PIONEER PRESCHOOL, LLC

Geri Allcorn- Director/Owner
913-338-4282
www.pioneerpreschool.com
11100 College Boulevard
Overland Park, KS 66210

Thank you for inquiring about 2023-2024 enrollment at Pioneer Preschool LLC. Enrollment forms will be accepted in the order in which they are received. Please make sure to indicate your preference of class days and time as these will be honored as space allows.

3 YEAR OLD PRESCHOOL CLASSES

Monday and Wednesday **OR** Tuesday and Thursday AM classes- 9:00-11:30 AM $175.00 per month.
Tuesday and Thursday PM classes- 12:15-2:45 PM $175.00 per month.

KINDERGARTEN READINESS CLASSES (4 AND 5 YEAR OLD CHILDREN)

Monday, Wednesday and Friday AM class- 9:00-11:30	$200.00 per month
Tuesday, Wednesday and Thursday PM Class- 12:15-2:45	$200.00 per month

TRANSITIONAL KINDERGARTEN CLASSES (5 YEAR OLD CHILDREN)

Monday, Tuesday, Thursday and Friday AM class	$ 240.00 per month
Monday, Tuesday, Thursday and Friday PM class	$240.00 per month

Extended day

We offer an extended day session in the morning or afternoon for an additional fee of $70.00 per month for one extended day per week. Children can enroll in more than one extended day per week as long as space is available. Children enrolled in a morning preschool class will extend their day until 2:30 PM. Children enrolled in afternoon preschool will start their extended day at 9:30 AM. If you are interested in enrolling your child for an extended day(s) please mark your preference on the enrollment form.

FEES AND TUITION

A non-refundable registration fee of $100.00 must be submitted with your enrollment form. Enrollment forms will not be processed until the registration fee is paid.

One month's tuition is due by July 31, 2023. **THIS TUITION WILL BE APPLIED TO MAY 2024**. You may include this amount with your enrollment forms, or an email reminder will be sent at a later date.

All enrollment forms and payments can be returned in person or mailed to:
Pioneer Preschool LLC
11100 College Blvd.
Overland Park, KS 66210
PLEASE WRITE YOUR CHILD'S NAME IN THE MEMO SECTION OF YOUR CHECK

FORMS

Attached are the state of Kansas required forms. The medical record form is completed by the parent and the health assessment form must be completed by your child's physician.

ALL FORMS MUST BE ON FILE BEFORE YOUR CHILD CAN ATTEND THE FIRST SESSION.

We are looking forward to getting to know you and your child. It's going to be a great school year.

For Office Use Only

Date application received _____

Date registration fee paid _____

Check #_____ Cash_____

Teacher_____ Class_____

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PLEASE PRINT:

Name: _____ Circle One: Male Female
First Middle Last

Prefered Name:_____ Birthday: ____/____/____

Home Address:_____ City:_____ State:_____ Zip:_____

Mother's Name:_____ Mother's cell phone number:_____

Mother's address **(if different)**:_____

Mother's Email address:_____

Mother's place of employment:_____ Mother's business phone number:_____

Father's Name:_____Father's cell phone number:_____

Father's address **(if different)**:_____

Father's Email address:_____

Father's place of employment:_____Father's business phone number:_____

Child lives with: Both Parents:_____ Mother:_____ Father:_____ Other:_____

Other children living in the home and ages:_____

Previous group experiences that your child has had (Sunday school, preschool, sports activities etc.):_____

_____

School district your child will be attending:_____

Is your child: Right handed:_____ Left handed:_____

Does your child speak any other language besides English? Yes:_____ No:_____

If yes, please give details:_____

Does your child have allergies?_____ If yes, please explain:_____

_____

Please explain any pertinent medical information that we should be aware of: (asthma, speech problems, vision problems, premature birth, toilet problems, etc.)

_____

_____

Permission to give First Aid: (Bandaids, Bactine, Ice Packs ets.) _____ (Please Initial)

Please list any fears, dislikes, interests etc. that your child may have:_____

AUTHORIZATIONS:

Emergency contacts

Person(s) other than parent that we can contact in case of illness/emergency if parents are unavailable.

Two emergency contacts are required.

Name/Relationship:_____ Cell Number:_____

Name/Relationship:_____ Cell Number:_____

Person(s) authorized to pick up your child from school

(child will only be released to those listed with proper ID)

Name/Relationship:_____ Cell Number:_____

Name/Relationship:_____ Cell Number:_____

Name/Relationship:_____ Cell Number:_____

Class preference: Please indicate your 1st and 2nd choices

Morning session is 9:00-11:30 Afternoon session is 12:15-2:45

Kindergarten Readiness Program
4 and 5 year old children
_____ Monday, Wednesday, Friday AM
_____ Tuesday, Wednesday, Thursday PM

3 Year old preschool
3 years old children
_____ Monday, Wednesday AM
_____ Tuesday, Thursday AM
_____ Tuesday, Thursday PM

Transitional Kindergarten
5 year old children
_____ Monday, Tuesday, Thursday, Friday AM
_____ Monday, Tuesday, Thursday, Friday PM

Extended Day(s) Monday _____, Tuesday _____, Wednesday _____, Thursday _____ **check day(s) that you are interested in**

Please read, initial and sign:

_____ I understand that the non refundable registration fee of $100.00 is due with this application and **my application will not be processed until the registration fee is paid.**

_____ I understand that one month's tuition is due by July 31, 2023. **THIS TUITION WILL BE APPLIED TO MAY 2024.**

_____ I understand that the tuition rate is figured over a nine month period and that there are no deductions for absences, vacation time or inclement weather days. This includes extended day tuition.

_____ I understand that I must give a 30 day written notice to withdraw my child from Pioneer Preschool.

_____ I understand that the following forms are required by the state of Kansas.

1. Kansas Authorization for Emergency Medical Care
2. Kansas Medical record forms including: **(1)** medical record completed and signed by parent, **(2)** history of immunizations and **(3)** child's health assessment completed and signed by your child's physician.

ALL FORMS MUST BE ON FILE BEFORE MY CHILD CAN ATTEND PIONEER PRESCHOOL

These forms can be picked up at the preschool office or they are available on the preschool website.

Parent Signature: _____ **Date**: _____

Admission policy of Pioneer Preschool LLC shall be nondiscriminatory in regard to race, color, religion, national origin, ancestry, physical handicap or sex, in accordance with Kansas civil rights statute K.E.A 44-1009

CCL. 029
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
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

Kansas
Department of Health and Environment

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care_____ Name of Child Care Facility_____

Child's Name_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____
Home Address_____
Street City Zip Code
Home Phone Number_____
Employer_____
Work Phone Number_____
Cell Phone Number_____
E-mail Address _____
Best way to contact_____

Parent/Guardian Information

Name_____
Home Address_____
Street City Zip Code
Home Phone Number_____
Employer_____
Work Phone Number_____
Cell Phone Number_____
E-mail Address_____
Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____
Address _____ Address _____
Phone Number _____ Phone Number _____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows: _____

_____

_____

Any known allergies or medical conditions of child:

_____

_____

Any major changes at home that might affect your child in care:

_____

_____

Please provide additional information or special instructions that will help the person caring for your child:

_____

_____

Parent/Guardian Signature:_____ **Date:**_____

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:_____ **Date of Birth:** _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month, Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II.
Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

_____DTaP/DT _____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA _____HepB ____Hib
_____PCV ____Varicella ____Other

Physician's Signature (required): _____ **Date:**_____

☐ **(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.**

Section III.

Parent/Guardian Signature:_____ **Date:**_____

CCL. 029a
Rev. 05/2020

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: ____ **IN/CM %ILE** ____		**Weight:** ____ **LB/KG %ILE** ____
Physical Examination	✓ **If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) ☐ None		
Signature of Licensed Physician or Nurse approved for Child Health Assessments		Date
Print the Name of the Individual Signing Above		Phone Number
Address	City	Zip Code

CCL 010
Rev. 5/2020

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

Kansas Department of Health and Environment

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

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

Name of facility exactly as stated on the license.	**License #**
Poineer Preschool Child Care Center	0015266-018

I authorize staff (*caregiver/staff*) who is (are) representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (*child's first and last name*) while child or youth is in the facility's custody between 08/28/2023 (MM/DD/YYYY) and until no longer in our care (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.

State of Kansas
County of _____

Signed or attested before me on _____ (MM/DD/YYYY) by _____ (Name of Person).

(Seal, if any.)

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is transported by the facility.