Youth you worked with:

I attest, under penalty of perjury, that the information on this form and all its attachments is true and correct.

Applicant's Signature	Date Completed (MM/DD/YYYY)
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FOLLOWING THIS PAGE ARE
CURRENT KDHE FORMS
FOR YOUR USE.

PLEASE MAKE COPIES OF THESE FORMS
OR DOWNLOAD ADDITIONAL FORMS AT
www.kdheks.gov/kidsnet

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



REQUEST FOR KB/DCF CHILD ABUSE REGISTRY CHECK FOR CHILD CARE AND RESIDENTIAL CARE FACILITIES

Directions: COMPLETE BOTH SIDES OF THIS FORM. All blank spaces must be completed; however, social security number is optional. Incomplete forms will be returned. If a person does not have a Maiden or other name, write N/A. DO NOT include children or youth for whom you provide services. **K.A.R. 28-4-125(c) requires the facility to keep a copy of the completed form on file.**

Type of Facility: _____ Child Care Facility _____ Child Care Resource & Referral Agency _____ 24-Hour Residential Care _____ Child Placing Agency
Or School Age Programs _____ Including Family Foster Care

Name of Facility exactly AS STATED ON THE LICENSE		License #	Date (MM/DD/YYYY)
Street Address of Facility		City	Zip Code
First and Last Name of the Individual Completing This Form		Phone Number	E-mail address

I. This request for background check is being completed to meet the requirements (CHECK ONLY ONE of the THREE OPTIONS BELOW):

_____ **Initial Application (New Facility, Move or Change of Ownership)**
 _____ **Renewal Application**
 _____ **Adding a New person(s) living, working or volunteering in the facility. The information provided on this form is to include only the identifying information for new individual(s).**

II. Check Yes or No for each question below with regard to the persons listed on this form. If yes, complete all the information in this section for the person. The information provided on this form is to include: yourself; all other persons 10 years of age and older living in the facility and all persons working and/or volunteering in the facility; all substitutes and other caregivers and staff including relief and support staff.

Yes	No	Name of Person	Date	Court of Action County and State
		Had a misdemeanor or felony conviction of a crime against persons, a sexual offense or crimes affecting family relationships and children?		
		Had a felony conviction under the uniform controlled substances act?		
		Been adjudicated (found or determined in a court of law to be) a juvenile offender, delinquent, or miscreant?		
		Committed physical, mental or emotional abuse or neglect or sexual abuse as validated by DCF?		
		Had a child declared in a court order to be deprived or in need of care based on allegation of physical, mental or emotional abuse or neglect or sexual abuse?		
		Had parental rights terminated?		
		Signed a diversion agreement involving child abuse or a sexual offense?		
		Been found to be a disabled person in need of a guardian or conservator or both?		

Name of Facility exactly AS STATED ON THE LICENSE

License #

Date Completed (MM/DD/YYYY)

1.	Last	First	Middle	Maiden or Any Other Name Ever Used (Alias)	Social Security #	Date of Birth (MM/DD/YYYY)	Gender Male or Female	Race	Address - Street, City, Zip Code Phone
2.									Phone
3.									Phone
4.									Phone
5.									Phone
6.									Phone
7.									Phone
8.									Phone
9.									Phone
									Phone



**HEALTH STATUS FORM FOR PERSONS 14 YEARS OF AGE OR OLDER
WORKING OR VOLUNTEERING IN SCHOOL AGE PROGRAMS**

As required by K. A. R. 28-4-590(b)(4), each operator and each staff member who has regular, ongoing contact with children or youth shall attest to that individual's health status on a form supplied by the department or approved by the secretary. The health status form shall indicate if the individual has been exposed to an active case of tuberculosis or has been diagnosed with suspect or confirmed active tuberculosis. Each individual shall update the health status form annually or more often if there is a change in the health status or if the individual has been exposed to an active case of tuberculosis.

PLEASE PRINT.

Name of the School Age Program exactly as stated on the license.	License Number
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Facility Street Address:	City	Zip Code + 4	County
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First and Last Name of the Individual for which this Health Status applies:	Date of Birth (MM/DD/YYYY)
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In case of emergency, program staff should contact the following person. First and Last Name:	Relationship to you.	Their Phone Number ()
--	-----------------------------	--

Please check each question. **If answer is yes, please explain.**

- | | | |
|---|------------|-----------|
| | <u>Yes</u> | <u>No</u> |
| 1. Do you see a health care provider regularly for any health condition? | ___ | ___ |
| 2. Have you had any surgery in the past 3 years? | ___ | ___ |
| 3. Do you have any health conditions which might interfere with your care of children or youth? | ___ | ___ |
| 4. Do you take any medications which might interfere with your care of children or youth? | ___ | ___ |
| 5. Do you have any chronic illness conditions that might interfere with your care of children or youth such as: | | |

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Headaches	___	___	Cancer	___	___	Alcoholism	___	___
Heart Disease	___	___	Diabetes	___	___	Arthritis	___	___
High Blood Pressure	___	___	Convulsions	___	___	Liver Disease	___	___
Lung Disease	___	___	Mental Illness	___	___	Other	___	___

<p>If you answer yes to any of the above, please explain further. Attach an additional page if needed.</p>

Please check each of the following statements:

- Yes No I am free from physical, mental, or emotional handicaps as necessary to protect the health, safety, and welfare of the children or youth as required by K.A.R. 28-4-590(b)(1).
- Yes No When I am working or volunteering in the School Age Program, I will not be under the influence of alcohol or illegal substances or impaired due to the use of prescription or nonprescription drugs as required by K.A.R. 28-4-290(b)(2).
- Yes No I am free from any infectious or contagious disease as specified in K.A.R. 28-1-6 (see below) as required by K.A.R. 28-4-590(b)(3).
- Yes No I have not been exposed to active tuberculosis.
- Yes No I have not been diagnosed with suspect or confirmed active tuberculosis.

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

Signature	Date Signed (MM/DD/YYYY)
ANNUAL UPDATE	
Signature _____	Date Updated _____

K.A.R. 28-1-6

- (a) Amebiases;
- (b) Anthrax;
- (c) Chickenpox;
- (d) Cholera;
- (e) Diphtheria;
- (f) E. coli 0157:H7;
- (g) Gonorrhea;
- (h) Malaria;
- (i) Meningitis, meningococcal;
- (j) Meningitis, aseptic and other;
- (k) Mumps;
- (l) Pediculosis;
- (m) Pertusis;
- (n) Plague;
- (o) Poliomyelitis;
- (p) Rubeola;
- (q) Rubella;
- (r) Salmonellosis (nontyphoidal);
- (s) Scabies;
- (t) Shigellosis;
- (u) Staphylococcal disease;
- (v) Streptococcal disease, hemolytic;
- (w) Taeniasis (beef or pork tapeworm);
- (x) Tinea capitis and corporis (ringworm);
- (y) Tuberculosis;
- (z) Typhoid fever;
- (aa) Sexually transmitted diseases;
- (bb) Viral hepatitis type A;

OVER - COMPLETE BOTH SIDES OF FORM



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

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

Mother/Guardian's Work Place Name & Street Address	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 Work Place 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?

Circle 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 circled 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?
X	X	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 Infl. 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



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 _____ (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 _____.
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 <u>Kansas</u>	
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: _____	

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.



Authorization for Dispensing Medications to Children or Youth Short-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label.

Medication #1		

First and Last Name of Child or Youth		

Name of Medication		

Reason for Medication		

Dose	Time to be Given	Stop Date

Name of Licensed Physician/Nurse Practitioner prescribing the medication (_____)		
Phone number of Health Care Provider _____		
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.		
_____		_____
Parent's Signature		Date

Medication #2		

First and Last Name of Child or Youth		

Name of Medication		

Reason for Medication		

Dose	Time to be Given	Stop Date

Name of Licensed Physician/Nurse Practitioner prescribing the medication (_____)		
Phone number of Health Care Provider _____		
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.		
_____		_____
Parent's Signature		Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.



Authorization for Dispensing Medications to Children and Youth Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label. A record of administration must be kept.

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or**

First and Last Name of Child or Youth			
Name of Medication (only one medication per authorization)		Prescription OR Non Prescription	
Reason for Medication			
Dose	Time to be Given	Start Date	Stop Date**
Name of Licensed Physician or Nurse Practitioner prescribing the medication		Phone # of Physician	
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.			
Parent's Signature			Date Signed

instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.



Authorization for Self-Administration of Medication (Children/Youth in School Age Programs)

According to K.A.R. 28-4-590(e)(5)(A) any operator may permit a child or youth with a **chronic illness, condition requiring prescription medication on a regular basis, or a condition requiring the use of an inhaler** to administer the medication under staff supervision. The operator shall obtain written permission for the child or youth to self-administer medication from the child's or youth's parent or other adult responsible for the child or youth, and from the licensed physician or nurse practitioner treating the condition of the child or youth. Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. A record of administration must be kept.

First and Last Name of Child or Youth			
Name of Medication (only one medication per authorization)			
Reason for Medication			
Dose	Time to be Given	Start Date	Stop Date**
Print the Name of licensed Physician or Nurse Practitioner prescribing the medication		Phone# of Health Care Provider	
I authorize the self-administration of the above medication by my child or youth under staff supervision.			
Signature of Parent or Responsible Adult			Date Signed
I authorize the self-administration of the above medication by the child or youth listed above under staff supervision.			
Licensed Physician or Nurse practitioner Signature			Date Signed

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature and the licensed physician or nurse practitioner signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT SELF ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member supervising the self-administration of medication to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

Kansas Department of Health and Environment
 Bureau of Family Health
 Child Care Licensing Program
 1000 SW Jackson Street, Suite 200
 Topeka, KS 66612-1274
 Phone: (785) 296-1270 Fax: (785) 296-0803
 Website: www.kdheks.gov/kidsnet



Notification of Injury, Illness or Critical Incident

This form is to be used to report injury or illness of children or youth in child care or school age programs.

Name of Facility (exactly as it appears on the license):		License #:	Date Completed (MM/DD/YYYY):
Street Address of Facility:	City:	County:	

SECTION I: TYPE OF NOTIFICATION:

Indicate type of report: _____ Illness _____ Injury _____ Critical Incident such as missing child, fire, etc.

Provide a summary of the incident:

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SECTION II: WHO WAS INVOLVED:

First and Last Name of Child or Youth:

	Date of Birth (MM/DD/YYYY):
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First and Last Name of adult(s) responsible and/or observing the incident:

	Relationship to the Facility: (Staff member, Volunteer, etc.)
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SECTION III: DESCRIPTION OF INJURY, ILLNESS OR CRITICAL INCIDENT:

Date of Incident (MM/DD/YYYY)	Description of Injury, Illness or Critical Incident including what happened, time of day, location of children or youth at the time, etc.	Remarks about the child's initial appearance and condition if illness or injury	Action taken by the facility. What did you do?	Was Medical attention required? (Yes or No). If so, describe and note if on site or transported to clinic/hospital.

NOTES

Date	Comments/Remarks

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

Print First and Last Name of Individual Completing This Form:

Signature:

Date Signed (MM/DD/YYYY):