Horizon Kids

Personal Data Form
2022 - 2023 School Year

Child's Information		
Last Name	First Name	Middle Initial
Address	City/State	Zip
Current Grade Level	DOB	Gender
School		
Ethnicity	Ethnicity: **H** = Hispanic or Latino, **N** = Not Hispanic or Latino	
Race	Race: **W**=White, **B**=Black or African American, **I**= American Indian or Alaskan Native, **A**=Asian or **P**=Native Hawaiian or Other Pacific Islander	
Does your child have a 504 plan or an IEP? ☐ NO ☐ YES* *If yes, please attach a copy		
Does your child need a special care plan? ☐ NO ☐ YES* *If yes, please attach a copy		
Will your child need to take medication while in our care? ☐ NO ☐ YES		

Guardian Information		
Mother/Guardian 1 First and Last Name		Relationship
E-mail		
Home Phone#	Cell Phone#	Work Phone#

Father/Guardian 2 First and Last Name		Relationship
E-mail		
Home Phone#	Cell Phone#	Work Phone#

The child resides with: (check all that apply)				
Mother ☐	Father ☐	Step-Parent ☐	Foster-Parent ☐	Other _____

Authorized Pick-Up List: **These are individuals (in addition to guardians) that are authorized to pick up your child from the Horizon Kids program. Please attach an additional sheet if necessary. Photo ID is required for pick-up.**		
Name	Phone#	Relationship
Name	Phone#	Relationship
Name	Phone#	Relationship
Name	Phone#	Relationship

Payment Information

Child's Name		
Payer Name	Payer Phone Number	Alt Phone Number
Payer Address	City/State	Zip

Financial Assistance: ☐ DCF ☐ VA subsidy ☐ KVC ☐ Other _____

Electronic Funds Transfer Authorization (checkmark below)	For Currently Enrolled Families
☐ I authorize payments from the account information listed below. ☐ I understand that this authorization will remain in full force and effect until care is terminated. ☐ I understand that drafts occur every Monday for the following week of care. ☐ I am aware that all returns for insufficient funds will result in a $40 fee.	☐ Use my payment on file ☐ Use new account info listed below

For Current Families Only - Check to use my payment on file ☐ If Checked skip bank info below

Bank Name	Print Name on Account	
Bank Address	City/State	Zip
Check Type of Account ☐Checking ☐Savings	Routing Number	Account Number
Signature	Date	

Program Enrollment

☐ Sibling Discount 10% per child

☐ USD 453 Employee Discount 20% per family

Before and After School Care	Rate
☐ Full-Time (4-5 days per week)	$70 per week
☐ Part-Time (1-3 days per week)	$55 per week

☐ **Before School ONLY**	$55 per week rate

☐ **After School ONLY**	$65 per week rate

No School Days	Rate
☐ Full-Time Horizon Kids	$30 per day

Permissions and Waivers

(1) Horizon Kids Program Waiver Statement Between Providers and Parents of Children

The undersigned states that he/she understands that the Leavenworth Public Schools Education Foundation and the Leavenworth Public School District is not and shall not be responsible for or liable for any illness, or injury to person or damage to property resulting from the program in which the undersigned is enrolling or being enrolled or from his/her participating in said program. The participant and the undersigned, if the participant is a minor or under other legal disability, hereby forever releases and holds harmless the said Leavenworth Public Schools Education Foundation and the Leavenworth Public School District, their employees, agents and representatives from any and all claims of any kind 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. Also, the undersigned and the participant authorize the Leavenworth Public Schools Education Foundation and the Leavenworth Public School District to use at their discretion any photograph(s) or video taken of the participant while participating in their program and waive any and all claims that the participant or undersigned or their heirs, executors, administrators, or assigns may have or claim to have resulting from such photograph(s) or reproductions thereof. The district, foundation and/or mass media outlets may from time-to-time photograph or videotape students engaged in educational or extracurricular activities. Limited student information may be posted on the district's websites, including social media. Personal information such as address and telephone numbers will not be printed or broadcast. The foundation and district retains the right to reproduce, copy, exhibit, publish, sell or distribute photographs or videotape productions for educational, evaluative or public information purposes. **I have read and understand the waiver statement.**

(1) Parent Signature	(1) Date

(2) Horizon Kids Memorandum of Agreement

This Memorandum of Agreement (MOA) is entered into by and between the parent/guardian of a Horizon Kids participant and the Horizon Kids program. The purpose of the MOA is to confirm that both parties are aware of and should adhere to the policies and procedures set forth in the parent packet. This agreement also acknowledges receipt of the parent packet (which includes the Emergency Plan) for the Horizon Kids program. Any revisions or additions to the parent packet throughout the duration of the program will be distributed to participants and a new MOA will be collected for receipt. This agreement will be in effect from the child's start date in the Horizon Kids program until withdrawing from the program or termination, whichever comes first. The parent packet is always available for reference or copies on the Leavenworth Public School website, www.usd453.org/families/horizon_kids_childcare

(2) Parent Signature	(2) Date

(3) Mutual Exchange of Information

As the lawful guardian/custodian, I give permission for the mutual exchange of information/records between Leavenworth USD 453 Public Schools and the Horizon Kids program. The purpose of this exchange of information is to provide appropriate support during before and after school and summer care to the student. Individuals in Leavenworth USD 453 schools are able to share information with the Horizon Kids program staff and vice versa which includes teachers, nurses, paras, aides, office staff, school counselors, school psychologists and principals. I understand that my signature grants permission for the mutual exchange of information between the parties listed above. I further understand that this permission will remain valid until revoked by me.

(3) Parent Signature	(3) Date

(4) USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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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) 559-4244
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

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

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

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

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

Mother/Guardian's Home Street Address	City	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?

Check 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?**
☒	☒	**If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.**

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

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

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

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

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

Signature of person completing this form	Date Signed

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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) 559-4244
Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

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

I authorize ____ (*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

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: ______________________
MM/DD/YYYY

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

____

____

____

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

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: ______________________

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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.