| Child Care Registration Form | | | Date child entered care | Date child left care |
|---|---|---|---|---|
| Child's name Last | First | Middle | Name (Nickname) used | Birthdate |
| Street address | | City | | Zip code |
| Child's parent/guardian name | home phone # ( ) - | | cell phone# ( ) - | alternative phone # ( ) - |
| Street address | | City | | Zip code |
| Address where you can be reached while child is in care | | City | | Zip code |
| Child's parent/guardian name | home phone # ( ) - | | cell phone# ( ) - | alternative phone # ( ) - |
| Street address | | City | | Zip code |
| Address where you can be reached while child is in care | | City | | Zip code |

Other than you, who else has permission to pick up your child?

| Name | Address | Telephone number |
|---|---|---|
| Name:<br>Relationship: | | Home: ( ) -<br>Cell: ( ) -<br>Alternative: ( ) - |
| Name:<br>Relationship: | | Home: ( ) -<br>Cell: ( ) -<br>Alternative: ( ) - |
| Name:<br>Relationship: | | Home: ( ) -<br>Cell: ( ) -<br>Alternative: ( ) - |
| Name:<br>Relationship: | | Home: ( ) -<br>Cell: ( ) -<br>Alternative: ( ) - |

In case of an emergency, I give permission for any of the following individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: _____

| Name | Address | Telephone number |
|---|---|---|
| Name:<br>Relationship: | | Home: ( ) -<br>Cell: ( ) -<br>Alternative: ( ) - |
| Name:<br>Relationship: | | Home: ( ) -<br>Cell: ( ) -<br>Alternative: ( ) - |
| Name:<br>Relationship: | | Home: ( ) -<br>Cell: ( ) -<br>Alternative: ( ) - |

| Who does not have permission to pick up your child? If applicable (A copy of supporting court document must be on file) | |
|---|---|
| Name | Reason |
| | |
| | |

| Child's health information | | |
|---|---|---|
| Date of child's last physical exam: | Child's health care provider | Telephone number<br>( ) - |
| Street address | City | Zip code |
| Special health problems?<br>Yes or no? If yes, specify. | Allergies, including drug reactions<br>Yes or no? If yes, specify. | |
| Regular medications?<br>Yes or no? If yes, specify. | Other important information<br>Yes or no? If yes, specify. | |
| Child's dentist's name | | Telephone number<br>( ) - |
| Street address | City | Zip code |

| Child's medical insurance coverage | |
|---|---|
| Insurance company name | Member/policy number |
| Policy holder name | Employer name |
| Insurance company name | Member/policy number |
| Policy holder name | Employer name |

**Consent to medical care and treatment of minor children**

I give permission that my child,_____, may be given first aid/emergency treatment by a the child care licensee and/or qualified staff at:

Name of Licensee_____,

Address of Licensee_____.

| Parent/guardian signature | Date | Parent/guardian signature | Date |
|---|---|---|---|
| | | | |

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

| Parent/guardian signature | Date | Parent/guardian signature | Date |
|---|---|---|---|
| | | | |

# 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

# AGREEMENT

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

| NAME OF CHILD | | |
|---|---|---|
| FEE AMOUNT<br>$ | PER-DAY-WEEK | DAY PAYMENT TO BE MADE |
| Services to be provided as part of the day care fee (example; transportation, care, meals, etc.) | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| CHILD'S ARRIVAL TIME | CHILD'S DEPARTURE TIME | PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASE |
| LATE FEE<br>$ | 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/parent consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

| DATE OF CHILD'S ADMISSION | PERIODIC REVIEW |
|---|---|
| DATE OF WITHDRAWAL | SIGNATURE-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.