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.

Parent/Guardian Agreement

To protect our children and staff, I agree to keep my child at home if he/she has a COVID-like illness.

A COVID-like illness is defined as:		
At least ONE of these symptoms		At least TWO of these symptoms
☐ new or persistent cough ☐ shortness of breath ☐ new loss of sense of smell ☐ new loss of sense of taste	OR	☐ fever ☐ chills ☐ muscle pain ☐ headache ☐ sore throat ☐ nausea/vomiting ☐ diarrhea ☐ fatigue ☐ congestion/runny nose

If my child has any of these signs of COVID-19, I will not send him/her back to school until:

- My child tested negative for COVID and is otherwise well enough to go back to school
  OR
- A healthcare provider has seen my child and documented a reason for the symptoms other than COVID
  OR
- All are true: 1) at least 10 days since the start of symptoms AND 2) fever free off anti-fever medicines for 1 day AND 3) symptoms are getting better.

If my child is diagnosed with COVID-19, I will not send him/her back to school until the following:

- It has been at least 10 days since my child first had symptoms
  AND
- My child has had no fever off anti-fever medicines (ex: Tylenol, Ibuprofen) for 1 day
  AND
- My child's symptoms are getting better

If someone in my household is diagnosed with COVID-19 or my child is exposed to COVID-19, I will keep him/her home for 10 days. ***If anyone in my household has been tested for COVID-19 and results are pending, I will keep my child home until I receive a negative result.***

If someone in my household develops new cough, shortness of breath or two of the following: sore throat, chills, muscle pain, headache, new loss of taste or smell, I will get that person tested for COVID-19. If that person tests positive, I will keep my child home for 10 days.

Child's name: _____

Parent/guardian name: _____

Parent/guardian signature: _____

Date: _____

********Failure to share health information or comply to terms of this agreement may result in termination.**

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)

ALPHABET ACADEMY INC.
1510 E. PASSYUNK AVENUE PHILADELPHIA, PA 19147
NONDISCRIMINATION IN SERVICES

To: PARENTS
From: Alphabet Academy Administration

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, nation origin (including limited English proficiency), age, or sex. Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any student (and/or their guardian) who believes they have been discriminated against, may file complaint of discrimination with:

ALPHABET ACADEMY
1510 EAST PASSYUNK AVENUE
PHILADELPHIA. PA 19147

COMMONWEALTH OF PA, DEPARTMENT OF HUMAN SERVICES, BUREAU OF EQUAL OPPORTUNITY
SOUTHEAST REGIONAL OFFICE
801 MARKET STREET, SUITE 5034 PHILADELPHIA, PA 19107

COMMONWEALTH OF PA DEPARTMENT OF HUMAN SERV
BUREAU OF EQUAL OPPORTUNITY
ROOM 225, HEALTH &WELFARE BLDG P.O. BOX 2675
HARRISBURG, PA 17110

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS
SUITE 372, PUBLIC LEDGER BUILDING
150 S. INDEPENDENCE MALL WEST
PHILADELPHIA. PA 19106-9111

PA HUMAN RELATIONS COMMISSION PHILADELPHIA REGIONAL OFFICE
110 NORTH 8TH STREET, SUITE 501
PHILADELPHIA, PA 19107

PARENT'S SIGNATURE _____
STAFF SIGNATURE_____

TUITION AGREEMENT

- All currently enrolled families are required to sign up for automatic payments unless other arrangements have been made and approved by our billing department and Area Director.

- A registration fee of $125 per child and a deposit of $400 is required to register and hold a spot. Both are non-refundable and your deposit will be applied to your final week(s) of care.

- An annual registration fee of $125 per child is applied with each August's tuition.

- Tuitions payments are collected on a weekly basis in advance. Tuition is due the Monday preceding each week of care. A $25.00 late charge will be applied for each day (weekends and holidays included) the payment is late. If additional fees are incurred after tuition is collected, our billing department will process the remaining balance using your chosen payment method on file.

- No credit on tuition is given for vacations, absences, scheduled center holidays, or emergency closings.

- All payments that are returned by the bank for insufficient funds will have an additional charge of $40.00.

- Our center closes promptly at 6:00 p.m. Children need to be picked up and off the premises at 6:00 p.m. A late charge of $40.00 (per child) for the first fifteen minutes or fraction thereof that a child remains in the building after 6:00, and a $20.00 charge per 5 minutes thereafter, will be charged. Payment must be made to the office the following day.

- Parents must provide the center with 30 days written notice of withdrawal. Parents are responsible for tuition for during their notice period whether their children attend during the period or not.

Child's Name_____

Parent's Signature_____

Director's Signature_____

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	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN _____ DATE _____