EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER

2416 Swope Parkway – Kansas City, MO 64130
(816) 921-3164 Fax – (816) 861- 1270

Dear Parents,

Thank you for your interest in Emmanuel Family and Child Development Center. We are eager to offer your child(ren) quality childcare services.

The flowing items are required to enroll your child:

- ☐ $30 Registration Fee
- ☐ Enrollment Form
- ☐ Immunization Records
- ☐ Medical Examination Report
- ☐ Income Eligibility Form (Please complete one per family.)
- ☐ Photography and Videotaping Release
- ☐ Childcare Payment Agreement
- ☐ Authorization for Pick-up
- ☐ Parent Consent to Evaluation
- ☐ Parent and Child's Social Security Cards
- ☐ Child's Medical Insurance Cards
- ☐ Parent/ Guardian Photo ID
- ☐ Foster Child Placement Papers (if applicable)
- ☐ Current Picture of Your Child
- ☐ Proof of Birth or Proof of Pregnancy
- ☐ Proof of Income (e.g. most current tax return W-2 or paystubs, proof of SSI or TANF)
- ☐ Proof of Residency for Jackson, Clay, Platte Counties. (e.g. utility bill, rental contract, or Missouri State property tax receipt with your current address.)
- ☐ Copy of Work Schedule
- ☐ Lead Poisoning Prevention
- ☐ UMKC School of Dentistry Department of Pediatric Dentistry

After your child has been accepted for enrollment you will receive a Parent Handbook. Please refer to the Parent Handbook for the policies and procedures of the Center.

If you are receiving state assistance from the state for childcare services you will need to notify your case worker immediately with EFCDC DVN#, which is 001478584. The number to childcare authorization services is 1-855-373-4636. If you are paying or childcare services privately, please see the office about the fee schedule.

Once again, thank you for your interest in our Center. We hope to welcome you and your family to our Center soon!

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

SAVE PRINT RESET

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
Emmanuel Family & Child Development Center		
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

MOTHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
FATHER'S/GUARDIAN'S NAME	HOME TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS ABOVE ☐	CELL PHONE NUMBER
E-MAIL ADDRESS	
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY (OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ YES ☑ NO — HOW IS CHILD RELATED TO CHILD CARE PROVIDER?

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: ☐FULL TIME OR ☐PART TIME		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MONDAY	☐	AM PM	AM PM	
TUESDAY	☐	AM PM	AM PM	
WEDNESDAY	☐	AM PM	AM PM	
THURSDAY	☐	AM PM	AM PM	
FRIDAY	☐	AM PM	AM PM	
SATURDAY	☐	AM PM	AM PM	
SUNDAY	☐	AM PM	AM PM	

CACFP REQUIREMENT

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ BREAKFAST ☐ MORNING SNACK ☐ LUNCH ☐ AFTERNOON SNACK ☐ SUPPER ☐ EVENING SNACK ☐ NONE

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ NEW YEARS'S DAY (JANUARY)	☐ MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	☐ PRESIDENT'S DAY (FEBRUARY)	☐ EASTER (MARCH/APRIL)
☐ MEMORIAL DAY (MAY)	☐ INDEPENDENCE DAY (JULY)	☐ LABOR DAY (SEPTEMBER)	☑ COLUMBUS DAY (OCTOBER)
☑ VETERANS DAY (NOVEMBER)	☑ ELECTION DAY (NOVEMBER)	☐ THANKSGIVING (NOVEMBER)	☐ CHRISTMAS DAY (DECEMBER)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.

IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE

Emmanuel Family & Child Development Center

DAY CARE PROVIDER OR HOME PROVIDER

TO CONTACT THE FOLLOWING:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGEMENTS

A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.	PARENT/GUARDIAN INITIALS
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.	PARENT/GUARDIAN INITIALS
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR, AND INDIVIDUAL NEEDS.	PARENT/GUARDIAN INITIALS
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.	PARENT/GUARDIAN INITIALS
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.	PARENT/GUARDIAN INITIALS
F	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR FIELD TRIPS/EXCURSIONS. I UNDERSTAND I WILL BE NOTIFIED IN ADVANCE WHEN THEY ARE PLANNED.	PARENT/GUARDIAN INITIALS
G	I ☐ DO ☐ DO NOT GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD.	PARENT/GUARDIAN INITIALS
H	I HAVE BEEN INFORMED AND HAVE RECEIVED A COPY OF THE FACILITY'S SAFE SLEEP POLICY WHEN ENROLLING A CHILD LESS THAN ONE (1) YEAR OF AGE.	PARENT/GUARDIAN INITIALS
I	I HAVE BEEN NOTIFIED THAT I MAY REQUEST NOTICE AT INITIAL ENROLLMENT OR ANY TIME THERE AFTER WHETHER THERE ARE CHILDREN CURRENTLY ENROLLED IN OR ATTENDING THE FACILITY FOR WHOM AN IMMUNIZATION EXEMPTION HAS BEEN FILED.	PARENT/GUARDIAN INITIALS
PARENT'S/GUARDIAN'S SIGNATURE ▸		DATE

CACFP REQUIREMENT

FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

SAVE PRINT RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____, this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)	IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)
	TELEPHONE NUMBER

EMMANUEL
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816-921-3164 FAX 816-861-1270

Child and Adult Care Food Program
Parent Letter – Non-Pricing Child Care Centers
July 1, 2016 through June 30, 2017

Dear Parent or Legal Guardian:

Our center is currently participating in the Child and Adult Care Food Program. This program reimburses the center for the partial cost of meals provided to children and allows the center to provide nutritious meals without increasing the center's fees to you. If your yearly income is equal to or below the amount listed for your family size on the chart below, your child is eligible for free or reduced-price meals. If the income is higher than the amount listed for your family size, you do not need to complete the income application.

Family	Yearly Income	Family Size	Yearly Income
1	$21,978	5	$52,614
2	$29,637	6	$60,273
3	$37,296	7	$67,951
4	$44,955	8	$75,647

For each additional Family Member, add +$7,696

To apply for free or reduced-price meal benefits for your children, you must complete the attached Income Eligibility Form (IEF). Your application for free or reduced-price meal benefits cannot be approved unless the attached application is completed according to the directions provided; however, you are not required to complete the IEF. Notify the center should the household income decrease and/or if the household size increases. A participant may be eligible for free or reduced-price meals. The application is valid until the last day of the month in which the form was approved/dated/signed one year earlier.

Sincerely,

Emmanuel Family & Child Development Center

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1 CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

PART 2 HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE): YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3 RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐

PART 4 SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY)	DATE
PRINTED NAME OF ADULT	**ADDRESS**	**PHONE NUMBER**

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐ MONTH ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐ SNAP (Food Stamp) ☐ TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER
2416 Swope Parkway - Kansas City, MO 64130
816-921-3164 FAX 816-861-1270

Photography & Videotaping Release

From time to time Emmanuel Family & Child Development Center or its subsidiaries, or the news media may videotape or photograph your child and/or their class.

By signing my name on this document, I acknowledge and agree:

- That Emmanuel Family & Child Development Center or its subsidiaries have my permission to allow the recording of my child's likeness or photograph for future use.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to my child's participation in activities which may result in such photography or videotaping.
- That Emmanuel Family & Child Development Center or its subsidiaries are under no obligation to provide notification prior to the use of such photography or videotaping.
- That I and/or my child will receive no financial or in-kind compensation for the use of my child's likeness or image by Emmanuel Family & Child Development Center or its subsidiaries as well as the media.
- This authorization in no way guarantees that my child's likeness or image will be used.

If I do not wish for my child's likeness or image to be used according to such above-stated conditions, I acknowledge and agree that I will provide the Director with written notification of such intent, prior to my child's enrollment within Emmanuel Family & Child Development Center, or at a later date if need should arise.

I hereby authorize my child to participate in activities which may be videotaped or photographed, and acknowledge my understanding and agreement to the terms and conditions stated with this document.

_____

Child's Name

_____

Parent or Guardian Signature & Date

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER
2416 Swope Parkway - Kansas City, MO 64130
PHONE 816-921-3164 FAX 816-861-1270

Childcare Payment Agreement For:

_____
Child's Name & Date of Birth

_____
Child's Name & Date of Birth

_____
Child's Name & Date of Birth

The Center hours of operation are Monday through Friday from 6 a.m. to 12 a.m. I understand the hours of the program for which I have registered my child and agree to adhere to them promptly. I also understand that I must escort my child(ren) into the building and leave him/her in the care of a staff member. The staff will release my child(ren) only to the parents or to the persons designated that is at least 18 years old.
I further agree to read the Center's guidelines located with the parent handbook and to adhere to those guidelines as stated. I acknowledge that I understand and have received a copy of the Center's current prices and payment policies, including but not limited to the following policies:

A. All registration fees, activity fees, co-pays, and tuition are non-refundable in whole or in part. I have been informed that the payment is due promptly on Mondays and is late after Friday, at which time late fees may be assed. EFCDC has the right to terminate the contract due to repeated late payments, returned checks, or if the child(ren)'s behavior endangers the other children or the Provider.
B. If I receive state childcare assistance, I know I am responsible for making sure that my case remains open during the duration of my child's attendance at the Center or I will be charged full tuition for my children. If my childcare case does close and my children have attended the center after it closes, I am responsible for paying full tuition.
C. Because my child(ren)'s spot is reserved, I am responsible for payment of tuition/copay even if my child is absent due to sickness, vacation, or any other reason. I understand that a collection agency will be used to collect any monies not paid on this account if I withdrawal my child(ren) from the Center leaving a remaining balance.
D. I may take up to 2 weeks (as a block of 5 consecutive days each) vacation credit (non-cumulative from year to year) without obligation for tuition if my child has been enrolled for 12 consecutive months on a continuing basis and if I give the Center two weeks' notice of vacation.
E. Late fees are charged for late payments in the amount of $25 per week and late pickups at a rate of $1 per minute per child.
F. The Director and other program staff are available for individual conferences concerning your child(ren)'s adjustment to and progress in the program. If any special problems arise in the school affecting your child, such occurrences will be promptly brought to your attention. If these problems continue and we determine that we cannot properly care your child due to high behavior issues, we will give you a two-week notice informing you that you will need to make other arrangements for the care of your child(ren). Please refer to the behavior policy in the parent handbook.
G. In the event of withdrawal from the program, a two-week withdrawal notice is required; your regular tuition/copay charges continue during this two-week notice period. A new registration fee will be due upon re-enrollment.

I agree to the terms of this contract as stated above. The agreed upon fee for childcare is $ _____ per week.

_____ _____ _____
Parent or Guardian Signature Date Parent Social Security Number

_____ _____
EFCDC Representative Date

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Authorization for Pick-Up

Child's Name _____

Parent's Name _____

Home #: _____

Work #: _____

Cell #: _____

Person(s) listed below are authorized by the parent/guardian to take their child(ren) from the facility.

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to Child: _____

Address: _____ Phone #: _____

EFCDC Office Staff will check each person for identification. We will not all any child to be removed from the Center without proper authorization.

EMMANUEL
FAMILY & CHILD DEVELOPMENT CENTER

2416 Swope Parkway - Kansas City, MO 64130
816-921-3164 FAX 816-861-1270

Parent Consent to Evaluation:

The first five years are very important for your child because this time sets the stage for success in school and later in life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please sign below indicating that you agree to have your child participate in the screening/ monitoring programs used at Emmanuel Family & Child Development Center.

- The Ages & Stages Questionnaires (ASQ-3)
- The Department of Education and Second Education Core Competencies (DESE)
- The Devereux Early Childhood Assessment Development Screenings (DECA)
- Rockhurst University Speech and Language Therapy

_____
Parent or Guardian Signature & Date

_____
Child's Name

_____
Child's Date of Birth

_____
Child's Primary Care Physician

Health Department
City of Kansas City, Missouri

Childhood Lead Poisoning Prevention

(816) 513-6048

2400 Troost Avenue, Suite 3400
Kansas City, Missouri 64108

What does lead do to Children?

Lead affects all body systems, but especially the brain and nervous system causing problems such as hyperactivity, learning difficulties, impaired growth, lower IQ.

Where is lead? Everywhere-but particularly:

Lead-based paint, contaminated soil, dust, air, water, hobby supplies, folk medicine, and poorly glazed pottery.

Precautions you can take:

Good nutrition, frequent hand washing and housecleaning to remove lead-contaminated dust, safe clean-up and disposal of paint chips, avoidance of folk remedies and poorly glazed pottery.

CONSENT FORM

I give permission for my child to have a lead screening blood test. I understand this procedure involves a finger stick to obtain a few drops of blood. The test will be performed by nurses from the Kansas City, Missouri Health Department and results may be released to your child's day care program.

****(Please Print)****

Child's Name:_____ Today's Date:_____

Sex:_____ Race:_____ Date of Birth:_____ Medicaid #:_____

Address:_____
Street City State Zip code

Phone#:_____ Signature – Parent/Guardian:_____

Alt. Phone#:_____ **Print** Parent/Guardian Name:_____

For office use only: Date of Screening:_____

Screening Site:_____ RN:_____

UMKC School of Dentistry
Department of Pediatric Dentistry

Dear Parent/ Guardian:

We are pleased to have your child's school as part of our program for Oral Health Care with the UMKC-School of Dentistry. In order for us to provide care for your child, we REQUIRE the Parent/Legal Guardian to fill out and sign the following forms and return them to the school nurse/coordinator. Children will have their turn on a first come, first serve basis. We recommend that you complete and return these forms as soon as possible.

1. Child's Health History
2. Parental Consent Form
3. Form on HIPPA regulations (Privacy and Confidentiality Act)

I appreciate your cooperation. If you have any questions please contact your school nurse/coordinator or Ms. Monica Rolf (816) 235-2145.

Sincerely,

Dr. Brenda Bohaty
Chair, Department of Pediatric Dentistry
UMKC School of Dentistry

UMKC University of Missouri-Kansas City
School of Dentistry

E.O. 2nd 3rd 4th Grad. N/Acc
ENDO PERIO OPER FIXED
PARTIAL DENTURE - FULL DENTURE

REGISTRATION FORM
(RE-REGISTRATION FORM)

Assign to _____ Accepted _____
(Faculty Signature)

Student No. _____

Patient's Number _____ Date ____ - ____ - ____

Name _____
(Last) (First) (Middle Initial)

Address _____
(Street and Number) (City) (State) (Zip)

Phone Numbers ( ) _____ ( ) _____ Date of Birth _____
(Home) (Work)

Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ Am. Indian ☐ Mixed

Marital: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Dental Insurance: ☐ No ☐ Yes If yes, please list: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY OR PARENT OR LEGAL GUARDIAN'S NAME AND ADDRESS IF DIFFERENT FROM CHILD'S:

Name _____
(Last) (First) (Middle Initial)

Address _____
(Street and Number) (City) (State) (Zip)

Relation _____ Phone Number ( ) _____

Past patient at UMKC Dental Clinic? ☐No ☐Yes When _____ List previous name _____

Reason for present visit _____

Best day for appointments: ☐Mon. ☐Tue. ☐Wed. ☐Thur. ☐Fri.

Referred by: ☐ Dentist ☐ Relative ☐ Friend ☐ Other Name: _____

Have you ever had or do you now have any of the following?

	Yes	No
Heart trouble		
Heart attack (MI) (414.80)		
Rheumatic fever (390.00)		
Heart murmur (785.20)		
High blood pressure (401.00)		
Emphysema (510.90)		
Tuberculosis (011.90)		
Asthma (493.90)		
Diabetes (250.00)		
Ulcers (533.90)		
Intestinal trouble		
Hepatitis B (070.30)		
Hepatitis (other) (070.50)		
Liver disease		
Kidney or bladder disease		
Bleeding problems (459.00)		
Sickle Cell Anemia (282.60)		

	Yes	No
Stroke (436.00)		
Epilepsy (345.90)		
Venereal disease (099.90)		
Arthritis (716.90)		
Emotional problems		
Psychiatric treatment		
Skin disease		
AIDS (042.90)		
HIV+ (044.90)		
Cancer (199.1)		
Lupus (695.40)		
TMD/TMJ (524.60)		
Other (Please list)		

Please answer these questions:	Yes	No
Have you ever taken Fenfluramine and/or Dexfenfluramine (Fen-Phen or Redux)?		
Do you drink alcoholic beverages?		
Do you smoke or use tobacco? (305.10)		
Do you have any allergies?		
Are you allergic or sensitive to any medicines?		
Are you allergic to latex?		
Do you now or have you ever taken cortisone?		
Have you had any difficulty with tooth extractions?		
Are you taking any medicines now?		
Are you currently under the care of a physician?		
Have you ever been in a hospital as a patient?		
Have you ever had radiation treatments?		
Will you consider being in a research project?		
WOMEN: Are you or might you be pregnant?		
Does your mouth feel dry when eating a meal?		
Do you sip liquids to aid in swallowing dry foods?		
Does the amt. of saliva in your mouth seem too little?		

To the best of my knowledge the above is complete and correct. I hereby give permission for dental treatment to be accomplished and for the development of photographic recordings of the conditions and treatment for the advancement of Dental Science through use in professional publications, lectures or television presentations.

Signature (patient, parent or guardian)	Date

UMKC SCHOOL OF DENTISTRY
Department of Pediatric Dentistry

PARENT'S CONSENT FORM

Please complete all information.

CHILD'S NAME _____ Date of Birth:_____

SCHOOL _____ GRADE:_____

PHONE _____ ROOM NUMBER: _____

I, _____give my consent for
(Parent or Legal Guardian- print please)

_____to receive free dental services consisting of:
(Child's Name – print please)

Clinical dental examination
Toothbrush prophylaxis

I hereby and on behalf of _____ who is under the age of eighteen
(Child's Name)
(18) years, consent that above named child may participate in this program sponsored by the University of Missouri-Kansas City School of Dentistry.

_____
(Parent/Legal Guardian's Signature)

Date: _____

University of Missouri Kansas City School of Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

UMKC SCHOOL OF DENTISTRY
POTENTIAL RISKS AND LIMITATIONS OF DENTAL TREATMENT

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus the following information is routinely supplied to anyone considering dental treatment in our school. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings and problems of growth and development, extensive dental disease, genetics, and patient cooperation, achieving perfection is not always possible. You will be treated by a dental student (supervised by faculty) who will do everything within his/her capacity to insure the best possible care.

Throughout life, teeth are constantly changing. Regular examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal are a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected infected or dead tooth may flare up during any dental treatment and may require endodontics (root canal) treatment to maintain it. It may even have to be removed.

There is also a risk during or following treatment, that soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions that may surface during treatment. Decay, which may appear small on x-ray, may be larger than anticipated and result in much more extensive treatment.

INFORMED CONSENT

I understand that during treatment any of the above problems occasionally can occur. These can include, but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that to achieve a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1. Strict adherence to instructions.
2. Cooperation in keeping appointments.
3. Excellent oral hygiene.
4. Proper diet controls.

I understand that there is no warranty or guarantee for my result and/or care. I understand that I can, at any time, ask for and receive a full recital of all possible risks related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification, who are constantly late for their appointments, who continue to excessively cancel their appointments, who fail to practice acceptable oral hygiene, or who are uncooperative with students and staff providing care.

I also understand that records, photographs and/or video recordings may be made during my treatment and will be used for the advancement of dentistry through use in professional publications, lectures or television presentations. However, my identity will not be disclosed without my expressed permission.

I understand as a service to patients, UMKC School of Dentistry provides courtesy appointment reminder calls and possibly other important calls that may be placed using a prerecorded message. By providing your telephone number, you consent to receiving such calls at this number.

University of Missouri-Kansas City School of Dentistry
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Changes in our privacy practices and the new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request and on our website at dentistry.umkc.edu.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment:
We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:
We may use and disclose your health information to obtain payment for services we provide to you. This includes disclosures to companies with which we have business associate agreements.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorizations:
In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to person(s) identified by you, for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures of your health information permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends:
We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, unless you object.

Persons Involved in Care:
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with any opportunity to object to this. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Disaster Relief:
We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services:
We will not use your health information for marketing communications without your written authorization.

Required By Law:
We may use or disclose your health information when we are required to do so by law. These include but are not limited to public health activities, workers' compensation, judicial and administrative proceedings, coroners and medical examiners activities and law enforcement.

Abuse or Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. In accordance with the applicable law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security/Military/Correctional:
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose, as required by law, protected health information to correctional institution or law enforcement officials having lawful custody of an inmate or patient.

Alternative Communication:
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will accommodate reasonable requests.

Amendment:
You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Right to Notification of a Breach:
We will notify you if there has been a breach of your health information unless we determine that there is a low probability that your information has been compromised.

Electronic Notice:
You may receive this Notice on our web site or by electronic mail (e-mail); you are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Linda M. Wells, DMD, MBA

Telephone: 816-235-2137

Fax: 816-235-5472

E-Mail: wellslm@umkc.edu

Address: 650 East 25th Street
Kansas City, Missouri 64108

September 18, 2013

Para Su Familia y Amigos:
Nosotros le debemos divulgar la información de su salud a usted, como está descrito en la sección de Derechos al Paciente de esta Notificación. Nosotros podremos divulgar la información de su salud a un miembro de familia, amigo u otra persona con el propósito de ayudarle con su tratamiento de salud o con pagos para su tratamiento, pero nosotros lo haremos sólo si usted está de acuerdo.

Personas Envueltas en Cuidado:
Nosotros podemos usar o divulgar la información de su salud para notificar o asistir en la notificación (esto incluye identificar o localizar) a un miembro de familia, su representante personal u otra persona responsable por su cuidado, o su localización, su condición general o muerte. Si usted está presente, entonces antes del uso o divulgación de la información de su salud, nosotros le vamos a proveer con una oportunidad para oponer dichos usos o divulgaciones. En el evento de circunstancias de su incapacidad o en casos de emergencia, nosotros vamos a divulgar su información de salud basados en una determinación usando nuestra opinión profesional divulgando solo la información de su salud que sea revelante a la persona directamente envuelta con su cuidado de salud. Nosotros también utilizaremos nuestro juicio profesional y nuestra experiencia con prácticas comunes para hacer inferencias razonables que sean de su mejor interés y que permitan a una persona recoger sus recetas, suplidos médicos, radiografías y otras formas similares de información de salud.

Medidas de Desastre:
Nosotros podremos usar o divulgar la información de su salud para asistir y colaborar con las medidas de ayuda del gobierno en casos de desastre.

Publicidad de Servicios Relacionados a la Salud:
Nosotros no utilizaremos la información de su salud para comunicaciones publicitarias sin su autorización escrita.

Requisito por Ley:
Nosotros podemos usar o divulgar la información de su salud cuando estemos requeridos a hacerlo por ley. Esto incluye pero no está limitado a actividades de salud pública, compensación por trabajo, procedimientos judiciales y administrativos, actividades de médicos forenses, y aplicación de la ley.

Abuso o Negligencia:
Nosotros podremos divulgar la información de su salud a autoridades apropiadas si creemos razonable que usted sea víctima de abuso, negligencia o violencia doméstica o posible víctima de otro crimen. Nosotros podremos divulgar la información de su salud a la extensión necesaria para prevenir amenazas a su salud o seguridad o la salud o seguridad de otros.

Seguridad Nacional:
Nosotros podremos divulgar la información de su salud a autoridades militares de las Fuerzas Armadas bajo algunas circunstancias. Nosotros podremos divulgar a oficiales federales autorizados información de salud requerida para inteligencia legítima y otras actividades de seguridad nacional. Nosotros podremos divulgar a instituciones correccionales u oficiales de la ley que tengan custodia bajo ley de información de salud de un recluso o paciente bajo algunas circunstancias.

Secretaría de HHS (Salud y Servicios Humanos):
Nosotros divulgaremos la información de su salud a la Secretaría del Departamento de Salud y Servicios Humanos de los Estados Unidos cuando es requerida para investigación o para determinar cumplimiento con HIPAA u otras leyes.

Investigación:
En algunas situaciones limitadas, la ley nos permite que usemos la información de su salud sin su autorización para investigaciones relacionados a la salud. La Escuela dental (UMKC) y sus practicantes sirven como investigadores en conexión con ciertas pruebas clínicas. Nuestra participación puede ser de beneficio para usted, para lograrlo nosotros tendremos que revisar su expediente dental periódicamente y determinar si califica/elegible para participar en algunos estudios de investigación. Solamente nuestro personal clínico revisará su expediente dental durante estos análisis y no incluirá ninguna información de salud privada/confidencial. Los investigadores también podrán utilizar su información de salud cuando sus investigaciones hayan sido aprobadas por un comité de revisión institucional (IRB) y exista una garantía para la privacidad de su información de salud.

Recuerdos de Citas:
Nosotros podremos usar o divulgar la información de su salud para proveerle a usted con un recordatorio de citas (como mensajes de voz, tarjetas postales o cartas por correo).

Nosotros apoyamos su derecho a la privacidad de la información de su salud. No tomaremos represalias de ninguna forma si usted decide presentar oficialmente una queja con nosotros o con el Departamento de Salud y Servicios Humanos de U.S.

Oficial de Contacto: Linda M. Wells, DMD, MBA

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