PRESCHOOL-PRE K

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 3 DAYS	DAY PAYMENT TO BE MADE BY FRIDAY PRIOR TO SERVICE

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

CHILDCARE

2 SNACKS

E-MAIL----

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME.	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $ 15.00	PER MIN-HR 15 MIN.	

Extra services to be provided at an additional fee if applicable

REGISTRATION $25.00

DEPOSIT (1 WEEK OF CARE)

CURRICULUM FEE $15.00- DUE ON 1ST OF EVERY MONTH

BOOK FEE $20.00 PER SCHOOL YEAR

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)

_____ _____ X _____ _____

SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	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	BIRTHDATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'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 CONDITIONS
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 _____

Smithfield Learning Center, Inc.

I/We, _____, the parent(s)/legal guardian(s) of _____, acknowledge that I/We have received a copy of the Smithfield Learning Center's Parent Handbook and have been given the opportunity to read the manual and ask questions about and understands the policies contained therein. Furthermore, I/We agree to abide by the policies set forth in the manual.

I/We understand that the policies described in the Parent Handbook are not conditions of enrollment, and the language does not create a contract between Smithfield Learning Center and the parents. Smithfield Learning Center reserves the right to alter, amend, or otherwise modify these guidelines, in its sole discretion, without prior notice.

I/We acknowledge that this Parent Handbook is the property of Smithfield Learning Center, and must be returned to Smithfield Learning Center when the aforementioned child is no longer enrolled at Smithfield Learning Center. I/We acknowledge that our failure to return the Parent Handbook to Smithfield Learning Center, within 5 business days following the end of enrollment, will result in $25.00 being deducted from the deposit taken at the time of enrollment.

Signature:_____ Date:_____

Print Name:_____

Signature:_____ Date:_____

Print Name:_____

Family History

Date:_____

Name of Child:_____Sex:_____ Birthdate:_____

Address:_____
Street City State Zip County Ph.

Mother's Name:_____ Father's Name:_____

Address:_____Address:_____

_____ _____
Phone# DOB Phone# DOB

Pregnancy History

Age at delivery_____Length of pregnancy_____Hospital name_____

Obstetrician Name:_____Type of delivery_____

Baby birthweight and length_____Feeding: Breast/bottle_____
How many mos.

Reactions to formula if any_____What formula was used_____

Child's Daily Routine

Awakens_____Meal and snack times_____

Favorite Meals/snacks/foods_____Allergies to any foods_____

Nap time/times and lenghts_____Comforting objects_____

Favorite play_____Fears_____

Discipline methods_____

Medical History

List all childhood illness and allergies_____

_____

Does child require any medications: Yes/No If yes what type and how often_____

_____

Pediatricians Name and Address and Phone_____

Date of last examination_____Immunizations_____

Mother's current observation of child

Age:_____Weight:_____Height:_____Personality_____

Interaction with other children_____Current concerns: (behavioral or health)_____

Paternal History

Father_____Age____DOB_____Race_____Religion_____

High School_____Year Graduated_____Other Schooling_____

Marital Status:_____Legal custody or visitation rights_____

Employer name/address/phone_____

Significant health problems_____Describe father-child relationship_____

Maternal History

Mother_____DOB_____Race_____Religion_____

High School_____Year Graduated_____Other schooling_____

Marital status_____Legal Custody or visitation rights_____

Employer name/address/phone_____

Significant health problems_____Describe mother-child relationship _____

_____

List siblings names and ages and school attended if any_____

_____

Please use this space to provide any additional information that you feel would help us in providing the best possible mom-like care for your child.

RELEASE AND WAIVER OF LIABILITY FOR ADMINISTERING EMERGENCY CARE TO CHILDREN WITH SEVERE ALLERGIES

This is a RELEASE AND WAIVER OF LIABILITY FOR ADMINISTERING EMERGENCY TREATMENT TO CHILDREN WITH SEVERE ALLERGIES (hereinafter, referred to as the "Release")

Made this _____ day of _____, 200___, by and between Smithfield Learning Center and _____

(Parent(s)/Legal Guardians) who are the Parent(s) and/or Legal Guardian(s) of _____ _____ (child's name).

WHEREAS, Smithfield Learning Center provides child care services and the Parent(s)/Legal Guardian(s) have engaged Smithfield Learning Center to provide child care services for _____ (child's name);

WHEREAS, Smithfield Learning Center has been requested by the Parent(s)/Legal Guardian(s) to administer emergency treatment (including the administration of epinephrine) to the child during certain emergency situations when the child has come in contact with an allergen and is in danger of anaphylaxis , as prescribed in writing on the child's "Authorization for Emergency Care of Children with Severe Allergies Form" all in accordance with and subject to Smithfield Learning Center's policy for administering emergency treatment to children with severe allergies.

NOW THEREFORE, in consideration of the agreements and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. Parent(s)/Legal Guardian(s) hereby release and forever discharge Smithfield Learning Center and its employees or agents from any liability arising in law or equity as a result of Smithfield Learning Center's employees or agents administering epinephrine and providing other emergency care in conformance with the child's "Authorization for Emergency Care of Children with Severe Allergies From" (hereinafter referred to as the "Authorization"), provided that Smithfield Learning Center has used reasonable care in administering epinephrine and in providing other authorized care in accordance with the Authorization.
2. This Release shall be governed by the laws of the State of Pennsylvania which is the location of the Smithfield Learning Center facility in which the child is enrolled, excluding its choice of law Provisions.
3. This Release supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning all subject matters covered herein. This instrument, along with the Authorization (including any additional health care provider's instructions or clarifications), that is hereby incorporated by reference, constitutes the entire agreement among the parties with respect to the subject matters discussed herein.

4. The reference in this Release to the term Smithfield Learning Center shall include Smithfield Learning Center its affiliates, successors, directors, officers, employees, and representatives. The terms Parent(s)/Legal Guardian(s) shall include the dependents, heirs, executors, administrators, assigns, and successors or each.
5. If one or more of the provisions of this Release shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect or impair any other provision of the Release. This Release shall be construed as if such invalid, illegal, or unenforceable provisions had not been contained herein.

Smithfield Learning Center

25 Main Street

Suite 6

Smithfield PA 15478

Name: (print) _____

Signature: _____

Title: _____

Date: _____

PARENT(S)/LEGAL GUARDIAN(S):

Name: (print) _____

Signature: _____

Relationship: _____

Date: _____

Name: (print) _____

Signature: _____

Relationship: _____

Date: _____

PART II: (to be completed by the child's Parent(s) and/or Legal Guardian)

By Signing this form, I/We authorize Smithfield Learning Center to follow the instructions contained in this Authorization For Emergency Care of Children with Severe Allergies Form. I/We agree to update this form every six (6) months, or sooner if my/our child's needs change.

PARENT(S)/LEGAL GUARDIAN(S):

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact #: _____

Signature: _____ Date: _____

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact #: _____

Signature: _____ Date: _____

This completed Authorization for Emergency Care for Children with Severe Allergies Form was received by Smithfield Learning Center on (date) _____. This Form must be updated by (date) _____.

Received By: (Print Name) _____

Signature: _____

Title: _____

AUTHORIZATION FOR EMERGENCY CARE OF CHILDREN WITH SEVERE ALLERGIES

Date:

Dear Health Care Provider,

Your patient,_____ is enrolled in Smithfield Learning Center and we have been requested to provide certain emergency care for the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at Smithfield Learning Center so we may assist with the allergy care and needs of the child. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become a part of this record and will be kept with this form in the child's file at Smithfield Learning Center.

PART I (to be completed by a Licensed Health Care Provider)

Child's Name:_____Child's Birth Date:_____

Known Allergens: (Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (i.e. Anaphylactic shock) in the child.)

_____ Bee Sting

_____ Other Insect Bite(s): (identify):_____

_____ Animal(s): (identify): _____

_____ Food Allergy: (identify all foods or groups of foods that must be avoided): _____
_____

_____

_____

_____Other: (identify): _____

SYMPTOMS: (Please provide a complete list of all symptoms that indicate the child has come into contact with an allergen and requires emergency treatment.)

_____Shortness of Breath

_____Swelling of the Face or Lips
_____Hives

_____Vomiting

_____Diarrhea

_____Other: (explain):_____

PROCEDURES: (Please indicate all steps necessary and the order in which they should be taken.)

_____Administer the following Medication: (provide name, dosage, and method of administration):_____
_____

_____Administer EPI-PEN: (provide instructions for administration)

_____Call Emergency Medical Services (911)

_____Call the child's parent or guardian

_____Other (explain): _____

_____DO NOT administer medication in the absence of KNOWN exposure to allergen

RECREATIONAL ACTIVITIES:

1. The child may participate in recreational activities. [ ] yes [ ] no

2. Recreational Activity Restrictions: [ ] none [ ] some restrictions
   (explain recreational activity restrictions): _____
   _____
   _____

HEALTH CARE PROVIDER INFORMATION:

Office: _____

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Signature: _____ Date: _____

THE SMITHFIELD LEARNING CENTER
PRE-SCHOOL-DAYCARE

I hereby give my consent for SLC to review all records pertaining to my child. Confidentiality of all records will be maintained. Information cannot be released without parental permission.

_____
PARENT SIGNATURE

_____
Date

_____
ADDRESS/PHONE NO.

PHOTO PERMISSION FORM

Permission To Photograph Child

I give my permission for _____ to be photographed and/or videotaped by teachers and staff of the Children's Center of local news organizations approved by and accompanied by the Director of the Center for purposes of advertising, public relations, and family enrichment. The snapshots which may include my child may be published and/or sold to other parents to cover the expense involved.

*Parent's Signature*_____ *Date*_____

I give the Child Care Center permission to have my child photographed by the press of the facility to use for Public Relation purposes at any time.

*Parent's Signature*_____ *Date*_____

THE SMITHFIELD LEARNING CENTER PRE-SCHOOL-DAYCARE

I hereby give my permission for the SLC staff to assist my child in his/her diapering or toileting needs.

Diapering needs include the administration of provided diapering ointments or powder as specified by the parent to the staff.

_____
Child's Name

_____
Parent Signature

_____
Date

Individualized Education Plans (IEP) & Individualized Family Service Plans (IFSP) Information Sheet

The information found on an IEP/IFSP is protected by privacy laws including the Health Insurance Portability and Accountability Act (HIPAA), and will only be shared with the member of the Smithfield Learning Center, Inc. staff.

Parent Sign-off Sheet

Child's Name:_____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

- ☐ I am providing a copy of my child's IEP or IFSP.
- ☐ I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Signature:_____ Date:_____

Printed Name:_____

ATTACHMENT 6 – CHILD PICK-UP AUTHORIZATION

I, _____, authorize ***Smithfield Learning Center***

to release my child(ren) _____

to the person(s) designated . This is in consonance with the ***Smithfield Learning Center*** Emergency Operations Plan.

Designated Custodian(s) Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Your Signature Relationship Date

_____

Print Name

_____

Address

(Home Phone)_____(Work)_____(Cell)_____

NOTE: Parents and guardians should designate themselves as designated custodians. Friends, neighbors and other relatives may also be designated.

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: SMITHFIELD LEARNING CENTER INC. 25 MAIN ST. SUITE 6 SMITHFIELD, PA 15478 (724) 569-0824	
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: X

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.