

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 minimum. (§ 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

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)

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:		

Parents may write immunization dates; health professional should verify and complete all data.

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:						
		PHONE:		LICENSE NUMBER:		DATE FORM SIGNED: