Top Flight Kids Learning Center

300 S. Rogers Road
Olathe, KS 66062
913-768-4661

Dear Top Flight Kids Parents,

Welcome to top Flight Kids Learning Center! My staff and I are excited that you have chosen us for quality childcare for your child.

We want to do everything possible to make your child's first day smooth and comfortable, so please let us know if there is anything we can do to assist you.

As your enrollment day approaches, please look over the following checklist to make sure you have everything your child needs for the first day of school:

- Completed enrollment forms
- Items from supply list – please label all items with permanent marker with child's name
- Completed infant care plan (if needed)
- 45 minute orientation visit with child and parent in the classroom before first day
- Parent handbook reviewed – on our website topflightkids.org
- Classroom orientation packet received
- Child's schedule completed

Child cannot attend unless all paperwork is completed

OBJECTIVE

The objective of the B.E.S.T. Choice, Inc. at the Top Flight Kids Child Care Center is to offer high quality childcare and education in Olathe, which is conveniently located for FAA employees and community patrons. We will offer regular full time, part time and occasional hours for children from 6 weeks to pre-kindergarten.

HOURS OF OPERATION

The center will be open Monday-Friday 6:00a.m.-6:00p.m. Additional hours may be available upon written request and with approval from the Board of Directors. The center will be closed New Year's Day, Thanksgiving Day, and Christmas Day.

OPERATIONS

The staff and day-to-day operations are the responsibility of The B.E.S.T. Choice, Inc., the contracted provider.

If you have any questions, please call the front desk at 913-768-4661. Welcome to Top Flight Kids!

Top Flight Kids Learning Center
Tuition Rates

CLASSROOM	5 DAYS	4 DAYS	3 DAYS	2 DAYS	1 DAY
Infant Federal	$320.95	$295.27	$240.71	$173.31	$86.66
Toddler 1 Federal	$257.29	$236.71	$192.97	$138.84	$69.47
Toddler 2 Federal	$233.40	$214.72	$175.05	$126.03	$63.02
Preschool Federal	$206.88	$190.32	$155.16	$111.71	$55.86
Pre-K Federal	$185.66	$170.80	$139.25	$100.26	$50.13
Infant Community	$350.10	$322.09	$262.58	$189.06	$94.58
Toddler 1 Community	$278.51	$256.23	$208.88	$150.40	$75.20
Toddler 2 Community	$254.62	$234.24	$190.96	$137.49	$68.75
Preschool Community	$222.79	$204.97	$167.10	$120.30	$60.15
Pre-K Community	$201.57	$185.44	$151.18	$108.85	$54.43

Tuition rates include breakfast, lunch and an afternoon snack. The parent or guardian of an infant will need to furnish formula and baby food. Weekly rates are based on a maximum of 5 ten-hour days. Due to fixed costs of maintaining the center there will be no reduction in tuition for children's illnesses, absences or holidays.

Annual Enrollment Fee

A non-refundable annual registration fee of $125.00 for a full year will be due upon enrollment. This fee helps defray the cost of insurance for each child for one year. You will be billed for the enrollment fee each January. Please see the chart below if you have more than one child enrolled at Top Flight.

First Child	$125
Second (third, fourth…) Child	$50/each

Discretionary Days

We provide discretionary days for scheduled days that cannot be used due to vacation, illness or holidays. The number of discretionary days is computed by taking into account the following; number of days per week the child attends and starting date of the child in the center. Discretionary days are renewed each January 1 for all families. Upon enrollment, each family is given a schedule of days.

Scheduled Days of Care per Week	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
5	5	5	4	4	3	3	2	2	1	1	0	0
4	4	4	3	3	2	2	1	1	1	0	0	0
3	3	3	3	2	2	2	1	1	1	0	0	0
2	2	2	2	2	1	1	1	1	0	0	0	0
1	1	1	1	1	1	1	0	0	0	0	0	0

Classroom Supply Lists

Infant Room

Completed Infant Care Plan
Unbreakable bottles
Formula (if used)
Baby food (if used)
Diapers
Diaper wipes in one of the hard plastic containers (not the refill packaging)
Extra Clothes (3-4 full sets)
Diaper Ointment
Pacifier (if used)
Sunscreen
3" binder with page protectors for Portfolio
Family picture
Canvas cubby storage bin (11"H x 15"W x 16"D)

Toddler One & Two Rooms

Diapers
Diaper wipes in a box
Extra Clothes (2-3 full sets)
Toothbrush
Pacifier (if used)
Sunscreen
Crib Sheet
Blanket
Sleep buddy (optional)
Family picture
3" binder with page protectors for Portfolio (new students only)
Canvas cubby storage bin (11"H x 15"W x 16"D)
Rain Boots – Our playground gets muddy, but we will still go outside. Rain boots will save your child's shoes and our classroom!

Preschool & Pre-K Rooms

Crib sheet
Blanket
Extra clothes (2-3 full sets)
Toothbrush
Sunscreen
Tissues (2 boxes)
Sleep buddy (optional)
Family picture
3" binder with page protectors for Portfolio (new students only)
Canvas cubby storage bin (11"H x 15"W x 16"D)
Rain Boots – Our playground gets muddy, but we will still go outside. Rain boots will save your child's shoes and our classroom!

All items need to be labeled with your child's name or initials.

Student Questionnaire

Who lives in your household? Names and ages of other children living at home.

What extended family do you have in the area?

What other childcare centers has your child attended? Has he/she had group play experience? Where?

In what community activities is your family involved?

What kinds of goal do you have for your child?

Are there any special holidays or customs that your family observes?

How would you describe your child's personality?

What are your child's likes? Favorites?

What are your child's fears? Dislikes?

Which types of animals has your child been exposed to?

Please describe any special needs your child may have.

Have there been any major changes at home which might affect your child?

Has your physician approved the use of any non-prescription medication for your child such as acetaminophen, cough syrup or ointment, which can/should be used by caregiver?

Please list any allergies your child may have.

Does your child take any regular medication? Will your child take this medication at school? (Need individualized child care plan completed by the physician.)

Does your child have any of the following problems (if yes, please explain condition)

Allergies

Allergic reactions

Ear infections

Frequent sore throats

Frequent colds

Sinus problems

List any childhood diseases or other illnesses your child has had.

Top Flight Kids, Inc.
Membership Application

History: Several years ago, a need was recognized for extended hour childcare for employees of the Kansas City Air Route Traffic Control Center. The FAA agreed to build a facility on the condition that it would be leased (rent free) to an incorporated parent organization for providing childcare. Today, each family unit with a child at the facility is a member of the corporation.

The original Board of Directors contracted with the Best Choice, Inc. (BCI) to provide the childcare. All staff at the facility are employees of BCI. Additionally, BCI staff handles all day-to-day functions at the facility. The Top Flight Kids, Inc. Board of Directors oversees the operation through monthly management reports from BCI and direct contacts with management. Furthermore, with the exception of paying the utilities and conducting background checks on BCI employees, the FAA has no part in operating the facility.

Please provide the following information. It allows your Board of Directors to be better informed as well as keep you better informed.

Parent/Guardian

Name:_____

Address: _____

Telephone: Work _____ Home _____

Are one or both parents/guardians a federal employee: Yes _____ No _____

If yes, what agency?_____

Child Information

Name:_____ Birth date:_____

Name:_____ Birth date:_____

Name:_____ Birth date:_____

The Top Flight Kids, Inc. Board of Directors has established a $20.00 annual fee. Each family is required to pay only $20.00 regardless of how many children are enrolled. The purpose of the fee is to cover corporate expenses (i.e. licensing, P.O. Box, mailings, etc.) Additionally the Board will spend funds to replace toys, furniture and materials that the teachers request. The $20.00 fee is due during the Spring each year.

Please place your check or money order in the Top Flight Kids, Inc. suggestion box.

Thanks,

Board President

TOP FLIGHT KIDS LEARNING CENTER POLICY AGREEMENT

1. HOURS OF OPERATION

The Top Flight Kids Learning Center will be open from 6:00am-6:00pm Monday-Friday. I understand that I may not drop off before or pickup after my child's scheduled time unless other arrangements have been made with the administration in advance. There is an additional charge for children who attend more than 10 hours per day, or who are in care beyond their scheduled time.

2. ILLNESS

When my child is ill it is understood and agreed that she/he may not be accepted into care. Furthermore, I agree to arrange for my child to be picked up within the hour if she/he becomes ill while at the center.

3. DISCLOSURE

I understand that the administration of this facility reserves the right to disenroll a child at any time and for any reason.

4. LICENSE

I understand that this facility is licensed by the State of Kansas and they will comply with those rules and regulations.

5. COMMUNICATION

The provider and I have agreed on a plan for a continuing communication regarding my child's development, behavior, etc. I agree to provide current information regarding emergency phone numbers, emergency contacts, addresses, work places, etc.

6. MEDICAL INFORMATION

The medical information concerning my child is current and accurate to the best of my knowledge. I will promptly notify the center in writing of any changes, including immunization updates.

7. CANCELLATION

I understand that it is my responsibility to pay for any cancellation of my child's attendance. I am responsible for payment of all scheduled days whether my child is in attendance or not.

8. PHOTOGRAPHS/VIDEOS

Photographs and videos of children participating in Top Flight Kids Learning Center activities may be taken from time to time and may appear in newspapers, magazines, brochures or other publicity materials. Your permission for photographs including your child, to be used without compensation, is part of this agreement.

9. NATURE WALKS/EXCURSIONS

I understand that my child may take part in nature walks or excursions with Top Flight Kids Learning Center under proper supervision. Parents will be notified when such excursions are planned.

10. TOYS AND OTHER OBJECTS FROM HOME

Parents are asked to help your child understand that it is not wise to bring toys to the center or other objects they may not wish to share with the group. Top Flight Kids Learning Center and the B.E.S.T. Choice, Inc. cannot assume responsibility for loss or damage to any personal possessions children bring to the center.

11. TUITION

I understand that tuition is due on the first day of attendance each week. A late fee of $10 will be automatically charged to any account not paid in full by Tuesday (or the second day of the week attended). In addition, I understand that if my account becomes delinquent by more than two weeks or is delinquent on a regular basis, my child will be disenrolled from the center. I also understand that I must give a two-week notice, in writing before leaving the center.

We have read the policy agreement, accept, and agree with the conditions as stated.

_____ _____

Parent/Legal Guardian Signatures Date

TOP FLIGHT KIDS LEARNING CENTER
300 S. ROGERS ROAD
OLATHE, KANSAS 66062

COMMUNITY FEDERAL
ENROLLMENT OPTION
Full-time
Part-time
Drop-in

CHILD'S ENROLLMENT FORM

START DATE:_____

Child's Name _____Nickname_____

Home Telephone _____ Sex _____ Birthdate_____

Child lives with: Both Parents Mother Father Other_____

IDENTIFYING INFORMATION

A.) Father's Name_____
Address_____
City _____ State_____Zipcode _____
Employer (or school attended) _____
Work Address _____
Work Hours _____ Work Phone _____
Email Address _____ Cell Phone _____

B.) Mother's Name_____
Address_____
City _____ State_____Zipcode _____
Employer (or school attended) _____
Work Address _____
Work Hours _____ Work Phone _____
Email Address _____ Cell Phone _____

_____
Physician's Name Phone Number

_____
Dentist's Name Phone Number

EMERGENCY CONTACTS (other than parent or doctor)

_____
Name Phone Relationship to Child

_____
Name Phone Relationship to Child

PERSON(S) AUTHORIZED TO TAKE CHILD FROM THE FACILITY

_____
Name Phone Relationship to Child

_____
Name Phone Relationship to Child

_____
Parent/Legal Guardian Signature

_____
Date

CCL. 029
Rev. 5/2019

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

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_____

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)_____

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:

_____

Does your child have any of the following conditions (yes or no)? <u>If yes, provide information on Authorization for Emergency Medical Care form CCL. 010</u>.

_____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_____

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

_____

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. 3/2017

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. 3/2017

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

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 #**

I hereby authorize _____ (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 _____ and _____.
MM/DD/YYYY MM/DD/YYYY

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 if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ by_____.
MM/DD/YYYY Name of Person

(Seal, if any.)

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

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

_____

_____

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: _____

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.