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March 1, 2024

Dear Rainbows Families,

Thank you for your interest in your child attending on-site Camp Woodchuck 2024! It will be an exciting summer! We have many fun activities planned for Camp and would like to provide you with information to assist in Camp preparation. Spots will fill up quickly and are assigned on a first come first serve basis.

All forms in the application must be completed and received in the Rainbows Kids' Cove office by April 12, 2024, in order to receive a June 3, 2024 start date. Partially completed packets will not be accepted and enrollment in Camp Woodchuck is not finalized until the entire packet is received in the Kids' Cove office. **Upon completion of the packet an appointment must be scheduled.** Please contact Tiffany Graf 316-239-7217 to schedule an appointment to review the packet. Please make sure to leave a voicemail.

A note about signatures: A doctor's signature on the **Medication Administration and CACFP Meal Modification forms** are required in order to provide appropriate care for your child. The **Authorization for Emergency Medical page must have a witness signature before you come to your appt.** All forms are required by KDHE to be on file.

A note about medications: A Rainbows' Nurse or CMA will provide medications between 10 am and 4 pm. Medications needed before 10 am or after 4 pm should be given at home, unless other arrangements are approved ahead of time. Per KDHE guideline, all medications must be sent in original container and submitted to the nurse.

If you have any questions or concerns, please contact Tiffany Graf 316-239-7217 or tgraf@rui.org.

We are excited for a fun summer!

Tiffany Graf

Tiffany Graf | Family Support Services Coordinator | tgraf@rui.org
Rainbows United, Inc. | 2258 N. Lakeway Circle | Wichita, KS 67205 | RainbowsUnited.org
Office: 316. 945.7117 ext. 201 | Fax: 316.945.7447

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FAMILY SUPPORT SERVICES
REQUEST FOR SERVICES

Legal Name of Child:_____ **Today's Date:**_____

Child ID # _____Date of Birth:_____Social Security Number: _____

Sex: M or F Ethnicity: Hispanic Y or N

Race: White Black or African American Asian American Indian or Alaskan Native
Native Hawaiian or Pacific Islander Two or more races Some other race

____ In-Home Support Services _____ Camp Woodchuck (Information sent out in March)

Name of School:_____Grade in School: _____

Child has: (Indicate all that apply)

____ Behavior Plan (If yes, indicate where it is from)_____

____ Takes medications to alter mood or behavior

____ Diagnosis (examples: Aspergers, PTSD, Bi-Polar, etc.) _____

Attach current photo of child.

I/DD Case Management Agency:_____Case Manager Name: _____

Case Manager Phone Number:_____Case Manager E-mail:_____

Medical Care (MCO) Agency: _____ MCO Name: _____

Medical Care (MCO) Phone Number: _____ MCO Email: _____

Parent/Guardian Information
Child lives with: Both Parents Father Mother Grandparents Foster Parents Uncle/Aunt

Parent/Guardian Name:_____	Parent/Guardian Name:_____
Address: _____	Address: _____
City, State, Zip:_____	City, State, Zip:_____
Home Phone: _____	Home Phone: _____
Cell Phone:_____	Cell Phone:_____
Work Name:_____	Work Name:_____
Work Phone: _____	Work Phone: _____
E-mail: _____	E-mail: _____
Relationship to Child: Father Mother Uncle Aunt	Relationship to Child: Father Mother Uncle Aunt
Foster Parent Grandparent Other: _____	Foster Parent Grandparent Other: _____
Education Level: 9-12th Graduated Some College	Education Level: 9-12th Graduated Some College
College Degree: AA BA/BS Grad School Masters PHD	College Degree: AA BA/BS Grad School Masters PHD

How did you hear about RUI: Family Friend Physician School SRS RUI Staff Other:_____

_____ Print Parent/Guardian Name

_____ Signed Parent/Guardian Name

_____ Date

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FAMILY SUPPORT SERVICES
2024 CAMP WOODCHUCK REQUEST FOR HOURS

Child's Name: _____ Date of Birth _____ Today's Date_____

Parent/Guardian Name: _____

Phone: Home _____Cell _____ Work _____

Schedule: Indicate times your child **will attend** Camp.
Camp Hours: 8:00 AM – 4:00 PM

Put an X through days your child **will not attend** Camp.

						Office Use Only	
Week	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Weekly Hours**	**Weekly Total ($)**
Ratio:	**JUNE**						
1	3	4	5	6	7		
2	10	11	12	13	14		
3	17	18	19	20	21		
4	24	25	26	27	28		
					June Total		
	JULY						
5	1	2	3	4 Agency Closed	5		
6	8	**9**	10	11	12		
7	15	16	17	18	19		
8	22	23	24	25	26		
9	29	30	31				
					July Total		
OFFICE USE ONLY							
Funding	June:			July:		Total:	

Summer Activities:
Indicate the name and dates of any additional summer school/programs your child will attend.
_____Name of Summer School/Program Location _____ Dates _____

Transportation: Indicate the times your child will arrive/depart from Camp Woodchuck using a transportation system.

	ARRIVING	**DEPARTING**
____ MTA (Metro Transit Authority) will transport my child.	_____	_____
____ School Bus will transport my child.	_____	_____

Child's shirt included with enrollment, to be provided in June. Please indicate T-Shirt size below:

Youth:_____Small_____Medium_____Large

Adult:_____Small ____Medium_____Large_____ X Large_____2X Large

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FAMILY SUPPORT SERVICES
STATEMENT OF RESPONSIBILITY AND APPOINTMENT OF AGENT

STATEMENT OF RESPONSIBILITY

On behalf of (child's name) _____, 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 Services staff.

In the event emergency medical treatment is deemed necessary, and I am not readily available, I authorize such procedures as are necessary to ensure 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 Services staff, 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.

_____	_____	_____
Print Parent/Guardian Name	Parent/Guardian Signature	Date

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 (child's name) _____

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

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.

_____	_____	_____
Print Parent/Guardian Name	Parent/Guardian Signature	Date

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FAMILY SUPPORT SERVICES
CLIENT RELEASE FORM

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

Child lives with: _____Father ____ Mother ____Other (specify) _____ _____

Indicate the order in which Family Support Staff should contact the parents/guardians and provide a primary and secondary contact number used for contacting in an emergency situation.

Primary Parent/Guardian Contact Name _____ Father or Mother

Primary phone number: _____

Secondary phone number: _____

Secondary Parent/Guardian Contact Name _____ Father or Mother

Primary phone number: _____

Secondary phone number: _____

In addition to parents/guardians, I authorize Rainbows United Inc., Family Support Services staff to release my child to the persons listed below to pick up my child from Rainbows United, Inc. center or in-home care. List a minimum of two adults (required) and the preferred order of contact.

Name	Address	Home/Mobile Phone Number	Work/other Phone Number	Relationship to child

Rainbows United, Inc., Family Support Services staff is authorized to place my child on or off a Unified School District transportation vehicle (school bus/van) or MTA bus, or other transportation service vehicles if applicable.

Name of Transportation Services	Contact Person	Approximate Time of Day (RUI arrival or departure)	Location (arrival or departure from)	Company Phone Number

I understand that I am responsible for the following:

1. Notifying Rainbows United, Inc. Family Support Services in writing if any person on this list no longer has my permission to pick up my child.
2. Advising all persons listed above about the need to provide picture identification and that the identification must be presented in order to pick up my child.

_____ Printed Parent/Guardian Name

_____ Parent/Guardian Signature

_____ Date

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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 of 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: _____

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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF HEALTH INFORMATION

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

Address: _____

AUTHORIZATION
I hereby authorize Rainbows United to:
____ Disclose health information to ___ Request health information from

To the following person or entity:

Name: _____

Address: _____

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

Phone: _____ **FAX:** _____

For treatment date(s): _____

For the following purpose(s):

_____ Evaluation _____ Case coordination _____ Treatment _____ Follow-up care

_____ Other (specify) _____

INFORMATION TO BE DISCLOSED (MARK ALL THAT APPLY): ___COMPLETE RECORD

_____ Summary report of services received

_____ Consultation and/or verbal communication between the above named parties

_____ Other (specify) _____

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 90 days after the date listed below.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives 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 that 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 Mental Health Department.

_____ _____
Date Signature of Individual/Individual's Representative

_____ _____
Printed Name of Representative and Relationship Representative Address and Telephone Number

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

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FAMILY SUPPORT SERVICES
INCOME INFORMATION AND VERIFICATION

Child's Name:_____ **Parent's Name** _____

Total number of members in household: _____ Number of Adults _____Number of Children_____

My child has medical insurance (*circle*): Yes or No Medical Card/Insurance Number:_____

My child receives SSI (*circle*): Yes or No

Include the total household income for all people living in the household who receive income. If you would like access to the sliding fee scale, please **complete the following chart** and provide **one month of pay stubs and/or source of income** documentation.

Household Member Name (First & Last)	Relationship to Parent/Guardian	Date of Birth	Gross Wage (pre- tax)	SRS TANF Benefits	SSI Or SSDI	Adoption Subsidy or Child Support	Other Amount (specify source)	Total Monthly Income
							Total Monthly Income	
							Annual Income (Monthly Income x 12) =	

Additional Information

- All care that is not covered by Family Support Funding or HCBS/IDD funding requires full payment before receiving care.
- 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.
- Sliding Fee Rate will not be adjusted according to the level of care a child needs.
- Rainbows does not provide care for typical sibling in either a family's home or Rainbows' Center.
- I will notify Rainbows when there is a change of income or change of number of members in the household.

The above information is true and a correct reflection of our household income. I understand 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.

_____ _____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian Date

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FAMILY SUPPORT SERVICES PAYMENT AGREEMENT

This Agreement is entered between Rainbows United, Inc. and (parent/guardian's name)_____,

the parent(s) and/or legal guardians(s) of (child's name)_____.

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., paycheck 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 initial the option that applies:

_____ My child receives **HCBS-I/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.

_____ My child has supplemental funding from: ☐ (agency)_____for _____

I understand that this funding will be billed at the rate of $18.80 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.

A $50 returned fee will be charged for any returned bank drafts/checks, in addition to any applicable late fees. Accounts with more than one returned check will be required to pay by money order or credit card.

I understand Rainbows United, Inc. may terminate services for the following reasons for non-compliance of statements:

_____ 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.

Please initial 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 Family Support Services Department. I have completed and enclosed the Private Pay Income Information and Sliding Fee Scale form and verification of my household income with this Agreement.**

Printed Parent/Guardian Name	Signature of Parent/Guardian	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 Family Support Services Department. I choose not to complete the Private Pay Income Information and Sliding Fee Scale form and/or enclose proof of total household income.** Therefore, I may not access the Sliding Fee Scale, and my **rate will be $18.80 per hour**.

Printed Parent/Guardian Name	Signature of Parent/Guardian	Date

CCL. 358
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas
Department of Health and Environment

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

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SEIZURE CARE PLAN

Child's Name:_____Date of Birth: _____

Physician: _____

Physician Phone Number: _____

Do we have your permission to call the above physician should questions arise regarding your child's health here at school? ❑ Yes ❑ No

How long has your child been diagnosed with a seizure disorder? _____

I would describe my child's seizures as:

❑ **Simple Partial** – Remains conscious, twitching or numb sensation, usually lasting less than 30 seconds.

❑ **Complex Partial** – Altered consciousness, transient staring, feelings of unreality and detachment. May have hallucinations, unexplained feelings of fear, disrupted memory, teeth grinding, lip smacking, chewing, swallowing, scratching or pulling at buttons. Usually lasts no longer than 1-2 minutes.

❑ **Tonic-Clonic** – Abrupt arrest of activity, loss of consciousness, symmetrical and rhythmical alterations of contraction and relaxation of major muscle groups. Ends suddenly in less than 5 minutes.

❑ **Atonic** – Abrupt loss of postural tone, loss of consciousness, confusion, lethargy and sleep. (May just fall asleep suddenly; when laughing, the child may fall down.)

❑ **Myoclonic** – Brief random contractions of a muscle group, may occur on one side of the body, no loss of consciousness.

❑ **Absence** – Very brief periods of altered awareness, eyelids may flutter or twitch, blank facial expression, lasts 5-10 seconds but can occur repeatedly.

❑ **Tonic** – Lack of movement, stiffening of the entire body musculature, arms flex, legs, neck and head extend. Peculiar, piercing cry, cyanosis (bluish coloring to skin), may temporarily stop breathing, increased salivation.

❑ **Akinetic** – No movement, but muscle tone is maintained. Like "freezing into position," may lose consciousness.

My child ❑ does ❑ does not have an aura before his/her seizures. (An aura is a sensation just before a seizure happens – may be a sound, sight, smell, feeling – they usually can tell if a seizure is about to happen.)
If so, what is the aura? _____

_____ _____
Parent/Guardian Signature Date

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TREATMENT PLAN FOR SEIZURES

Child's Name:_____Date of Birth: _____

Treatment:

- Assist the student to the floor, if needed.
- DO NOT put anything between teeth or in mouth.
- DO NOT restrain.
- Clear area to protect student from injury.
- Start a written record of the seizure behavior and treatment including length of seizure activity.
- Notify parents.
- CALL 911 IF: seizure activity is different from "usual seizure activity" documented below, child's breathing is affected, it lasts longer than five (5) minutes or child fails to regain consciousness after seizure activity has stopped.
- Child's usual seizure activity includes: _____

  _____

  _____
- Should the seizure activity last longer than_____, 911 should be called. (Please note: 911 will be called by school staff for any seizure activity lasting five (5) minutes.)

After seizure:

- Permit student to rest.
- Continue to document the episode.
- Monitor for second episode.
- Monitor for confusion or lack of consciousness.

If I cannot be reached by phone and my child does not respond to the above medication and treatment, I give my permission for school staff to call the physician listed on front side of care plan and follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

_____ _____

Parent/Guardian Signature Date

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 #**
Rainbows United, Inc. - Kids' Cove	**0030446-010**

I hereby authorize **Rainbows United, Inc. Staff** (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 **until termination from program**.
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 **NA**

Signed or attested before me on **NA** by **NA**.
MM/DD/YYYY Name of Person

(Seal, if any.)

NA
Signature of notarial officer

NA
Title (and Rank)

My appointment expires: **NA**

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.

CACFP Meal Modification Form

Important! Select the applicable meal modification category from the three listed below. Then carefully read and follow the procedures for that category. The center/home will return an incomplete Meal Modification Form to the parent/guardian. If you have questions about this form, the center/home will assist you.

1. **Modification due to a disability:**
   - A center/home is *required* to make meal modifications prescribed by a medical authority to accommodate a participant's disability. See the definition of disability on the back of this form.
   - Part B of this form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (ARNP) authorized by their responsible licensed physician.
   - Parts A and C of this form must also be completed before the center/home can make meal modifications.
   - The meal modifications will continue until the medical authority requests that the modifications be changed or stopped by completing Form 4-G with the change. The form is available from the center/home.
   - It is strongly recommended that the medical authority annually update the prescribed diet order.
2. **Modification due to a food allergy/intolerance, or other medical condition that does not rise to the level of a disability:**
   - A center/home has the *option* to make meal modifications prescribed by a medical authority due to a food allergy/intolerance or other medical condition that does not rise to the level of a disability.
   - Part B of this form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (ARNP) authorized by their responsible licensed physician.
   - Parts A and C of this form must also be completed before the center/home can make meal modifications.
   - If a center/home chooses to make the meal modifications, they will continue until a medical authority requests that the modifications be changed or stopped by completing Form 4-G. The form is available from the center/home.
   - It is strongly recommended that a medical authority annually update the prescribed diet order.
3. **Substitution for fluid cow's milk due to lactose intolerance, allergy, religious, ethical or cultural reasons:**
   - A center/home has the *option* to make a substitution for fluid cow's milk that is requested by a parent/guardian, but that is not prescribed by a medical authority.
   - Parts A and D of this form must be completed before the center/home can make a substitution for fluid cow's milk.
   - If a center/home chooses to provide such a substitution, they will continue until a parent/guardian requests that the substitution be changed or stopped by completing Form 4-G. The form is available from the center/home.

Part A. Participant, Parent/Guardian & Center/Home Information – To be completed by a parent/guardian or center/home contact person	
Participant's Name:	Date of Birth:
Parent/Guardian's Name:	Parent/Guardian's Phone:
Center/Home Name:	Center/Home's Phone:

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

Check ONE:

☐ Disability OR

☐ Food allergy/intolerance or other medical condition that does not rise to the level of a disability

2. Specify the disability, food allergy/intolerance, or medical condition related to the prescribed diet order.

3. If the participant has a disability, what major life activity is affected? Example: Allergy to peanuts affects ability to breathe.

4. Type of Special Diet:

☐ Check if not applicable OR specify the type of special diet (e.g. gluten-free, diabetic, etc.).

5. Modified Texture:	☐ Not Applicable	☐ Chopped	☐ Ground	☐ Pureed
6. Modified Thickness of Liquids:	☐ Not Applicable	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick

7. Special Feeding Equipment:

☐ Check if not applicable OR list special feeding equipment (e.g. large handled spoon, sippy cup, etc.).

8. Foods to be Omitted and Substituted:

☐ Check if not applicable OR list special foods to be omitted and substituted. If more space is needed, sign and attach additional sheet of paper.

IMPORTANT: For a participant who does <u>not</u> have a recognized disability, the only fluid cow's milk substitutions allowed by USDA are: (1) lactose-free fluid cow's milk or a (2) non-dairy beverage with a nutrient profile equivalent to fluid cow's milk as specified in federal regulations. Currently the only beverages meeting these specifications are certain brands of soymilk.

Omit Foods Listed Below:	Substitute Foods Listed Below:

9. Medical Authority's Information

Signature:	Title:	
Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for the center/home responsible for implementing my participant's prescribed diet order to discuss my participant's special dietary accommodations with any appropriate center/home staff and to follow the prescribed diet order for my participant's CACFP meals. I also give permission for my participant's medical authority to further clarify the prescribed diet order on this form if requested to do so by center/home.

Parent/Guardian's Signature: Date:

Part D. Request Substitution for Fluid Cow's Milk due to Lactose Intolerance, Allergy, Vegan Diet, Religious, Cultural or Ethical Reasons – To be completed by a parent/guardian

Instead of fluid cow's milk, please provide the participant named in Part A. of this form with the following substitute (Check ONE):

☐ Lactose-free cow's milk ☐ Non-dairy beverage with a nutrient profile equivalent to fluid cow's milk per federal regulations

Parent/Guardian's Signature: Date:

Definition of Disability:
Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a "person with a disability" means "any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment."

Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working and major bodily functions. The term "physical or mental impairment" includes, but is not limited to, such diseases, conditions, and functions as:

- Orthopedic, visual, speech and hearing impairments
- Cerebral Palsy, Epilepsy, Muscular Dystrophy and Multiple Sclerosis
- Digestive, bowel and bladder
- Neurological and brain
- Respiratory
- Cancer
- Cardiovascular, circulatory and heart
- Metabolic and endocrine
- Food anaphylaxis (severe food allergy)
- Intellectual Disability
- Emotional illness
- Drug addiction and alcoholism

Individuals who take mitigating measures to improve or control any of the conditions recognized as a disability are still considered to have a disability and require an accommodation.

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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: _____

When to Administer: As Needed Special Consideration: _____

Special Instructions to Administer Medication: _____

Medication: _____ Dosage: _____

Purpose_____

Requested Starting Date: _____ Expected Duration: _____

When to Administer: _____ Special Consideration: _____

Special Instructions to Administer Medication: _____

Medication: _____ Dosage: _____

Purpose_____

Requested Starting Date: _____ Expected Duration: _____

When 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 ofan 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: ______________________
When to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
When to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
When to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
When to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
When to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
When to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

Medication: ______________________ Dosage: ______________________
Purpose______________________
Requested Starting Date: ______________________ Expected Duration: ______________________
When to Administer: ______________________ Special Consideration: ______________________
Special Instructions to Administer Medication: ______________________

PHYSICIAN'S SIGNATURE:______________________Date: ______________________