Enrollment $____ 1st Week $____

Receipt # _____ Date _____

Start Date _____ Staff _____

Amount $_____ Ck# ___ CC ___

Paid By:_____

HAYSVILLE RECREATION
LATCHKEY ENROLLMENT FORM
2025-2026

Child's Name _____ Age _____

Grade _____ Date of Birth _____ Sex _____

Registered Attendance	AM/PM Only	Both	School Attending (CIRCLE)
☐ Morning Only	$45/Wk/Child		☐ Freeman ☐ Nelson
☐ Afternoon Only	$45/Wk/Child		☐ Oatville ☐ Prairie
☐ Both Before and After School		$55/Wk/Child	☐ Rex ☐ Ruth Clark

Parent/Guardian (Mother) _____

Address _____ City/Zip _____

Employer _____

Phone Numbers Cell _____ Work _____

Home _____ Email Address _____

Parent/Guardian (Father) _____

Address _____ City/Zip _____

Employer _____

Phone Numbers Cell _____ Work _____

Home _____ Email Address _____

Lives With: Both Mother & Father: ☐ Mother ONLY: ☐ Father ONLY: ☐

Split Custody: ☐ Other: ☐ If Other, Specify Whom:_____

Emergency Contacts authorized to pick up your child(ren) (Other than Parents or Guardian)

1._____ Relation:_____ Phone:_____

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

2._____ Relation:_____ Phone:_____

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

3._____ Relation:_____ Phone:_____

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

4._____ Relation:_____ Phone:_____

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

(Continued……)

Acknowledgement of Latchkey Policies

At the time of initial enrollment, a **registration fee ($35/child)** must be paid. Prior to Friday, August 9th, the first week's fee must also be paid in full.

Weekly fees are due by 6:00pm on the Friday PRIOR to the next week; payments are made in advance of the service provided. Payments received after Friday will be charged a $10 late fee. If payment is not received by the following Wednesday (the week of attendance) your child will not be able to attend again until payment is made in full.

FEES ARE BASED ON ENROLLMENT, NOT ATTENDANCE. You will be required to pay for the days you have enrolled for, even if you do not use them, until you drop from the program at the HAC. **Fee adjustments will NOT be made due to sick/absent days, early school dismissals, school cancellations for weather and/or no school days**. Fees will be adjusted the week of Thanksgiving, Christmas and the last week of school accordingly; you will be responsible for payment even if your child(ren) does not attend. **NO CREDITS ARE GIVEN FOR DAYS OF SCHOOL THAT ARE MISSED OR THAT THE CHILD DOES NOT ATTEND.**

All latchkey children must be picked up no later than 6:00pm. Any parent arriving late will be charged $1 per minute per child that he/she is late. CHILDREN WILL NOT BE ALLOWED TO RETURN UNTIL THE FEE IS PAID. If latchkey staff are unable to contact a responsible party after 30 minutes, the Haysville Police Department will be contacted. If parents are late more than three times, their child will be dismissed from the program. Official time will be kept by the site's cell phone.

My signature below acknowledges that I understand the above enrollment, late fee, fee adjustment and pick-up policies and that I have received a copy of the latchkey parent handbook.

Signature of Responsible Party: _____ Date: _____

HRD Staff Signature: _____ Date: _____

CCL. 358
Rev. 5/2020

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?

Circle any of the following conditions or difficulties that affect this child or youth. IF IT DOES NOT APPLY, PUT "N/A"			
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 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

CCL.010
Rev. 07/2024

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

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 #**
Nelson Elementary SAP - #42718, Freeman Elementary SAP - #42725, Prairie Elementary SAP - #61570 Oatville Elementary SAP - #42716 Rex Elementary SAP - #42719, Ruth Clark Elementary SAP - #42917, Haysville Activity Center - #48593	

I authorize ______________________________HRD & Staff Members__________________(*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 ___08/13/25 ______ and _____05/19/26____________.
MM/DD/YYYY MM/DD/YYYY

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

____
____
____

Signature of Parent or Guardian	**Date Signed**

- -

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 off premised from the facility.