EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME	BIRTH DATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

A Child's Future Early Learning Center

Tuition Agreement

Child's Name _____

Fee Amount: _____ per week Payment Due: Friday the week before care

Services to be provided as part of the tuition: (ie: full time or part time children)

_____

_____

Child's Arrival Time: _____ Child's Departure Time: _____

**Late fee: $1.00 per minute per child after 6:00pm

***$25.00 late fee will be assessed on Tuesday if tuition is not paid by the close of business on Monday, and an additional $10.00 will be assessed on Wednesday if tuition and late fees are not paid by the close of business on Tuesday.

Person(s) designated by parent to whom child may be released:

_____

_____

I, the parent/guardian: (Please initial)

_____ received/accessed complete program information including A Child's Future's Parent Handbook at the time of enrollment.

_____ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at minimum.

_____agree to pay any legal fees incurred by A Child's Future if an attorney or collection agency is required to collect any unpaid tuition.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature- Operator Date

Date of Child's Admission:_____ Date of Withdraw:_____

Periodic Review

_____ _____
Signature of Parent or Guardian Date

FOR OFFICE USE ONLY:
Additional services and/or benefits if applicable_____

A Child's Future Early Learning Center

Getting to Know You Meeting

Child's Name (s): _____

Names of Meeting Attendees: _____

Meeting Date:_____ Enrollment Date:_____

FAMILY INFORMATION

Tell me about the people in your household? _____

_____

Does your child have any parents that do not live in the home? _____

_____

If yes does your child visit this parent? _____

Are there any custody issues that we should know? _____

Does your child have any siblings? _____

CHILD INFORMATION

What type of pregnancy did you experience? Full Term _____ Premature _____

If premature, how many weeks? _____

Were developmental milestones met? _____ If yes, are they receiving any early intervention services, such as PT or OT? _____

_____

If no, would you be interested in receiving information regarding these services? _____

Has your child been in care before? _____

If yes, would you share information with us? (Where? When? For How Long?) _____

_____

What kind of care (family home care, relative/neighbor care, group, center)? _____

_____

Is there a reason for leaving that program? _____

Are there any special problems or concerns that we should be aware of? _____

_____

Does your child have any imaginary friends? _____

Any special needs (medical, developmental, social, mental health)? _____

_____

Does your child have an IEP (Individual Service Plan) or IFSP (Individual Family Service Plan)? __

_____

If so, we would like a copy of the plan so that we can provide the best possible learning experience for your child. What program or individuals work with your child in regards to these special needs? _____

Does your child have any allergies? _____

Food Allergies: _____

Environmental Allergies: _____

Medicine Allergies: _____

How are your child's allergies treated? _____

Do you have a Care Action Plan regarding these allergies for an emergency situation? _____

_____

Any other medical or special needs? _____

Describe your child's schedule:

Normal bedtime, waking time, nap time and duration: _____

_____

Does your child have a different schedule at any other child care setting (babysitter, relative/neighbor, school)? _____

If your child toilet trained? _____

Is there information that will help us make the transition to our program easier for your child? _

_____

Is there any other information you would like to share that was not addressed? _____

_____

PARENT INFORMATION

What are your expectations of our program? _____

_____

Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know? Would you and/or your family like to be a resource for any cultural awareness activities? _____

_____

Are you willing to be a volunteer in our classroom? _____

Are there other ways you would like to be involved? _____

_____

What times are best for us to reach you and for you to come in for parent conferences? _____

_____

Tell me about your child's:

Favorite Toys: _____

Other: _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Director Signature Date

A Child's Future Early Learning Center

Individual Education Plans (IEP) & Individual Family Service Plans (IFSP)
Information Sheet

Parent/ Guardian Sign Off Sheet

Because of the diverse set of needs of the children it is important to gather as much information as possible about each child. If your child has an IEP or IFSP in place, we all benefit from sharing this information so that we may care for your child in the best possible way.

Child's Name: _____

Your child's growth and development is measured with the developmental assessments. If your child currently has an IEP or an IFSP, it would be beneficial to share a copy of this plan with us so that we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

_____ I am providing a copy of my child's IEP or IFSP.

_____My child does not have/I am not providing an IEP or IFSP.

_____ _____
Parent/Guardian Signature Date

A Child's Future Early Learning Center

Handbook Signature Page

I/We, _____ the parents of _____, have received, read, had the opportunity to ask questions about, understand and agree to abide by the policies set forth in A Child's Future Early Learning Centers parent handbook.

Furthermore, I/We agree to abide by the policies set forth in the manual. I/We understand that the policies described I the Parent Handbook are not conditions of enrollment, and the language does not create a contract between A Child's Future and the parents. A Child's Future Early Learning Center reserves the right to alter, amend, or otherwise modify these guidelines, in its sole discretion, without prior notice.

I/We also understand that future questions regarding policies in the parent handbook may be directed to the Center Director or CEO.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

A Child's Future Early Leaning Center

Video/Photo Release

I hereby give permission for images of my child captured at A Child's Future through video, photo or digital camera to be used in the following manor/s and waive any rights to compensation or ownership thereto.

Child's Name: _____

Please initial all that apply:

_____promotional material and publications or which includes website, social media, and advertisement.

_____bulletin boards, portfolios, and classroom projects on A Child's Future's premises.

_____ _____

Parent/Guardian Signature Date

A Child's Future Early Learning Center

Diaper Cream Permission Slip

Dear Parents,

If you would like for us to apply any diaper cream or ointment on your child, please bring your choice of ointment or cream labeled with your child's name. Sign and date the permission slip below and we will be happy to apply cream on your child whenever needed. You will only need to fill this form out once as long as the cream needed is over the counter and not prescribed by a doctor. If you have any questions or concerns regarding this please do not hesitate to ask.

Thank you,
A Child's Future Early Learning Center, LLC.

Amy Ocasio
CEO

I _____ give permission for the staff at A Child's
PARENT SIGNATURE

Future to apply cream/ointment that I have provided for _____
CHILD'S NAME

as needed or directed by me. _____
DATE