

**REGISTRATION FORM
THE KID'S STOP**

School Age Care
Kindergarten Extended Day
Preschool – Toddler

PLEASE PRINT CLEARLY

Return completed forms along with non-refundable registration fee to:
THE KID'S STOP Main Office ~ Gauntlett Community Center
 Mailing Address: 20 Media Line Road, Newtown Square, PA 19073
REGISTRATION FEE
\$75 – 1st child / \$60 each additional child in same family
 Please make check payable to: *MN Leisure Services* and include child's name in the memo.

Name of Child	Sex	Age	Birth Date
Parent 1 / Guardian Name			Home Phone
Home Address			Cell Phone
Town / Zip		Email _____ @ _____	
Employer			Work Phone
Employer Address			Occupation
Parent 2 / Guardian Name			Home Phone
Home Address			Cell Phone
Town / Zip		Email _____ @ _____	
Employer			Work Phone
Employer Address			Occupation

I am the legal, custodial parent or guardian of this child and as such have full legal authority to sign contracts and indicate authorizations and permission with regard to child's participation in **THE KID'S STOP** Program.

Type or Print Parent / Guardian Name

Signature of Parent / Guardian

Name Child Goes By	Grade in September 2024	Junior KID'S STOP <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool
School Child Attends <input type="checkbox"/> Culbertson <input type="checkbox"/> Loomis <input type="checkbox"/> Russell <input type="checkbox"/> Worrall <input type="checkbox"/> Other:	Potty Trained Yes <input type="checkbox"/> No <input type="checkbox"/>	

Please list additional family members attending KID'S STOP or the MN School District

Name 1	Age	Relationship	Name 2	Age	Relationship
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KINDERGARTEN INFORMATION Times are approximate by school

My child attends Marple Newtown AM Kindergarten 9:00 am – 11:30 am
 My child attends Marple Newtown PM Kindergarten 12:30 pm – 3:00 pm

THE KID'S STOP (*Marple Newtown Joint Recreation Commission*) is an equal opportunity institution and will not discriminate on the basis of race, color, national origin, sex, handicap, or limited English proficiency in its programs, activities, or employment practices as required by Title VI, Title IX, and Section 504. For information regarding civil rights or grievance procedures, contact the Administrator of Child Care at 610-353-2326. For MN Joint Recreation Commission information regarding services, activities, and facilities that are accessible to and useable by handicapped persons, contact the Director of Recreation at 610-353-2326 or the Administrator of Child Care at 610-353-2326. Complaints of discrimination may be filed with the Pennsylvania DPW Bureau of Equal Opportunity; PA Human Relations Commission; U.S. Dept of Human Services Office for Civil Rights

I am aware that there are risks inherent in all recreational outlets and agree not to hold the *Marple Newtown Joint Recreation Commission, Marple Newtown School District*, or any of their agents or staff liable for personal injuries or property damage sustained by my child / myself in connection with such participation.

Parent / Guardian Signature _____ Date _____

EMERGENCY CONTACT and PARENTAL CONSENT FORM

CHILD'S NAME		BIRTHDATE	M	F
HOME ADDRESS				
MOTHER'S NAME / LEGAL GUARDIAN			HOME PHONE	
ADDRESS			CELL PHONE	
BUSINESS NAME			WORK PHONE	
BUSINESS ADDRESS		EMAIL _____ @ _____		
FATHER'S NAME / LEGAL GUARDIAN			HOME PHONE	
ADDRESS			CELL PHONE	
BUSINESS NAME			WORK PHONE	
BUSINESS ADDRESS		EMAIL _____ @ _____		
EMERGENCY CONTACT PERSON(S) (Other than parent)				
NAME		RELATIONSHIP	DAYTIME PHONE	
NAME		RELATIONSHIP	DAYTIME PHONE	
PERSON(S) TO WHOM CHILD MAY BE RELEASED (Other than parent) <i>If necessary, indicate additional names on reverse</i>				
NAME		Relationship to Child	DAYTIME PHONE	
ADDRESS				
NAME		Relationship to Child	DAYTIME PHONE	
ADDRESS				
<input type="checkbox"/> Check here if additional names are listed on back				

CHILD'S DOCTOR / MEDICAL PROVIDER		PHONE
ADDRESS		
SPECIAL DISABILITIES (IF ANY)		ALLERGIES INCLUDING ALLERGIC REACTION
MEDICAL OR DIETARY INFORMATION		MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HAS CHILD BEEN IDENTIFIED BY SCHOOL DISTRICT FOR SPECIAL PROGRAMMING? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If "YES", please submit a copy of child's IEP/504 Plan</i>		
HEALTH INSURANCE CARRIER FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)

A PARENT'S COMPLETE SIGNATURE IS REQUIRED FOR EACH ITEM BELOW	
EMERGENCY MEDICAL CARE	BASIC FIRST AID
SUPERVISED NEIGHBORHOOD WALKS	USE OF HAND SANITIZER
SCHOOL BUS TRANSPORTATION	

SIGNATURE of PARENT or GUARDIAN	DATE SUBMITTED
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Be sure to sign here!

PERIODIC REVIEW <i>Emergency Contact & Consent information must be reviewed every six (6) months.</i>	
Signature	Review Date

FEE AGREEMENT and ATTENDANCE SCHEDULE

Child's Name	Check session: <input type="checkbox"/> SCHOOL AGE <input type="checkbox"/> KINDERGARTEN <input type="checkbox"/> PRESCHOOL
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ATTENDANCE SCHEDULE

Please check the appropriate boxes. This information will be used to calculate tuition and is critical for scheduling purposes. Should your needs change, you must complete and get approval for an updated schedule/fee agreement.

ELEMENTARY GRADES
BEFORE and AFTER SCHOOL CARE
Before School Session: 7:30 am – 9:00 am
After School Session: 3:30 pm – 5:00 pm

Monday	<input type="checkbox"/> Before School	<input type="checkbox"/> After School
Tuesday	<input type="checkbox"/> Before School	<input type="checkbox"/> After School
Wednesday	<input type="checkbox"/> Before School	<input type="checkbox"/> After School
Thursday	<input type="checkbox"/> Before School	<input type="checkbox"/> After School
Friday	<input type="checkbox"/> Before School	<input type="checkbox"/> After School

TODDLER & PRESCHOOL
Full Time indicates more than 4 hours
Part Time indicates less than 4 hours

Monday	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
Tuesday	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
Wednesday	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
Thursday	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
Friday	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time

Toddler Room hours are 8:30am – 4:30pm

KINDERGARTEN
Check all boxes indicating when child is at KID'S STOP

Monday	<input type="checkbox"/> Before School	<input type="checkbox"/> 9am – 12 pm	<input type="checkbox"/> 12:30 pm – 3:30 pm	<input type="checkbox"/> After School
Tuesday	<input type="checkbox"/> Before School	<input type="checkbox"/> 9am – 12 pm	<input type="checkbox"/> 12:30 pm – 3:30 pm	<input type="checkbox"/> After School
Wednesday	<input type="checkbox"/> Before School	<input type="checkbox"/> 9am – 12 pm	<input type="checkbox"/> 12:30 pm – 3:30 pm	<input type="checkbox"/> After School
Thursday	<input type="checkbox"/> Before School	<input type="checkbox"/> 9am – 12 pm	<input type="checkbox"/> 12:30 pm – 3:30 pm	<input type="checkbox"/> After School
Friday	<input type="checkbox"/> Before School	<input type="checkbox"/> 9am – 12 pm	<input type="checkbox"/> 12:30 pm – 3:30 pm	<input type="checkbox"/> After School

FEE AGREEMENT and PAYMENT SCHEDULE

5% discount for 2nd and 3rd child shall be applied

Tuition Schedule: <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY	Weekly Fee \$	Monthly Fee \$
Child's Arrival Time:	Child's Departure Time	

I have read and fully understand the tuition rate sheet and have submitted a FEE AGREEMENT and ATTENDANCE SCHEDULE. At the time of signing, I have received and reviewed Program information and agree to update emergency contact and parental consent information whenever changes occur or every six (6) months. All conditions are clear to me and I understand that by signing this form I acknowledge my responsibility to abide by all policies & procedures concerning the payment of tuition and to follow the Attendance and Payment Schedule I have designated.

I further understand if I do not follow the conditions set forth action will be taken to terminate my eligibility for service.

Parent Signature	Date	Admission Date	Withdrawal Date
For KID'S STOP	Date	Updates when necessary	
Parent Signature _____		Date _____	
Parent Signature _____		Date _____	

KID'S STOP TUITION RATE SCHEDULE

Contracted rates remain constant regardless of attendance
There will be no credit for days your child does not attend

SCHOOL AGE PROGRAMMING

Before School Session 7:30 am – 9:00 am

# Days	Weekly Rate	Monthly Discount
5	\$61	\$224
4	\$51	\$188
3	\$41	\$152

After School Session 3:30 pm – 5:00 pm

# Days	Weekly Rate	Monthly Discount
5	\$67	\$248
4	\$57	\$212
3	\$47	\$176

Dual Session Discount

Before and After School Sessions

# Days	Weekly Rate	Monthly Discount
5	\$112	\$428
4	\$92	\$352
3	\$73	\$280

KINDERGARTEN

FULL TIME

This rate applies for students attending a wraparound session *plus* additional before or after school time

# Days	Weekly Rate	Monthly Discount
5	\$150	\$578
4	\$122	\$470
3	\$95	\$366

PART TIME

This rate applies for students attending either the morning or afternoon kindergarten wrap around session *only* 9 am – 12 pm or 12 pm – 3:30 pm

# Days	Weekly Rate	Monthly Discount
5	\$115	\$438
4	\$94	\$358
3	\$75	\$286

Kindergarten Mid-Day Transportation Fee

\$100 school year fee (non-refundable)

PRESCHOOL SESSION

FULL TIME

# Days	Weekly Rate	Monthly Discount
5	\$167	\$646
4	\$138	\$534
3	\$107	\$414

PART TIME

Morning classroom session *ONLY* 9 am – 12 pm

# Days	Weekly Rate	Monthly Discount
5	\$92	\$350
4	\$78	\$298
3	\$62	\$238

TODDLER

FULL TIME

# Days	Weekly Rate	Monthly Discount
5	\$230	\$890
4	\$200	\$782
3	\$150	\$586

***Must be fully potty trained to be in the Preschool rooms**

Subsidized Child Care Information

The State and Federal governments have made funding available to assist qualifying parents in meeting their child care expenses.

You may be eligible for *Financial Assistance*

For further information contact:

Early Learning Resource Center
20 South 69th St., Upper Darby, PA 19082
1-800-831-3117

Apply Online <https://www.compass.state.pa.us/Compass.Web/public/cmphome>

Kid's Stop

Parent Agreement - School Year Session

ALL TUITION FEES ARE NON-REFUNDABLE - KID'S STOP is 100% self-sustaining and as such relies on tuition fees to meet our financial obligations. Tuition fees are charged on the basis of enrollment schedule, not attendance.

There are no credits or discounts allowed for scheduled days that your child does not attend.

1. **School Year Registration Fees:** \$75 for 1st child - \$60 each additional child in same family. Registration fee is due at the time of registration and is non-refundable. Please make check payable to: MN Leisure Services and include your child's name in the memo.
2. **Contracted Monthly Tuition** is due by the 5th of each month and is paid to reserve an entire month of child care regardless of the actual number of days a child attends. There is no credit given for missed days. Monthly tuition not received by the 12th of the month will automatically be assessed a \$15 late payment fee.
3. **Contracted Weekly Tuition** is due the week before to reserve that week's child care, regardless of actual attendance.
4. **ELRC Subsidy:** all co-pays must be kept current. Failure to do so will result in adverse action by the ELRC.
5. **Returned Check Fee** - \$35.00. Following two returned checks, tuition payments will be by cash or money order only. No further personal checks will be accepted.
6. **Overtime Fee:** KID'S STOP closes promptly at 5:00 pm sharp. Parents who arrive after 5:00 pm will be charged \$5 cash fee for every 5 minutes or portion thereof that the child is left past the stated closing time. There is **NO GRACE PERIOD** for the final closing time and no exception will be made for payment of the overtime fee. Chronic late pick-up will result in termination of the child's registration due to the program's inability to meet your child care needs. ***Warning notices will be issued. After 3 notices, registration is terminated.**
7. Additional Fees are charged when child attends the program for unscheduled days/hours and on occasions when regular school is closed due to teacher in-service, holidays, early dismissals, etc.
8. Families with multiple children receive a 5% discount on tuition rates for 2nd and 3rd child.
9. The parent signing the TUITION AGREEMENT shall be the responsible party in all matters relating to tuition payments.

GENERAL INFORMATION

1. School age students in the after-school session **MUST BE REPORTED ABSENT** prior to 3 pm if they will not be attending on any scheduled attendance day.
2. Parents are responsible for providing necessary supplies for their child and must replenish them when needed. All preschool students must have naptime gear in a clearly marked draw string laundry bag.
3. **KID'S STOP** is not responsible for items lost or stolen. Personal items from home are not permitted.
4. Continuous disruptive behavior will result in conference, suspension or expulsion. See **BEHAVIOR CONTRACT**.
5. Photographs of Program activities will be taken throughout the school year session. Photographs are for **KID'S STOP** use.

ILLNESS and SICK CHILDREN

1. Children with fevers or communicable diseases will not be admitted to the facility. If a child becomes sick during the day, parents will be notified to take the child home when necessary. ***Children must be free of fever, vomiting and diarrhea for 24 hours without medicine before returning to school.***
2. Parents must follow the **MEDICATION POLICY** requiring full documentation of illness and treatment prior to the Program administering any medication.

Child's Name	Date of Admission
Parent's Signature	Office Personnel Initials

Kid's Stop Behavior Contract

Child's Name: _____ D.O.B. _____

THE KID'S STOP makes every effort to help children understand clear definitions of acceptable and unacceptable behavior. It is important that staff maintain good order and discipline in all program areas with the top objectives being safety and a positive atmosphere for learning and developing social skills.

A child's behavior is expected to be consistent with the following:

- ✓ Use appropriate language at all times
- ✓ Cooperate with staff and follow directions
- ✓ Follow all safety guidelines
- ✓ Respect other children and staff, equipment and facilities, and yourself
- ✓ Maintain a positive attitude
- ✓ Stay in program areas – running away or leaving program area is not acceptable

The following behaviors which may result in immediate dismissal include *but are not limited to*:

- pushing, kicking, shoving, tugging, tackling, pinching, choking, spitting or fighting
- name calling, talking about another's parents or family or making fun of someone's race or appearance
- throwing stones, rocks, sticks, toys or other objects
- tackle football, wrestling or rough play
- playing with toys that are considered look-alike or make-believe weapons
- harassment or bullying of any kind between students
- vandalism

Special Circumstances

Parents or guardians are required to inform **THE KID'S STOP** *in writing*, prior to a child's acceptance in to the Program, of any special circumstances which may affect the child's ability to participate fully and within the guidelines of acceptable behavior, including but not limited to any serious behavioral problems or special circumstances regarding psychological, medical or physical conditions.

Upon being informed of such circumstances, the Program Administrator (or an official designee, i.e., Site Director, Group Supervisor or Coordinator) may require a conference with the parent(s)/guardian(s) to discuss issues created by these circumstances.

I understand and acknowledge that:

1. It is the responsibility of the parent(s)/guardian(s) to make full disclosure to **THE KID'S STOP** of any special circumstances which may affect the ability of the child to participate, as described above.
2. It is the responsibility of the parent(s)/guardian(s) to inform **THE KID'S STOP** of any requested accommodation believed by the parent(s)/guardian(s) to be necessary and readily achievable for such participation; and
3. Full disclosure of any special circumstances is material to **KID'S STOP** evaluation of the child's ability to participate and the Program's consideration of any requested accommodation.

Please initial, indicating you have read and understand the above:

Parent/Guardian Initials: _____ Date _____

I have read, understand and agree with the policies as stated in this document and
have or will discuss the expectations of behavior with my child/ward.

Signature of Parent/Guardian

Please Print Name

Date

Kid's Stop
CIVIL RIGHTS COMPLIANCE PARENT AWARENESS

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your children, as a client of this facility, have the right:

- ✓ To be provided services at this facility and to be referred for services at other facilities without regard to your race, color, religious creed, disability, ancestry, national origin, age, or sex.
- ✓ To file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, disability, ancestry, national origin, age, or sex.

Complaints of discrimination may be filed with any of the following:

MN Joint Recreation Commission
Administrator of Child Care
20 Media Line Road
Newtown Square, PA 19073

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105

U.S. Department of Health & Human Services
Office for Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-9111

Pennsylvania Human Relations
Commission
Philadelphia Regional Office
110 N. 8th Street, Suite 501
Philadelphia, PA 19107

Commonwealth of Pennsylvania
DPW Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

Signature of Parent / Guardian Date

Staff Signature Date

Kid's Stop Medication Policy

This facility will administer medication to children for whom a plan has been made, reviewed and approved by Program Administration. **Because administration of medication in the facility is a safety hazard, families should check with the child's physician to see if a dose schedule can be arranged that does not involve the hours the child is at THE KID'S STOP.** Whenever possible, the first dose of medication should be given at home to see if the child has any reaction. Parents or legal guardians may administer medication to their own child during the child care day.

THE KID'S STOP will administer medication only if the parent or legal guardian has provided written consent, the medication is available in an appropriate labeled and stored container, and the Program has on file the written or telephone instructions of a licensed physician to administer the specific medication.

1. For prescription medications, parents or legal guardians will provide caregivers with the medication in the original, child-resistant container that is labeled by a pharmacist with the child's name, the name of the medication; the date the prescription was filled; the name of the health care provider who wrote the prescription; the medication's expiration date; and administration, storage and disposal instructions.
2. For over-the-counter medications, parents or legal guardians will provide the medication in the original, child-resistant container. The medication will be clearly labeled with the child's first and last names; specific legible instructions for administration and storage supplied by the manufacturer; and the name of the health care provider who recommended the medication for the child.
3. Instructions for the dose, frequency, method to be used, and duration of administration will be provided to Program Staff in writing (by a signed note or prescription label) or dictated over the phone by a physician or other person legally authorized to prescribe medication. This requirement applies to both prescription and over-the-counter medications.
4. A physician may state that a certain medication may be given for a recurring problem, emergency situation or chronic condition. The instructions should include the child's name; the name of the medication; the dose of the medication; how often the medication may be given; the conditions for use; and the precautions to follow. **Example:** children may use sunscreen to prevent sunburn; children who wheeze with vigorous exercise may take one dose of asthma medication before vigorous active play; children who weigh between 25-35 pounds may be given 1 teaspoon acetaminophen for up to two doses every hour for fever.
5. A child with a known serious allergic reaction to a specific substance who develops symptoms after exposure to that substance may receive epinephrine supplied by the parent from a staff member who has received training in how to use an auto-injection device (e.g., EpiPen®). In the case of severe allergies which require monitoring, special accommodation and/or emergency medication/response, an ANAPHYLAXIS and ALLERGY TREATMENT PLAN must be provided by child's physician
6. Medication will be kept at the temperature recommended for that type of medication, in a sturdy child-resistant, closed container that is inaccessible to children and prevents spillage.
7. Medication will not be used beyond the date of expiration on the container or beyond the expiration of the instructions provided by the physician or other person legally permitted to prescribe medication. Instructions which state that the medication may be used whenever needed will be renewed by the physician at least annually.
8. A medication log will be maintained by Program Staff to record instructions for giving medication; consent obtained from the parent or legal guardian, amount; time of administration; and the person who administered each dose of medication. Spills, reactions, and refusals to take medication will be noted on this log.
9. Parent or legal guardian will supply all devices or equipment necessary such as medicine spoon or measurement cup
10. **NOTE:** The Program does NOT keep a supply of pain/fever reducers on hand (ex: Tylenol/Motrin, etc.). **All medications must be provided by Parent.**

Signature of Parent or Legal Guardian indicating knowledge and understanding of THE KID'S STOP Medication Policy

Print Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date

KID'S STOP

Individualized Education Plan Statement

KID'S STOP works in cooperation with families and outside agencies to facilitate the provision of intervention services for children in need.

An EISP (Early Intervention Services Plan) generally refers to individualized plans for infants, toddlers, preschoolers and can include kindergarten students.

An IEP (Individualized Education Plan) for school-agers and kindergarten children generally refers to specialized plans created for elementary students.

While it may seem that an education plan for a school-ager need not be shared with the child's before and after school program, understanding the ways each child learns and functions during the school day is critical to providing an appropriate before/after school experience for the child.

Has your child been identified by the school district for special programming? If yes, please submit a copy of the IEP. Because of the importance of the IEP/EISP to a child's experiences, **KID'S STOP** should have a copy before the child begins to attend. Updated versions should be submitted as necessary.

Note: the information found on an IEP/EISP is protected by privacy laws

- My child **DOES NOT** have an IEP or EISP currently in place
- My child has an IEP My child has an EISP

My child is currently receiving:	Agency Providing Service	Service Provided
<input type="radio"/> Speech Therapy	_____	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site
<input type="radio"/> Physical Therapy	_____	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site
<input type="radio"/> Occupational Therapy	_____	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site
<input type="radio"/> Behavioral Services	_____	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site
<input type="radio"/> _____	_____	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site
<input type="radio"/> _____	_____	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site
<input type="radio"/> _____	_____	<input type="checkbox"/> On Site <input type="checkbox"/> Off Site

Additional details or information you feel may be relevant:

Child's Name
Parent's Signature
Date

Kid's Stop Child Health Assessment

KID'S STOP requires the parent of an enrolled child, including a foster child or relative of a facility person, to provide an initial health report at the time of initial attendance.

- The initial health report for a child two years of age to the date the child enters kindergarten must be dated no more than 1 year prior to the first day of attendance.
- The initial health report for a school age child must be dated in accordance with the requirements for medical examinations for school attendance (28 PA Code § 23.2).

Updated health reports for each child are due in accordance with the following schedule:

- At least every 12 months for an older toddler or preschool child
- School age children, including kindergarten students, must be dated in accordance with the requirements for medical examinations for school attendance (28 PA Code § 23.2)

A health report must be complete and signed by a physician, physician's assistant or a CRNP. The signature must include the individual's professional title.

The health report must include the following information:

1. A review of the child's health history
2. A list of the child's allergies
3. A list of the child's current medication and the reason for the medication
4. An assessment of an acute or chronic health problem or special need and recommendations for treatment or services, including information regarding abnormal results of screening tests for vision, hearing, or lead poisoning
5. A review of the child's immunized status according to recommendations of the ACIP Advisory Committee on Immunization Practices
6. A statement of the child's medical information pertinent to diagnosis and treatment in case of emergency
7. A statement that the child is able to participate in child care and appears free from contagious or communicable disease
8. A statement that age-appropriate screenings recommended by the American Academy of Pediatrics were conducted since the time of the previous health report required by this regulation. **KID'S STOP** may not accept or retain a toddler or a preschool child at the facility for more than 30 days following the first day of attendance unless the parent provides written verification from a physician, physician's assistant or CRNP of the dates the child was administered immunizations in accordance with the recommendations of the ACIP.
9. **KID'S STOP** must implement dismissal policies in accordance with the Department of health regulation in 28 PA Code § 27.77 (relating to immunization requirements for children in child care group settings).

Some pediatric practices may prefer to use their own form, usually computer generated, which provides all the necessary updates and information.

The doctor's office form is fine as long as it is appropriately signed and dated by the issuing practice.

If you have any questions about this important health & safety requirement, please do not hesitate to ask.

**Child Health Report must be received by Friday, August 16 in order for
your child to start on September 3.**

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:
<input type="checkbox"/> 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) <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>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.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
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.