Emergency Contact/Parental Consent Form

55 PA CODE CHAPTERS 3270.124(a)(b); 3270.181 & 182; 3280.124(a)(b); 3280.181 & 182; 3290.181 & 182

Child's Name:	Birth Date:	Enrollment Date:

Child's Address:

_____ Street/Apt #/PO Box _____ City _____ State _____ Zip Code

Mother/Legal Guardian Contact Information:	Father/Legal Guardian Contact Information:
Name: _____	Name: _____
Home #: ( ) _____	Home #: ( ) _____
Mobile #: ( ) _____	Mobile #: ( ) _____
Work #: ( ) _____	Work #: ( ) _____
Email Address: _____	Email Address: _____
Home Address: ☐ *same as child* _____ Home Address	Home Address: ☐ *same as child* _____ Home Address
☐ Employment OR ☐ School: Business or School Name: _____ *Address:*	☐ Employment OR ☐ School: Business or School Name: _____ *Address:*

Emergency Contact Person(s) (in addition to the parents) Name, Relationship, and Phone #:

1. _____
2. _____
3. _____

I give permission for my child to be released to any of the following person (s) (18 years of age of older) when I am unable to pick my child up from the classroom or bus stop (in addition to the parents). Name, Address, Relationship & Phone #

1. _____
2. _____
3. _____
4. _____

Physician Name: _____

Physician Address: _____

Physician Phone #: _____

Insurance Information: _____

ID#: _____ Group #: _____

Allergies: _____

Special Disabilities / Medical Conditions / Special Needs / Dietary Restrictions:

Parent/Legal Guardian Permission:

Obtaining Emergency Medical Care _____ *Initials*

Transportation by Facility _____ *Initials*

Admin. Of Minor First Aid Procedures _____ *Initials*

Walks and Trips _____ *Initials*

Wading/Sprinklers _____ *initials*

X _____

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: **Facility Location: New Castle or Pulaski**

Private Pay Amount: $_____ per day; due Monday prior to attendance
Agency Amount: $_____ per week; due Monday prior to attendance

Services to be provided as part of the daycare fee (example: transportation, care, meals, etc.)

- We shall provide a safe and pleasant environment that will enhance your child's growth and development.
- We provide good and nutritious meals aligned to the CACFP program standards (Breakfast, AM Snack, Lunch, PM Snack based on arrival and departure time).
- We enhance your child's social and emotional skill with peers and staff members.
- We provide opportunities for your child to enhance gross and fine motor skills both indoors and outdoors.
- We provide opportunities for your child to engage in problem solving.
- We enhance your child's language abilities through speaking, listening and checking for understanding through discussions and story books.
- We teach proper writing skills to each child.
- We observe and assess each child's development by using Ages and Stages and Vine assessments.
- We provide safe transfer of care for our school age children per our policy located in our handbook

Childcare

___Monday __Tuesday ___Wednesday ___Thursday ___Friday

3 Half Day or 3 Full days – Required.

Extra services to be provided at an additional fee if applicable:

- NSF checks and declined credit cards will accrue a $40.00 fee.
- Registration fee: $80 per child
- Re-registration fee: $50 per child
- Annual supply fee: $45 per family-around September
- $3.00 per day diapering fee for children 3 and older who are still in diapers/pull ups.
- A late payment fee of $35 will occur on Tuesday for nonpayment of previous week of service.
- Overtime fee will be charged on a prorated rate of $10.25 an hour for late pickups that are over 10 hours of service.
- Late pickup fee of $50 plus $10.25 per hour, for after business hour pickups.
- Vacation, absent week, non-scheduled week will occur a $85 Per Week, per child
- No schedule fee: $3

Childs Arrival Time: _____ AM/PM (Approx.) **Childs Departure Time: _____ AM/PM (Approx.)**

Person(s) designated by parent to whom child may be released: SEE EMERGENCY CONTACT SHEET

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 minimum. (§ 3270.121, 3280.121, 3290.121)**

Signature– Director	Date	Signature– Parent/Guardian	Date

Date of Child's Admission:_____ **Date of Child's Withdrawal:_____**

Getting to Know Your Child

Child's Name_____ Nickname (if applicable) _____

Has your child been in an early learning program or childcare center before? **Yes or No**

- If **yes**, would you share some information with us? (Where? When? For how long? Reason for leaving?)

_____

Does your child have any unusual eating problems or food dislikes? **Yes or No**

- If **yes,** please explain. _____

Does your child have any allergies? **Yes or No**

- If **yes**, what are they? How severe? What steps should be taking if your child has a reaction?

_____

Are there any important routines at drop off/pick up/naptime/etc., that would be helpful for us to know about? _____

Does your child usually nap? _____How long? _____ What Times? _____

Is your child in diapers? _____ Pull-ups? _____ Fully potty trained? _____

Does your child have any fears or nervous habits? **Yes or No**

- If **yes**, what are they and what can we do to help?

_____

What is your attitude towards discipline? _____

Any further information that might be helpful in understanding your child (visual or physical handicaps, for example):_____

_____

Names and ages of your child's brother(s) and/or sister(s): _____

What are your expectations from our program for your child? _____

_____

Where did you hear about us? (Please Circle) Internet Search, Our Website, ELRC, Facebook, Parent Referral, Center Referral, Other (please explain): _____

For office use Only

Start Date: _____

Reviewed By:

Director: _____ Date: _____

Group Supervisor: _____ Date: _____

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Permission Form

Child's Name: _____ Date: _____

I give permission for my **child** to be transported to and from Pre-K Kids Learning Center. _____ **Initials**

This permission form Authorizes Pre-K Kids Learning Center to transport my child in any emergency.

If the child named above has special needs or problems that require special care while being transported, such as seizures or motion sickness, please write instructions on back of this form.

I give permission for Pre-K Kids Learning Center to photograph my child for the following purposes: _____ **Initials**

Please check one for each line

Type of Use	Yes	No
Display photos in the teacher made books that may go home with current clients. (Only first names may be displayed with their pictures in teacher-made books)		
Display still photos on Pre-K Kids Learning Center website		
Send photos through our parent communication system (ex: ProCare) possibly containing your child to current clients		
Post photos on Pre-K Kids Facebook page		

I give Pre-K Kids Learning Center permission to use the following on my child, as needed. _____ **Initials**

I understand that only products I have supplied will be used.

Circle One

Sunscreen	Yes	No
Diaper Cream	Yes	No

This only applies for the New Castle Office

I give permission for my child to walk to Shenango Park with Pre-K Kids Learning Center Staff. _____ **Initials**
I/We understand all reasonable safety precautions will always be taken by Pre-K Kids Learning Center and its agents during the events and activities.

I understand that it is my responsibility to update this form if I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____

(Parent or Guardian Signature) (Date)

Rev 4/29/25

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.

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize **Pre-K Kids Learning Center** to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____ CVV Number _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

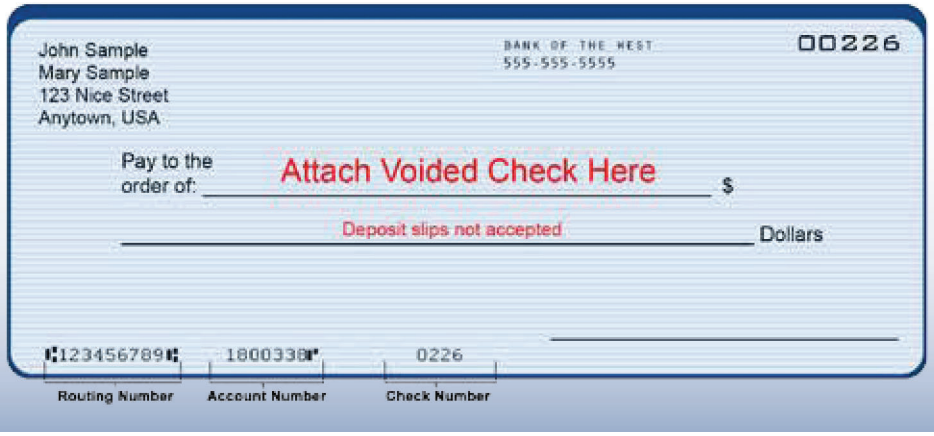
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ Checking ☐ Savings ☐

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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