Art of Play
A Child Inspired Preschool

Drop In Preschool Registration From

Child's Name: _____Child's Age/ Birthday: _____

Child's Address: _____

Parent or Guardian's Name: _____

Who will be responsible for picking up your child: _____

Best Cell Phone Number: _____Can you receive texts: yes or no (circle)

Best Email Address: _____(print clearly)

Emergency Contact: _____

Emergency Contact Phone Number: _____

Can the emergency contact pick up your child should you be unreachable: _____

Can your child have snacks? Yes or No (circle) **Parents Provide Packed Meals**

Does your child have any allergies? _____

_____

_____

I understand that by signing this form that the Art of Play is not a nut (or any other food) free facility and I understand the risks associated with sending my child if they have a nut or other food allergy. The Art of Play is also a dog friendly facility which might pose an allergy risk to some children.

Does your child have any medical or developmental needs that we should know about?

_____

_____

_____

The Art of Play Early runs from 8am- 2:30pm. Parents may drop off no earlier than 8:00am and pick up no later than 2:30pm. Any late pickups will result in denial to future drop in care. If you need to reach us you can call or text 717-612-2349 or email theartofplay@comast.net.

The drop in fee is **$70 due prior to care to hold the day for your child** (via Venmo or PayPal), or their spot will go to the next family on our waitlist for the day.

Due to the limited number of spaces in the event of a parent needing to cancel or pick up early the drop in fee is not refundable.

In the event of a cancelation by the Art of Play the parent will be refunded within 24 hours via Venmo or PayPal.

Children are not allowed to attend if they have had any of the symptoms below 24 hours prior to their drop in day or if they have had any fever reducing medicine within 24 hours prior to their drop in day. Children will be sent home if they have symptoms of a communicable disease or infection that can be transmitted directly or indirectly and may threaten the health of children in care. This includes: mouth sores, rash with fever or behavioral change, discharge from the eyes, productive cough with fever, temperature equal to or greater than 100° F, unusual lethargy, irritability, persistent crying, difficulty breathing, vomiting, diarrhea, or other signs of illness

The parents are responsible to provide water bottles, diapers, sunscreen, bug spray, and extra clothes in case we get extra messy.

At The Art of Play we believe in play and know the importance of big body play. Children are allowed to explore their world by climbing, jumping, and running in a controlled and supervised environment. Bumps and bruises might occur but it's part of learning and playing. By signing this form, you understand the risks associated with play and understand your children will be allowed to freely play and explore as much as possible without the situation becoming dangerous. The trampoline is off limits to children attending the Art of Play.

I understand that my child might be in contact with a dog. All animals are up to date on vaccinations, in good health (physically and mentally), comfortable with children, and clean. Vaccination records are available upon request.

I understand that my child might get messy or wet. We will be exploring nature, doing crafts, and having fun! I will send my child in clothing that is ok to get messy.

I understand that pictures or videos of my child participating at the Art of Play might show up on the Art of Play's Facebook page so families can see what we did and to be used in future advertisements.

I understand that I will be asked to update this form at a minimum of every 6 month should my child still be participating in drop in preschool with the Art of Play.

I understand that to participate my child will need a health assessment completed by their physician within 30 days of their first drop in day to continue with future drop in days.

I _____ the parent and guardian of _____ agree to the terms of this Drop In Care registration form.

Signature _____ Date: _____

Signature (Kris LeBeau, owner) _____

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	DATE OF BIRTH
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

PARENT'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)

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

PERIODIC REVIEW

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.