2020-2021After School CARES Program

APPLICATION & PICK-UP RELEASE FORM

Student Information:

Child's Name _____Grade_____

Address _____ Home Phone _____

Daily Pick-Up Time (circle one): by 4:00 p.m. by 5:00 p.m. by 6:00 p.m.

Indicate which days your child will attend CARES: ___M, ___T, ___W, ___Th, ___F

With whom does the child reside: Both Parents Mother Father Other _____

Parental Information: Married Separated Divorced Remarried

If divorced, please indicated who has legal (court decreed) custody of the student:

_____

Does this student have a sibling(s) attending CARES this year? ____ YES ____ NO

If yes, please list names and grades _____

_____

Parent/Guardian Information:

_____

(Mother's Name or legal guardian) (Cell phone) (Work #)

_____

(Father's Name) (Cell phone) (Work #)

Emergency Contact:

_____

(Name) (Cell Phone)

_____

(Name) (Cell Phone)

Student Name:_____

Pick-up Release Information:

In addition to the parents listed above, the following people also have my permission to pick up my child from the CARES Program.

_____

(Name) (Cell Phone)

_____

(Name) (Cell Phone)

Medical Information:

The staff at the CARES Program has access to all of the medical forms used by your child while in the school. However, please alert the CARES Staff to any additional information you feel is important. The distribution of medicine at the CARES Program follows the same policy as Our Lady of Port Richmond School.

Known Allergies/Additional Information:_____

_____

Payments and Billing:

Due to the staffing needs of our After CARES program, it is necessary for us to bill for After CARES services monthly through TADS, and students will be billed for all After CARES days each month regardless of their attendance. By signing below, you agree to make your payments for After CARES services by the due date each month through TADS. If your payments are not received on time, your student will be asked to not participate in the After CARES program until your After CARES account is paid current. Late payments are subject to a $35 late fee. A $35 NSF fee also applies for any returned checks. In addition, pick-up times are strictly adhered to – a late pick-up fee of $10.00 per child will be charged for every interval of 15 minutes (or portion thereof) beyond your scheduled pick-up time. By signing below, you acknowledge that you understand and agree to the terms and information above.

Parent/Guardian Signature:_____ Date:_____

_____Enclosed is my $30 registration fee.
Make checks payable to Our Lady of Port Richmond.

We are proud to be an equal opportunity child care provider.

OFFICE USE ONLY Paid by:_____ Check #:_____

Received by:_____ Spoken with:_____

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 | BIRTHDATE

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 CONDITIONS

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 _____

03891A

ORIGINAL

CY 867 - 1/93

CHILD HEALTH REPORT

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

Parent/Provider fill s 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 may v mmunization 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:

OUR LADY OF PORT RICHMOND SCHOOL

3233 E. THOMPSON STREET

PHILADELPHIA, PA. 19134

CONSENT FOR WALKING EXCURSIONS

I _____give Our Lady of Port Richmond faculty/staff my permission for my child_____ to participate in unannounced walking excursions in the neighborhood .

Signed:_____ Dated:_____

OUR LADY OF PORT RICHMOND SCHOOL
3233 E. THOMPSON STREET
PHILADELPHIA, PA. 19134

CONSENT FOR MINOR FIRST AID OR EMERGENCY MEDICAL CARE

I _____ give Our Lady of Port Richmond faculty/staff my permission to give minor first aid or emergency medical care to my child _____.

_____ _____

Emergency contact name & phone number Date

MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133

PLEASE PRINT

Page _____ of _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____ (Date) To _____ (Date)

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

_____

_____

I give permission to administer medication to my child as stated above.

_____ Parent Signature _____ Date

FACILITY STAFF COMPLETE THIS SECTION				
Date Administered (mm/dd/yyyy)	**Time Administered (a.m. / p.m.)**	**Amount of Medication Administered**	**Comments/Reactions**	**Staff Initials**

This information is confidential and may not be shared or released without the parent's written permission.