Piece of Our Puzzle – Parent Quick Start & Forms

This document is a quick reference and required forms packet to help your first days run smoothly.
For full policies and details, please refer to your Parent Handbook.

IMPORTANT – PLEASE REVIEW

To ensure a smooth experience, please follow:

- Program begins at 9:00 AM
- Latest drop-off is 9:30 AM (no exceptions)
- Remain in your car during drop-off and pick-up
- Use HiMama daily for communication

DROP-OFF & PICK-UP (QUICK GUIDE)

Drop-Off

- Complete health screening in HiMama
- Mark your child present
- Pull up to designated area
- Remain in your car

Pick-Up

- Mark pick-up in HiMama
- Remain in your car
- Staff will bring your child to you

Reminders

- Do not block driveways (residential area)
- Drive slowly and carefully
- Do not walk children into the building unless instructed

- Message staff in HiMama if assistance is needed

HIMAMA APP (REQUIRED)

We use HiMama for:

- Daily updates
- Photos
- Communication

Parent Responsibility:

- Download the app
- Accept your email invitation
- Check daily for updates

PROGRAM REQUIREMENTS (SUMMARY)

This is a brief overview. Full details are outlined in your handbook.

- Child must meet enrollment requirements (diagnosis or pending evaluation)
- Medical assistance must be active or in process
- Attendance expectations must be followed
- Ongoing lateness may impact services

REQUIRED FORMS

Media & Communication Consent

I give permission for Piece of Our Puzzle to:

- Photograph or video my child for use within the HiMama app
- Share classroom updates, photos, and activities

I understand:

- Other children may appear in shared content

- I will not share images of other children outside the app

☐ I give permission for photos/videos to be used on social media

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Acknowledgment of Procedures

I acknowledge that I have reviewed and understand:

- Drop-off and pick-up procedures
- Daily arrival expectations
- Use of HiMama for communication
- General program expectations

I understand that full policies are outlined in the Parent Handbook.

Parent/Guardian Information

Child's Name: _____

Parent/Guardian Name: _____

Email: _____

Signature: _____

Date: _____

Piece of Our Puzzle's

DAILY ROUTINE

8-9:30am	Arrival	
9:30am	Circle Time	
9:45am - 10:30am	Outside Time (rooms may go out separately)	
10:30-11am	Transition and Snack	
11am - 11:30am	Storytime and Literacy	
11:30am - 12:15pm	Academics and Outside Time	
12:15pm - 1:30pm	Lunch and Quiet Time	
1:30pm - 2:30pm	Art, Sensory Play and Centers	
2:30pm - 3pm	Snack and Pick Up	

ABOUT ME

MY NAME IS

GOALS FOR THIS SCHOOL YEAR

WHAT ELSE WOULD YOU LIKE US TO KNOW

I LIKE

I DON'T LIKE

MY FAVORITE :

FOOD

DRINK

COLOR

ANIMALS

DESCRIBE ME IN 3 WORDS

Piece of Our Puzzle's

SUPPLY LIST

Everything Must be Labeled

- bookbag
- folder
- 2 changes of seasonally appropriate clothes
- Tablet for nap time if your child does not nap
- diapers and wipes (if applicable)
- lunch box with enough food for 2 snacks and a lunch
- blanket and pillow

- 1 2-pocket folder
- 1 box of tissues
- 1 box of crayola markers
- 1 small box of 24 crayons
- Oversized shirt for messy activities (smock)
- 1 box of small ziplock sandwich bags
- 1 container of disinfecting wipes

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 | BIRTHDAY

ADDRESS

MOTHER'S NAME/LEGAL GUARDIAN | HOME TELEPHONE NUMBER

ADDRESS

BUSINESS NAME | BUSINESS TELEPHONE NUMBER

ADDRESS

FATHER'S NAME/LEGAL GUARDIAN | HOME 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 REACTION)

MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION | MEDICATION, SPECIAL SITUATION

ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD

HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS | POLICY NUMBER (REQUIRED)

PARENT'S 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 _____

WHITE COPY (Original) YELLOW COPY (Child Care Space) PINK COPY (Excursion) CY 867 5/07

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						

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

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

Immunization Exemption Form

Child's Name _____

I have been given information and the opportunity to discuss concerns with my child's healthcare provider and am aware that current research is available at www.cdc.gov/vaccines/pubs/vis/default.htm. I still decline the following nationally recommended immunizations.

Name of Vaccine	Initial if declined
Hepatitis B	
Diptheria, tetanus, acellular pertussis (DTap or Tdap)	
Diptheria, tetanus (DT or Td)	
Haemophilus influenza type b (Hib)	
Pneumococcal conjugate or polysaccharide	
Inactivated poliovirus (IPV)	
Measles-mumps-rubella (MMR)	
Varicella (chickenpox)	
Meningococcal conjugate or polysaccharide	
Hepatitis A	
Rotavirus	
Human papillomavirus (HPV)	
Influenza (flu)	

I understand:

- The purpose and need for the vaccine(s)
- The risks and benefits of the vaccine(s)
- That unvaccinated individuals can be exposed to these preventable diseases when travelling abroad
- Consequences of not being vaccinated can include greater risk of some cancers, pneumonia, illness requiring hospitalization, death, brain damage, paralysis, meningitis, seizures and deafness and other severe and permanent effects.
- Un-vaccinated individuals can be responsible for spreading preventable disease and illness to vulnerable populations, including very young children and babies
- My child may be excluded from care in the event of exposure to preventable illness

_____ _____

Parent/Guardian Signature/Date Director Signature/Date

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD

FEE AMOUNT	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
$		

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $	PER MIN-HR	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

SIGNATURE-PARENT OR GUARDIAN DATE

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CY 321 - 12/99

Piece of Our Puzzle

1 Sugarmaple Ln
Levittown, PA 19055
(p) 484-569-0377
(f) 267-583-3340
erin@pieceofourpuzzle.com

Dear Parents and Guardians,

This letter is to assure you of our concern for the safety and welfare of children attending Piece of Our Puzzle. Our emergency plan provides for response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- Immediate evacuation: Students are evacuated to a safe area on the grounds of the facility in the event of a fire, etc. In case of inclement weather, we may then proceed indoors at a neighbor.
- In-place sheltering: Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the building is the best immediate response.
- Evacuation: Total evacuation of the facility may become necessary if there is a danger in the area. In this case, children will be taken to a relocation facility. Currently, we would relocate to Faith Reformed Church, located at 479 Stonybrook Drive in Levittown 19055. If it ever becomes necessary to relocate, a sign will be posted on the door stating which facility we've gone to.
- Modified Operation: May include cancellation/postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems (such as utility disruptions) that make it unsafe for children but may be necessary in a variety of situations.

We ask that you do not call during an emergency. This will keep the main telephone line free to make emergency calls and relay information. Use the Himama app to message us with your concerns. The form designating persons to pick up your child is included in the initial parent welcome packet. Please ensure that only those persons you list on the form attempt to pick up your child.

I realize that emergency circumstances may require changes to your plans, but I urge you to not attempt to make different arrangements if at all possible. This will only create additional confusion and divert staff from their assigned emergency duties. In order to assure the safety of your children and our staff, I ask your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures, contact erin@pieceofourpuzzle.com

Sincerely,

Erin Farrell, M.Ed, LBS

Owner and Director

Instructions for Completing the Care Plan for Children with Special Health Needs (CH-15)

This Care Plan template is designed to supplement the Universal Child Health Record (UCHR, CH-14). It should be used for children with special health needs (CSHN). The UCHR is designed to be concise and does not provide sufficient space for detailed instructions that a CSHN might need. Use this Care Plan when your instructions for the child's care cannot be fit on to the UCHR. This Care Plan should be utilized as a template that can be adapted as needed. Not all parts need to be completed for some children, but other children may require extra pages to be attached to fully explain the instructions for the child's care.

In order to facilitate communication between the health care provider and the parent, it may be best to complete this form with the parent/guardian present. Parents often have practical knowledge that is important to incorporate into the plan, such as techniques to get the child to cooperate with treatments and specifics about the child care site/school like the hours attended and the resources/limitations of the out-of-home care provider. There is room at the end for optional parent notes and signature that will give permission for communication between the health care provider and the child care provider or school nurse.

Specific Instructions:

1. Complete the Universal Child Health Record (UCHR, CH-14).
2. Attach a copy of immunization record.
3. As appropriate check off the box labeled "Special Care Plan Attached."
4. Complete the Care Plan for Children with Special Health Needs
   - Complete the demographic information.
   - The Primary Health Care Provider is the medical home where the child's complete health records are maintained.
   - Specialty providers and their contact information should be included if the specialists play a major role in the child's health care such as adjusting medication doses.
   - Diagnosis – Include major diagnoses (preferably using lay terminology as necessary).
   - Allergies – Include medication allergies and other significant environmental allergies.
   - Routine Care – Complete the medication information. Include important side effects that child care providers should be watching for both with medications administered at home as well as those given at child care.
   - Describe any Needed Accommodations to particular activities.
     - Describe special diets or feeding techniques which may be needed such as feeding pureed foods, maintaining upright positioning during feeds, following a restrictive diet, etc.
     - Classroom activities – List any modifications needed to allow the child to participate such as extra rest breaks, use of adaptive equipment, etc.
     - Outdoor Activities/Field Trips- List any special precautions needed for class trips such as emergency kits, mobile phones, special vehicles, etc.
   - Special Equipment/ Medical Supplies
     - List special equipment that may be needed such as nebulizers, peak flow meters, glucometers, braces, hearing aids, wheelchairs, apnea monitors, etc.
   - Emergency Care
     - Help the child care providers to understand which signs/symptoms merit calling the parents and which are more serious and indicate that EMS should be activated.
     - Describe interim measures that should be taken while waiting for parent or EMS arrival such as administering an asthma nebulizer treatment or an Epi-Pen.
   - Special Staff Training
     - Are there special trainings that staff should attend in order to care for the child such as medication administration training, first aid/CPR, etc.? Include who might be available to provide such training.

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

Child's Full Name	Today's Date Date of Birth
Parent's/Guardian's Name	Telephone No. ( )
Primary Health Care Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Diagnosis(es)	
Allergies	

ROUTINE CARE

Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects

List medications given at home:

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

Classroom Activities: _____

Naptime/Sleeping: _____

Toileting: _____

Outdoor or Field Trips: _____

Transportation: _____

Other: _____

Additional comments: _____

_____

_____

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

_____

_____

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

_____

_____

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

_____

_____

_____

SUGGESTED SPECIAL TRAINING FOR STAFF

_____

_____

_____

Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)

_____

_____

_____

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.

Parent/Guardian Signature	Date

Important: *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*