RAINBOWS[SM]
bringing potential to life

Family Support Services
Enrollment Forms Checklist

Name:_____ **For Office Use**

Forms Needed for In-Home Care:	Scan to:	Date:
_____Enrollment Information Form	MIS/CDBG	_____
_____Information for FSS (4 pgs.)	Room	_____
_____Picture of Child		
_____Statement of Responsibility		
_____Client Indemnity Agreement (If you wish RUI employees to transport child)		
_____Income Information for FSS	CDBG	_____
_____Private Insurance Card (Copy)	Acctg.	_____
_____Payment Agreement	Acctg.	_____
_____Proof of Income	CDBG	_____
_____Plan of Care (POC)**	Acctg. If not RUI TCM	_____
_____Supportive Home Care Schedule (MR-10)**	Acctg. If not RUI TCM	_____
_____Family Support Documentation**	Coordinator	_____
_____Authorization for Emergency Medical Care	Room	_____
_____FSS Client Release Form	Room	_____
_____Authorization for Release and/or Disclosure (Additional copies available if needed)		
_____Request to Administer Medication (Dr. signature required)	Rm./Nurse	_____
_____Person Centered Support Plan(s)**	Room	_____
_____Behavior Plan(s)/Info.	Room/Beh. Con.	_____

Additional Items Needed for Center-Based Care:

_____Media Release	Room	_____
_____Appointment of Agent	Room	_____
_____KDHE Medical Record-Page 1& 2	Nurse	_____
_____Child Health Assessment-Page 3 (Dr. signature required)	Nurse	_____
_____Meal Substitutions (If Needed for Medical or Dietary Reasons-Dr. signature required)	Dir./Room/Kitchen	_____

Additional Items Needed for CAMP WOODCHUCK:

_____Camp Enrollment Form (Schedule)	Dir./Room/If PP to Sched.	_____
_____Camp Payment Agreement	Acctg./If PP to Sched	_____
_____Camp Enrollment Fee ($50)	Acctg.	_____

Items it would be helpful to have, but are not mandatory:

_____Individual Education Plan (IEP)	Room	_____

**You can obtain these items from your Targeted Case Manager. The forms a family needs will depend on the type of funding the client has for services.

Rainbows United, Inc — Enrollment Information Form

Child Information

Full Legal Name		SSN (optional)	
Birthday		Sex	
Child is of Hispanic/ Latino Ethnicity	Y N	Race	
Home address		School District	
City, State, Zip		Phone	
Physician name/phone			
Child lives with	☐ Both Parents ☐ Mother ☐ Father ☐ Aunt/Uncle ☐ Grandparent(s) ☐ Foster Parent(s) ☐ Other _____		

Parent/Guardian Information

Full Name		
Address		
City, State, Zip		
Home Phone		
Cell Phone		
Work name and phone		
Opt-Out Statement	☐ By checking this box, I choose to opt-out of text message alerts from Rainbows United, Inc.	☐ By checking this box, I choose to opt-out of text message alerts from Rainbows United, Inc.
E-mail		
Relationship to Child	☐ Mother ☐ Father ☐ Foster Mother ☐ Foster Father ☐ Grand Mother ☐ Grand Father ☐ Other: _____	☐ Mother ☐ Father ☐ Foster Mother ☐ Foster Father ☐ Grand Mother ☐ Grand Father ☐ Other: _____
Education level	☐ Did not Graduate HS ☐ HS Diploma or GED ☐ Some College ☐ AA/AS ☐ BA/BS ☐ Grad School ☐ Master's or higher	☐ Did not Graduate HS ☐ HS Diploma or GED ☐ Some College ☐ AA/AS ☐ BA/BS ☐ Grad School ☐ Master's or higher

Family Information

Alternate contact's name		Phone		Relationship				
Number of people living in home								
# of immediate family living in home		# Adults		# Minors				
Yearly household income (estimate to the nearest $1,000)								
How did you hear about RUI?	☐ Family/Friend	☐ Physician	☐ Medical	☐ School	☐ SRS	☐ RUI Staff	☐ Other _____	

Parent/Guardian Signature _____ Date _____

Since 1972, Rainbows United, Inc. has served the community as a not-for-profit agency. Rainbows prohibits discrimination in any aspect of the access to, admission, or treatment of consumers in its programs and activities, or in employment and application for employment on the basis of race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, or any other legally protected characteristics.

RAINBOWS℠
bringing potential to life

FAMILY SUPPORT SERVICES
2258 N. Lakeway Circle
Wichita, KS 67205
(316) 684-7060, Ext. 100
Emergency Cell # 259-9569

INFORMATION FOR FAMILY SUPPORT SERVICES

Date _____

Picture of Client

Height _____

Weight _____

CLIENT INFORMATION

Name _____

I would like my client to be enrolled for the following services as of _____ (date):

_____ In-Home Support Services
_____ Saturday Center (9 am – 3 pm)
_____ Sunday Center (1:30 pm – 5:30 pm)
_____ AM Latchkey (7:00 am – till bus arrival)
_____ PM Latchkey (bus arrival – 5:45 pm)
_____ All Day Latchkey (Preferred Hours are _____ till _____)
_____ Camp Woodchuck (more information to come later)

***Please note there may be a waiting list for one or more of these services.**

Current School: _____ Grade in school: _____

Client has: ____ Behavior Plan From: ____ School, ____ Parsons, ____ Other: _____
____ Takes medications to alter mood or behavior.
____ Mental Health Diagnosis (ex. Asbergers, PTSD, Bi-Polar, etc.)

Type of developmental disability/Diagnosis: _____

MR/DD Case Mgr/Agency: _____

Case Manager Phone: _____

Date of last health exam _____

Additional information about your child: _____

_____

Speech Ability: _____

Hearing Ability: _____

Primary Form of Mobility: _____

Activities to be limited or restricted: _____

_____

Special dietary needs or food preparation: _____

_____

Behaviors to be considered: _____

_____

Two great things about your child: _____

_____

Form No. 370 (Rev. 2/3/2012)

ADAPTIVE EQUIPMENT

Mobility equipment includes: _____

How to use it (placement and length of time): _____

_____

_____

Dressing/grooming equipment includes: _____

How to use it: _____

_____

_____

Mealtime equipment includes: _____

How to use it: _____

_____

_____

Bathing/toileting equipment includes: _____

How to use it: _____

_____

_____

Communication equipment includes: _____

How to use it: _____

_____

_____

Other equipment includes: _____

How to use it: _____

_____

_____

HOUSEHOLD EMERGENCY PLANS *(not needed for center only services)*

Fire **Fire Extinguisher is located:** _____

_____

_____

_____

Tornado

_____

_____

_____

Power Outage **Flashlight is located:** _____

_____

_____

_____

Client Becomes Ill/Injured **First Aid supplies are located:** _____

_____

_____

_____

Back-Up Plan in case agency staff not available for a scheduled shift:

_____

_____

_____

SIBLINGS:

Name	DOB	Address	Telephone

DUE TO STAFF ALLERGIES:

Pets/Names: _____ _____ _____

Does anyone in the household smoke? _____ yes _____ no

LOCATION OF HOUSEHOLD SUPPLIES *(not needed for center only services)*

Cleaning supplies: _____

Vacuum Cleaner/Broom: _____

Water Shut-off Valve: _____

HOUSEHOLD RULES

Meals/Snacks: _____

_____

_____

Pet care: _____

_____

_____

Family/Visitors: _____

_____

_____

Playtime/Games/TV Watching: _____

_____

_____

Naps/Bedtime Routine: _____

_____

_____

Off-Limits Areas/Items: _____

_____

_____

Outdoor Activities: _____

_____

_____

Behavior Information: _____

_____

_____

RAINBOWS[SM]
bringing potential to life

FAMILY SUPPORT SERVICES
2258 N. Lakeway Circle
Wichita, KS 67205
(316) 684-7060, Ext. 100
Emergency Cell # 259-9569

STATEMENT OF RESPONSIBILITY

On behalf of _____, my dependent, I wish to receive Family Support services. I have been fully informed of the scope of the Family Support Services program and agree to supply the staff with any and all information deemed necessary to safeguard the welfare of my dependent while being cared for by a Family Support provider.

In the event emergency medical treatment is deemed necessary, and I am not readily available, I authorize such procedures as are necessary to insure the health and well-being of my dependent. I understand that my dependent may become ill or injured during respite services and I agree that if this occurs through no negligence of the Family Support provider, I will not hold Rainbows United, Inc. and/or its employees liable for the illness or injury.

I have fully disclosed to the staff of Family Support Services, Rainbows United, Inc. all pertinent facts about my dependent's needs and problems; and acknowledge full responsibility if I fail to do so.

_____ _____
Signature Date

RAINBOWS℠
bringing potential to life

Client/Parent Indemnity Agreement

THIS AGREEMENT, dated this ____ day of _____, 20___, is a contract between: _____ (person served hereinafter "Client") and Rainbows United, Inc., and its present and former agents, successors, assigns, employees, officers, directors, representatives, divisions, subsidiaries, parents, affiliated companies, attorneys, and insurers (hereinafter collectively "Rainbows").

WHEREAS, Client strongly desires that Rainbows' employees provide transportation services in personal vehicles for the direct convenience and benefit of Client;

WHEREAS, the primary benefit of such transportation benefits will accrue to Client and not Rainbows; and

WHEREAS, Rainbows' employees would not provide such transportation services unless Client entered into this Agreement.

IN CONSIDERATION of the premises and mutual promises herein contained, the parties agree and acknowledge as follows:

1. Rainbows' employees shall provide transportation services to Client as permissible under any applicable state or federal programs that permit such service and as Rainbows finds acceptable in its sole discretion.

2. To the fullest extent permitted by law, Client shall indemnify and hold harmless Rainbows from and against all claims, damages, losses and expense, including but not limited to attorneys' fees, arising out of or resulting from any performance of the transportation services provided by Rainbows' employees for Client under this Agreement.

3. In signing this Agreement, Client understands that the terms hereof are contractual and not merely a recital, and that Client is not relying upon any statement or representation made by Rainbows, but, instead, Client is relying solely upon Client's own judgment and/or the advice of Client's attorney. Client acknowledges that this Agreement is the entire agreement of the parties regarding this matter.

4. This Agreement is to be interpreted and enforced according to the laws of the State of Kansas, without regard to the principles of conflicts of law, and shall be binding upon Client, Client's heirs, next of kin, executors, administrators, successors, and assigns, and shall inure to the benefit of Rainbows and all other persons and entities released herein.

____ I have read the foregoing Agreement. I understand it and have been given the opportunity to ask questions about it. No one has pressured me or threatened me. I have given the matter adequate thought. After sufficient time to consider it, I want to enter into this Agreement.

____ I do not give permission for Rainbows employees to transport this client in their personal vehicle.

_____ _____

Parent or Guardian Rainbows United, Inc.

Date: _____ Date: _____

RAINBOWS[SM]
bringing potential to life

INCOME INFORMATION FOR FAMILY SUPPORT SERVICES

CLIENT NAME: _____

PARENT'S/GUARDIAN'S NAME: _____

Total number in my household is: _____

Household Member Name (First and Last)	Relationship to Parent/Guardian	Date of Birth	Gross Wages (before taxes)	SRS TANF Benefits	SSI / SSDI	Adoption Subsidy or Child Support	Other (specify amount and source)	Total MONTHLY Income

Total Monthly Income	
X 12	
Annual Income	

	YES	NO
My child receives SSI	_____	_____
Medical Card # _____	_____	_____
My child has Medical Insurance	_____	_____

A copy of current insurance card is required.

I hereby certify that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of Federal Funds; that Rainbows United officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes.

When there is a change in family size or income, I will notify the Family Support Services office.

_____ _____
Signature of Parent/Guardian Date

RAINBOWS℠
bringing potential to life

FAMILY SUPPORT SERVICES
SLIDING FEE SCALE

The fee schedule is based on the total household income of the person receiving support services. An "enrolled" person is an individual with one or more developmental disabilities. Persons receiving family support may access the sliding fee scale once this funding source has been utilized at the $12.24 per hour rate.

SLIDING FEE SCALE FOR **IN-HOME CARE, LATCHKEY, OR WEEKEND CENTER:**

Household Income	Service Rate
$0.01 to $20,000.00	$3.55/hour
$20,000.01 to $30,000.00	$4.75/hour
$30,000.01 to $40,000.00	$5.85/hour
$40,000.01 to $50,000.00	$7.10/hour
$50,000.01 to $75,000.00	$8.85/hour
$75,000.01 and above	$12.24/hour
Trust Fund	$12.24/hour

SLIDING FEE SCALE FOR **CAMP WOODCHUCK:**

Household Income	Rate Per Hour
$0.01 to $25,000.00	$3.40/hour
$25,000.00 to $50,000.00	$4.25/hour
$50,000.01 to $75,000.00	$5.05/hour
$75,000.01 to $100,000.00	$5.90/hour
$100,000.01 to $150.000.00	$7.00/hour
$150,000.01 to $200,000.00	$8.40/hour
$200,000.00 and above	$11.60/hour
Trust Fund	$12.24/hour

*If child attends half-days, divide the above rates by two.

Additional Information

* Rainbows cannot provide care for a sibling of a child with HCBS-MR/DD funding.
* Rainbows cannot provide care for a typical sibling in a group setting such as the Weekend Center, Latchkey Program or Camp Woodchuck.
* Rainbows can provide care for a sibling at $2.25 per hour per sibling if the child with disabilities receives an allocation from Family Support OR you are privately paying for the care and the team agrees it is appropriate.
* Families using private or Family Support funds for camp will be charged for all days scheduled. Credit will not be given for days client does not attend.
* Rainbows charges a late fee of $5 for every 15 minutes past the scheduled time of pick-up.
* Sliding Fee Scale rate will not be ratio'd.

This fee schedule may be revised at Rainbows' discretion.

RAINBOWS℠
bringing potential to life

FAMILY SUPPORT SERVICES
PAYMENT AGREEMENT

This Agreement is entered between Rainbows United, Inc. and _____, the parent(s) and/or legal guardians(s) of _____.

As the parent/legal guardian of the above named person, I have asked Rainbows United, Inc. to provide services for him/her. I agree to pay Rainbows United, Inc. for services rendered by a person acting on behalf of this Agency.

I understand that the rate for care is based on the income of my household which may include but is not limited to wages, child support, SSI payments, subsidies (such as Adoption), and any direct financial assistance. Furthermore, I will provide Rainbows with proof of my household income before accessing the sliding fee scale. **Please submit proof of your total household income, for one month, with your application, i.e., pay check stubs , court order for child support, SSI letter showing monthly amount, food stamp notice showing monthly amount.** (Sliding fee scale does not apply to agencies funding a service i.e. foster care agencies.)

Please check the option that applies:

_____ My child receives **HCBS-MR/DD** or **HCBS/Autism Waiver** services, I understand that Medicaid will pay Rainbows for the service provided according to the approved hours of the Plan of Care. _____ I understand that Medicaid requires the Agency to bill private insurance before billing Medicaid. I will ensure that Rainbows has a copy of the Plan of Care and the Prior Authorization. After the approved hours are used, I can access the sliding fee scale for additional hours. My rate for additional hours, according to the sliding fee scale will be $_____ per hour. **This rate will not be altered by the staff to child ratio.**

_____ My child has supplemental funding from: ❑_____ ❑ _____
I understand that this funding will be billed at the rate of $12.24 per hour until the funding is no longer available. I will then be able to access the sliding fee scale. My rate according to the sliding fee scale will be $_____ per hour. **This rate will not be altered by the staff to child ratio.**

_____ I choose to **private pay** as my child does not receive any MR/DD funding to supplement the cost of services. My rate according to the sliding fee scale will be $_____ per hour. **This rate will not be altered by the staff to child ratio.**

_____ I choose to **private pay** the full rate of $12.24 per hour. **This rate will not be altered by the staff to child ratio.**

Payments are **due no later than 20 days from date of invoice**. I understand as the parent/guardian, I have a responsibility to track the number of hours used and/or amount of funding spent.

I understand Rainbows United, Inc. may terminate services for the following reasons:

* I do not complete a new application upon request; or
* I do not schedule care through the Family Support Services office; or
* I provide false and/or inadequate information regarding the above named person's care; or
* I refuse to comply with a request for verification of my household income; or
* I do not pay for the services received.

I understand Rainbows United, Inc. will not continue services beyond the services listed on the Plan of Care without this signed Payment Agreement on file. The same will apply if payments are not up to date. It is the responsibility of the family and/or guardian to ensure that this signed Payment Agreement has been returned and that payments are made on time.

Choose one of the following options:

_____ My dated signature on this form signifies my acceptance of this agreement until I revoke it in writing. I understand that all hours of services through Rainbows United must be scheduled with the Rainbows Scheduler. **I have enclosed verification of my household income with this Agreement.**

_____ _____
Signature Date

_____ My dated signature on this form signifies my acceptance of this agreement until I revoke it in writing. I understand that all hours of services through Rainbows United must be scheduled with the Rainbows Scheduler. **I choose not to enclose proof of total household income**. Therefore, I may not access the Sliding Fee Scale, and my **rate will be $12.24 per hour**.

_____ _____
Signature Date

CCL 010
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
Day Care Unit: Phone: 785-296-1270 Fax: 785-296-0803
Foster Care Unit: Phone 785-368-7015 Fax: 785-296-7025
Website: www.kdheks/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) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate.	**License or Certificate #**
Rainbows United Kids Cove	0030446-0004

I hereby authorize Rainbows United Employees (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 _____ (MM/DD/YYYY) and _____ (MM/DD/YYYY).

Signature of Parent or Guardian	**Date Signed**

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

~~**Notarization of Parent's or Guardian's signature only if required by local hospital or clinic.**~~

~~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: _____

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.

RAINBOWS℠
bringing potential to life

FSS CLIENT RELEASE FORM
(Regular and Emergency)

Client Name: _____

Client Lives With: ____ Mother _____ Father _____ Other (specify) _____

Parent/Guardian Information

Please circle which one applies to you: Single Married

Mother/Guardian

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
E-Mail: _____

Employer: _____
Address: _____
City, State, Zip: _____
Work Phone: _____ Work Hrs: _____
Working Days (circle): M Tu W Th F Sa Su

Father/Guardian

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
E-Mail: _____

Employer: _____
Address: _____
City, State, Zip: _____
Work Phone: _____ Work Hrs: _____
Working Days (circle): M Tu W Th F Sa Su

I authorize those persons listed below to pick up my client from Rainbows United, Inc. Rainbows' staff is authorized to take this client off the USD 259 bus, if applicable.

Authorized persons: you should indicate **at least two other than parent/guardian.** Please include transportation companies. This form will serve as a list for emergency notification as well as pick up. List in order of preference.

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP
1.			
2.			
3.			
4.			
5.			
6.			

I understand that I am responsible for the following:

1) Notifying Rainbows in writing if any person on this list no longer has my permission to pick up this client.

2) Advising all persons listed above about the need to provide a picture ID, and that the identification must be presented in order to pick up this client.

Signed _____

Date _____

RAINBOWS[SM]
bringing potential to life

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF INFORMATION

Child's Name: _____ **Date of Birth:** _____

Address: _____

AUTHORIZATION

I hereby authorize Rainbows United to:

_____ Disclose information to _____ Request information from

The following person or entity:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **FAX:** _____ **Email:** _____

For date(s) of: _____

For the following purpose(s):

_____ Eligibility Evaluation _____ Case Planning

_____ Observation and Consultation _____ Behavior Planning _____ Case Coordination

_____ Other (specify) _____

This authorization shall remain in effect until _____ at which time this authorization to disclose information expires. If this item is left blank, the authorization shall remain effective for 90 days after the date listed below.

I understand information in my health records may include information about alcohol or drug abuse, psychiatric treatment, mental status information, HIV testing, HIV results, or AIDS information, and I hereby consent to the release of such information.

I understand if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that reasonable fees may be charged for preparing and sending copies of records. I understand I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing written notification to Rainbows United.

_____ _____

Date Signature of Individual/Individual's Representative

_____ _____

Printed Name of Representative and Relationship Representative's address and telephone number

A photocopy of this Authorization shall be effective and valid as the original.

Rainbows United, Inc.
3223 N. Oliver / Wichita, KS 67220
(316) 260-4673

RAINBOWS[SM]
bringing potential to life

Family Support Services
Request To Administer Medication

FOR THE PHYSICIAN *Please provide all requested information:*

Name of Child: _____ Birth Date: _____

Weight: _____ Height: _____ Diagnosis: _____

Medication Allergies: _____

The above named client is to receive the following medication during his/her regular day. Please complete this form for *all* medications given at home, school and center. A physician's signature is required *prior to* nursing staff administering any medications, and to verify medications given to client.

Medication: Tylenol (Acetaminophen) Dosage: Weight/Age Appropriate

Purpose: _____

Requested Starting Date: Now Expected Duration: 1 year from start date

When to Administer: As Needed Special Consideration: _____

Special Instructions to Administer Medication: _____

Medication: _____ Dosage: _____

Purpose: _____

Requested Starting Date: _____ Expected Duration: _____

Times to Administer: _____ Special Consideration: _____

Special Instructions to Administer Medication: _____

Medication: _____ Dosage: _____

Purpose: _____

Requested Starting Date: _____ Expected Duration: _____

Times to Administer: _____ Special Consideration: _____

Special Instructions to Administer Medication: _____

FOR THE PARENT/GUARDIAN *Please complete the following:*

I hereby certify that *(Child's Name)* _____ has previously had at least one dose of the above prescribed medication and did not have an adverse reaction from it. I request that this medication be administered at school as directed above. I understand that Rainbows United, Inc. and any employee of Rainbow United, Inc. who administers this prescription to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug or because of mislabeled or altered product. I hereby authorize Rainbows United, Inc. personnel to exchange information regarding this request with the above named attending physician and with the pharmacy as identified on the affixed pharmacy label.

Signature: _____ Date: _____
Lawful Custodian

Please note: Physician's signature required on both sides of form if additional medications are listed on other side.

PHYSICIAN'S SIGNATURE: _____ Date: _____

Medication: ______________________ Dosage: ______________________
Purpose: ____
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ____
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ____
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ____
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ____
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose: ____
Requested Starting Date: ______________________ Expected Duration: ______________________
Times to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

PHYSICIAN'S SIGNATURE: ______________________________ Date: ______________

RAINBOWS℠
bringing potential to life

Media Release

ASSIGNMENT OF RIGHTS AND RELEASE OF INFORMATION
FOR MEDIA, MARKETING, DEVELOPMENT AND COMMUNICATIONS

Purpose for Release of Information: Media, internal and external awareness, including, but not limited to, websites, social media, artwork, contests, printed material, etc.

I, _____ The legal guardian of (CHILD'S NAME) _____

OR I, _____ an adult eighteen years if age or older do hereby assign ***RAINBOWS UNITED, INC. (and affiliates)*** and all staff members and forever release the right to PHOTOS, ELECTRONIC FILES, ARTWORK, OTHER VISUAL IMAGES, STORIES, QUOTES or PERSONAL INFORMATION taken on or created by this individual.

I understand that the intended use of these visual images, written stories and/or artwork is for media relations, marketing, communication or other means of public relations, advocacy, fund raising and development projects to benefit ***RAINBOWS UNITED***. I understand these images and artwork will become the property of Rainbows United and we will have no claim to future compensation, benefits, rights or royalties. I release ***RAINBOWS UNITED*** from any claim, suit or action based on the use or publication of visual images.

❑ I **do** give my permission for media release

❑ I **do not** give my permission for media release

Executed THIS _____ DAY OF _____, 20_____.

_____
Signature of Legal Guardian or Participant

Participant's Contact Information:

Address: _____

_____

Phone: ( ) _____

Email address: _____

RAINBOWS[SM]
bringing potential to life

APPOINTMENT OF AGENT

I hereby appoint Rainbows United, Inc. as my agent and representative for the purpose of authorization and consent for hospital and/or medical care for _____.
(Client's Name)

This appointment is for illness or injury that may occur while _____ is in the care or custody of Rainbows United, Inc. (Client's Name)

This appointment is effective (Today's Date) _____ and will remain valid throughout my child's enrollment at Rainbows United, Inc. unless I revoke it in writing. I understand that I remain legally liable for any and all bills for medical and/or hospital services, and I specifically release and hold harmless Rainbows United, Inc., agents, and employees from any liability thereof.

INFORMATION FOR EMERGENCY ROOM:

Client's Physician: _____

Drug Allergies: _____

Last Tetanus Toxoid: _____

Hospital Choice: _____

Insurance: _____ Number: _____

_____ _____
Parent or Guardian Signature Date

CCL. 029
Rev.02/2009

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

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES AND FAMILY DAY CARE HOMES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in registered family day care homes or 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 or family day care home.

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

Names and ages of children in family_____

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary._____

_____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

1. 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:

_____

2. Does your child have any of the following conditions? Please answer yes or no.

_____Allergies _____Frequent sore throats/colds _____Ear Aches
_____Asthma _____Speech, Visual, Hearing _____Diabetes
_____Epilepsy/Seizures _____Other_____

If yes answered to any above, please provide additional information_____

3. Have there been major changes at home that might affect your child in care? ___ No ___Yes, as follows:

_____

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

_____

Signature of Parent/Guardian_____ **Date:**_____

History of Immunizations

For all children in child care facilities and family day care homes, 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/Y

SECTION I.

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Physician Signature		Date of Illness:	
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
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 laws requiring immunizations [K.S.A. 65-508(d) and K.S.A. 65-519(c)].

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:

_____DTP ____Pertussis Only ____Tetanus ____Polio ____MMR ____Rubella Only ____Hep A _____Hep B
Hib _____PCV7 ____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.2/2009

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 Child Health Assessment is optional for children in Registered Family Day Care Homes. 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. Any Health Assessment Form should be attached to the KDHE Medical Record Form.

Child's Name_____ Date of Birth_____

Past Health History (Developmental – Illness – Hospitalization)_____

Allergies_____

Current Medications_____

Nutritional Status_____

Physical Examination

Height_____ Weight_____

Head_____ Abdomen_____

EENT_____ GU_____

Teeth_____ GYN_____

Heart_____ Skeletal_____

Lungs_____ Neurological_____

Screening Tests (Dates Done and Results)

Vision_____ TBC. Test_____

Hearing_____ Sickle Cell_____

Speech_____ HGB._____

DDST_____ U.A._____

Lead_____ Other_____

Diagnosis:

Recommendation:

Do you see this child for regular health supervision: Yes _____ No _____

_____ _____
Signature of Licensed Physician or Nurse Approved for Child Health Assessments Date (MM/DD/YYYY)

_____ Phone number_____
Print the Name of the Individual Signing Above

_____
Address of Physician or Nurse City Zip Code

RAINBOWS[SM]
bringing potential to life

Meal Substitutions

Name of Client: _____ **DOB:** _____

1) Is the client's diet restricted for one of the following reasons?
   - ___ Religious reasons
   - ___ Individual preference
   - ___ Medical Concerns
   - ___ Dietary Needs
   - ___ Medication Interactions
   - ___ Other: _____

   Substitute Food Suggestions:

   _____

   _____

   Parents may be asked to provide substitute food items.

2) If the clients diet is restricted by Medical concerns, Dietary needs, or Medication Interactions please complete the following.

   What are the restrictions (i.e. fed by g-tube only, allergic to strawberries, etc.)?

   _____

   _____

   _____

   If an alternate feeding method is needed other than oral in-take, provide feeding instructions. (i.e. how often, consistency, etc.)

   _____

   _____

   _____

If number two applies, please have a physician sign below.

_____ _____

Physician Signature **Date**

_____ _____

Parent/Guardian Signature **Date**