

**Youth Support Programs, Inc.**  
**314 Delaware Street Leavenworth, Kansas 66048**  
**(913) 682-8222 .Fax 913-682-7672 .Email dkgregor1@kc.rr.com**

Date of birth: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State & Zip \_\_\_\_\_

Home telephone #: \_\_\_\_\_ Work telephone #: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

My child does not have permission to leave the facility early. I or a person listed on the emergency contact will pick my child up at the end of regular-program hours unless I notify the center. (Signature) \_\_\_\_\_

Any child not picked up within 30 minutes of program end may be placed in police custody

**Emergency contact: Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_ **telephone number** \_\_\_\_\_

**Publicity Release**

I (signature) \_\_\_\_\_ give The Youth Support Programs, Inc. organization permission to use my child's name and photograph in any and all forms of media release that will further the mission of the organization. These publicity release's will include television, radio, newspaper articles, and other printed materials.

**Academic & Program Information Release**

I (signature) \_\_\_\_\_ give the Youth Support Programs, Inc. staff permission to contact my child's school for information concerning needed academic support, quarterly grades and to complete anonymous program surveys.

I understand that my child will participate in prevention programs.

**Following information is needed to better serve your child**

Income Guidelines: this information will not limit your child's access to any of our programs. Please circle the annual income that best reflects your family.

\$ 5,000.00 - 10,000.00    \$10,000- \$20,000 - \$20,000 - \$30,000 - \$30,000- \$40,000

Above \$40,000.00

**Child's personal information**

Name and ages of others living in the home: \_\_\_\_\_

Parents name and address not living in the home: \_\_\_\_\_

How often does parent not living with the child have contact with the child: \_\_\_\_\_?

Child's hobbies and interest: \_\_\_\_\_

School: \_\_\_\_\_ Grade level: \_\_\_\_\_ School subjects where

tutoring might be beneficial. \_\_\_\_\_

Name of facility exactly as stated on the license/certificate. <u>Leavenworth Youth Achievement Center</u>	License or Certificate # <u>0057521-002</u>
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I hereby authorize Deborah Gregor, Stou Garnit (Name of individual/staff member) and/or  
or Marquetia Deemer (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
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Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	Date Signed
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**Notarization of Parent's or Guardian's signature only 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: _____

**Complete information regarding health care insurance, if applicable.**

Health Insurance Policy Name: \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Medical Assistance Program \_\_\_\_\_ Card Number \_\_\_\_\_  
 Military Medical Care I.D. Number \_\_\_\_\_

If known, date of last Tetanus inoculation: \_\_\_\_\_

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

**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.**



**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
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Mother/Guardian's Home Street Address	City	Zip Code +4	Home Phone # ( )
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Mother/Guardian's Work Place Name & Street Address	City	Zip Code +4	Work Phone # ( )
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First and Last Name of the Child's or Youth's Father or Guardian
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Father/Guardian's Home Street Address	City	Zip Code +4	Home Phone # ( )
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Father/Guardian's Work Place Name & Street Address	City	Zip Code +4	Work Phone # ( )
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Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)
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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 +4	Phone # during program hours:
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First and Last Name of Physician & Street Address	City	Zip Code +4	Phone Number ( )
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Name of Hospital Preference in case of emergency.
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Yes	No	N/A	Complete the following information about medications for this child or youth.
		X	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
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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?
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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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CCL034  
Rev. 9/2003

Kansas Department of Health and Environment  
Bureau of Child Care and Health Facilities  
1000 SW Jackson, Suite 200  
Topeka, KS 66612-1274  
Phone 785-296-1270 Fax 785-296-0803  
Website: www.kdhe.state.ks.us/kidsnet/



PARENTAL PERMISSION FORM FOR OFF-PREMISE TRIPS

Name of the facility exactly as stated on the license or certificate HEAVENWORTH YOUTH Achievement Center, Inc.			License/Certificate # CO 57521-002	
Street Address of the Facility 314 Delaware	City heavenworth	Zip Code + 4 66848-2707	County heavenworth	

\_\_\_\_\_ may go to the following locations off the premises with adult supervision:  
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

## YAC after school schedule

After school program hours are 3- 6 pm Monday – Thursday when Leavenworth Public Schools are in session for a full day.

All other program hours will be announced through parent flyers.

No Friday after school program.

Do not have children dropped off at the YAC if school is cancelled due to weather.

Thank you