RISING SUN
Learning Center

1170 W 103rd Street
Kansas City, MO 64114
(816) 997-9030 PH
(816) 997-9031 FAX
www.risingsunkc.com
enroll@risingsunkc.com
RSLC DVN: 002594170

Enrollment Packet

Where Messy Kids, are Learning Kids!

We are thrilled you have selected RSLC to care for your child(ren)! Here is your To Do List for finalizing your enrollment with us:

- [ ] Enrollment Form – Completely Filled Out
- [ ] Missouri Child Physical Form – Completed by child(ren)'s Pediatrician
- [ ] Immunization Records – Up to date or in process for Foster Children
- [ ] Authorization of Additional Pick Ups
- [ ] Photo Release Form
- [ ] Family Handbook Acknowledgement
- [ ] RSLC Auto Payment Form
- [ ] Parents As Teachers Permission to Screen
- [ ] Health & Wellness Questionnaire
- [ ] Income Eligibility Form (Required for ALL Families)
- [ ] Infant – Toddler Care Plan Form (children under 2 years of age only)
- [ ] Getting to Know You Questionnaire
- [ ] Family Spotlight Questionnaire
- [ ] Family Picture (3-4 Emailed to enroll@risingsunkc.com)
- [ ] Family Registration Fee: $75
- [ ] First Week's Tuition or Copay $_____

Enrollment Process:

We ask parents to allow at least 48 hour for a response on admission and one week for enrollment. Admission nor Enrollment will be provided without the **$75 Family Registration** being provided.

Questions about the Paperwork or Supplies?

Please reach out to our Enrollment Team via email at **enroll@risingsunkc.com**

Student Supplies by Classroom:

Parents are responsible for providing
ONE container of Wipes & **ONE** box of Kleenex

Infant & Toddler Students

Newborns & Infants

- [ ] Diapers
- [ ] Wipes
- [ ] Barrier Cream
- [ ] Bottles
- [ ] Formula / Breast Milk
- [ ] Two complete changes of clothes
- [ ] Wearable Blanket **OR** Swaddler for nap

Toddlers & Walkers

- [ ] Diapers
- [ ] Wipes
- [ ] Barrier Cream
- [ ] Bottles
- [ ] Formula / Breast Milk
- [ ] Two complete changes of clothes
- [ ] Wearable Blanket **OR** Swaddler for nap

Preschool Students

Two Year Old's

- [ ] Diapers
- [ ] Barrier Cream
- [ ] Two complete changes of clothes
- [ ] Sunscreen

For Potty Training:

- [ ] Pull Ups with Velcro Sides, Plastic Underwear, & Big Kid Underwear (All Items Required)

Three's, Four's, & Five's:

- [ ] Sunscreen
- [ ] Two complete changes of clothes

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
Rising Sun Learning 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

Rising Sun Learning 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

RISING SUN
Learning Center

Additional Approved Pick Up List

Child(ren): _____

Name: _____ Phone: _____

Relationship to the Child: _____

City & State: _____

Name: _____ Phone: _____

Relationship to the Child: _____

City & State: _____

Name: _____ Phone: _____

Relationship to the Child: _____

City & State: _____

Name: _____ Phone: _____

Relationship to the Child: _____

City & State: _____

I _____ authorize the above people to pick up my child(ren). I will let Rising Sun Learning Center know with as much notice as possible if someone other myself or another parent will be picking up my child(ren).

_____ _____

Parent Signature: Date:

Child Photo Release

As the parent/guardian of _____, I agree to the following:

- I understand that my child(ren), whose name(s) are listed above, may be photographed at Rising Sun Learning Center during normal daycare hours, field trips, or activities.
- I understand that these photographs may be used in school newsletters or on the Rising Sun Learning
- I give permission for my child(ren)'s photographs to be displayed on Rising Sun Learning Center's website, social media pages, or newsletters. (When names are added, only first names will be used.)
- This permission is indefinite and does not expire unless it is rescinded in writing

☐ Yes, I confirm that I have read and understood the above and agree to have my child(ren)'s photos displayed on the Rising Sun Learning Center website, social media pages, or newsletters.

☐ No, I do not wish to have my child(ren)'s photographs published online but may be posted within the building

☐ My child is currently in state custody and therefore their image cannot be published anywhere public but may be displayed within the center

Parent Name (please print): _____

Parent Signature: _____ Date:_____

Family Handbook Acknowledgement

As the parent/guardian of _____, I agree that our family has received and read Rising Sun Learning Center Policies Parent Handbook.

I understand the policies and procedures given to me and agree to adhere to all school policies. I also acknowledge that the Rising Sun Learning Center Policies & Procedures are subject to change to reflect the needs of the program, children, and families we serve.

Rising Sun Learning Center may also make changes or modifications in our policies if required by our licensing agencies. Rising Sun Learning Center will inform parents of changes taking place whenever possible in a timely fashion.

Parent Name (please print): _____

Parent Signature: _____ Date:_____

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CREDIT CARD AUTO-PAYMENT FORM

RSLC Tuition & Fees Information & Acknowledgement:

Tuition Source: ☐ Private Pay ☐ State Child Care Assistance ☐ Foster Care ☐ Adoption Subsidy

_____ Initials

I acknowledge that Rising Sun Learning Center (RSLC) has my permission to process my Credit &/or Debit Card listed below to be processed for my child's

- ☐ Family Registration Fee
- ☐ Child Care Deposit
- ☐ Additional Administrative Fees

(*Parent(s) will be notified in advance by RSLC Leadership*)

_____ Initials

I acknowledge that Rising Sun Learning Center (RSLC) has my permission to process my Credit &/or Debit Card listed below to be processed for my child's Tuition as a:

- ☐ Weekly Tuition Payment
- ☐ Bi-Weekly Tuition Payment

_____ Initials

I understand that it is my responsibility to update RSLC of any changes that would impact my ability to pay or for this Credit &/or Debit Card to be charged. I also understand that my credit card information will be on file with RSLC, stored in a locked and secure place known only to RSLC Management.

Credit Card Information:

_____ - _____ - _____ - _____ Credit Card Number

____/____ Exp Date

_____ Security Code

_____ Billing Zip Code

_____ Billing Address

_____ City

_____ State

_____ Phone Number

_____ Preferred Email Address

_____ Secondary Email Address

_____ Signature

_____ Printed Name

_____ Date

For Office Use Only:	☐ Registration Fee ☐ First Week Deposit ☐ Tuition Schedule ☐ Administrative Fees	$_____ on ____/____/_____ ☐ CC ☐ Cash ☐ Chk#_____ Processed by: _____ (Print Name) _____ (Date)

Center School District Parents as Teachers

Permission to Screen

The Center School District's Parents as Teachers Program has my permission to screen my child:

Child's name: _____

Date of birth: _____

(If child was premature, # of weeks premature) _____

_____ Date_____
Parent's/guardian's signature

**I understand that all screening results are confidential and may not be released to any parties outside the school district without my express written consent.

For office use only:

Date of screening: _____ Hearing: P / F

	Concerns	
Communication: _____	_____	Vision: P / F
Gross motor: _____	_____	Gender: M / F
Fine motor: _____	_____	Race: _____
Problem solving: _____	_____	Entered VT_____
Personal-social: _____	_____	

Parents As Teachers Health Questionnaire

Child's Name_____ Birth Date_____ Sex_____

Parent/Guardian_____ Phone No._____

Address_____Date_____

Health History

Did your child weigh less than 5 lbs. at birth? ☐Y / N☐
Has your child had any illness with high fever? (104º for longer than 2 days) ☐Y / N☐
Has your child been hospitalized since birth for any reason? ☐Y / N☐
If yes, please state reason: _____
Does your child take medication regularly? ☐Y / N☐
If yes, please state reason: _____
Does your child have regular medical check-ups? ☐Y / N☐

Nutrition and Health

According to your healthcare provider, are your child's length/height and weight, OK? ☐Y / N☐
Describe any concern you have about your child's eating:
_____
Has your child been screened for lead levels? Results_____ ☐Y / N☐
Has your child been screened for anemia? Results_____ ☐Y / N☐

General Development

Was there ever any reason for concern about your child's general growth or development? ☐Y / N☐
If yes, why? _____
Do you have any concerns about your child's behavior? ☐Y / N☐
If yes, describe behaviors_____

Immunizations

Are your child's immunizations up to date? Y / N
If no, what are needed? _____

Dental Screening

Does anything appear abnormal (swelling, redness, apparent decay) on your child's teeth and/or gums? ☐Y / N☐
If yes, describe_____
Does your child take a bottle to bed, which contains anything other than water? ☐Y / N☐
Do you regularly brush or clean your infant / child's teeth? ☐Y / N☐
Has your child been seen by a dentist? ☐Y / N☐

Car Safety

Child **under** 2.: Does your child ride in a rear-facing child safety seat in the back seat? ☐Y / N☐
Child over 2.: Does your child ride in a forward-facing child safety seat in the back seat? ☐Y / N☐

Vision (12-36 months)

Has your child ever had a vision examination or treatment? Y / N Results: _____

1. Has frequent sties ☐Y / N☐
2. Stares at bright lights frequently or repeatedly flicks objects in front of face ☐Y / N☐
3. Places an object close to their eyes to look at it ☐Y / N☐
4. jhThere is a family history of lazy eye or vision problems ☐Y / N☐

Hearing

Family history of childhood deafness or hearing impairment? ☐ Y / N ☐
Has your child had ear infections? ☐ Y / N ☐ If so, how many _____
Has your child ever had a hearing examination or treatment? ☐ Y / N ☐
When _____ Results_____

*Children **under 1** year:*

1. Turns their head toward an interesting sound or when their name is called ☐ Y / N ☐
2. Coos to themselves and makes a noise when they are alone ☐ Y / N ☐
3. Uses their voice to get attention ☐ Y / N ☐
4. Tries to imitate you if you make their sounds ☐ Y / N ☐
5. Seems to have difficulty hearing ☐ Y / N ☐
6. There is a history of hearing problems in the family ☐ Y / N ☐

*Children **over 1** year:*

7. Seems to favor one ear over the other ☐ Y / N ☐
8. Jumps or appears to be more startled than others if there is a sudden noise ☐ Y / N ☐
9. Seems to hear you if you talk in a whisper ☐ Y / N ☐
10. Seems to speak as well as other children the same age ☐ Y / N ☐

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

RISING SUN
Learning Center

GETTING TO KNOW YOU!

Where Messy Kids, are Learning Kids

Child's Name: _____ Nickname(s): _____

How many children are in your home? _____ (_____ Brothers & _____ Sisters)

What are their Names & Ages? _____

How many pets are in your home? _____ (_____ Dogs, _____ Cats, _____ Other: _____)

What are their Names & Ages? _____

What is your child's favorite color(s)?

What is your child's favorite toy(s)?

What is your child's favorite books(s)?

Describe your child's personality:

_____

_____

My child is great at: _____

_____

My child needs extra help with: _____

_____

Something I love about my child is:

_____

_____

Has your child been in a Child Care setting before? ☐ Yes or ☐ No

Please describe your child's prior experience:

_____

_____

Does your child have a regular bedtime routine? ☐ Yes or ☐ No

Please describe your child's sleep habits and any concerns you have:

_____

_____

How are your child's eating habits? ☐ Good or ☐ No

What is your child's favorite food(s)? _____

Please describe your child's eating habits and any concerns you have:

_____

_____

Does your child have any known health concerns? ☐ Yes or ☐ No

Allergies? ☐ No or ☐ Yes: _____

Please describe your child's health concerns or any concerns you have:

_____

_____

How do you "reward" or "discipline" your child?

_____

_____

Does your child have any known behavioral concerns? ☐ Yes or ☐ No

Please describe your child's behavioral concerns and any concerns you have:

_____

_____

Does your child have any known developmental concerns? ☐ Yes or ☐ No

Please describe your child's developmental concerns and any concerns you have:

_____

_____

What are your expectations for your child while at RSLC?

_____

_____

_____

_____

Please return to RSLC Leadership by dropping off at the front desk or via email: enroll@risingsunkc.com

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FAMILY SPOTLIGHT QUESTIONNAIRE

Please provide as much information as you can regarding the questions below. We will provide you with a preview of the spotlight write up before it is published to ensure an accurate representation of your family.

1. What do you like to do as a family?

2. What do you like about RSLC? How long have you been with RSLC?

3. What room/rooms is/are your child/children in?

4. Does your family have any pets? (what kind of pets and their names)

5. Are you originally from the Kansas City area?

6. What's your family's favorite travel location/story?

7. What are you excited about for 2022?

8. Best thing that that happened in 2021?

9. Favorite family holiday?

10. Any advice for new RSLC families?

Thank you so much for taking the time to complete this questionnaire and for being part of the RSLC Family!