Fever Reducer Permission Slip

If ____________________ begins to run a temperature over 101 degrees, and I cannot be reached I give permission for the child care staff to give my child __________ (amount) or amount as per manufacturers directions, of aspirin-free fever reducer. (Such as children's chewable Acetaminophen) I understand that the center will be contacting my "emergency pick up person" to pick my child up.

We will always try to contact you first.

_________________________________ ______________________

Parent or Legal Guardian Signature Date

Sun Screen Permission Slip

I will provide sun screen and/or other sun protection for my child _____________________.

If I do not supply sun-screen for my child, I give permission for the child care staff to apply the sun screen that they may have to my child before sun exposure.

_________________________________ ______________________

Parent or Legal Guardian Signature Date

PHOTO RELEASE FORM

Providers name: Newport Learning Center
Child's full name: ___________________________

Photographs are taken on different occasions such as birthdays, holidays, outings and special occasions.

We use these pictures in our child care for teaching, graduation slide show, arts & crafts, albums, web site information, private facebook page updates, and various other things.

Please mark the appropriate box:

☐I give permission ☐I do not give permission

to the above named provider to take photographs or have photographs taken of the above named child should the occasion arise.

☐I give permission ☐I do not give permission

to the above named provider to take videos or have videos taken of the above named child should the occasion arise.

I understand that these photographs and/or videos will not be sold, or distributed or placed on any other internet websites nor will my child's name be used without my written permission.

Parent Signature:_________________________ Date: _______________________

Provider Signature:_________________________

"Getting to Know You"

* We would like to be as attentive as possible to your child and their needs and favorites, as well as, home situation. Please fill out the following page with what you are comfortable sharing with us.

Child's Name:_________________________ Age:_______________

Does your child have any nicknames and which one(s) may we use?

Tell us about the child's family—who lives with them and how many homes they have or visit:

Tell us what the primary language of your home is and if your child also has a secondary language?

Please share about the child's or family pets:

What is your child's favorite snack, color, game, book, toy, and song?

Is you child afraid of anything?

My child's learning challenges are and what he/she excels at:

He/she definitely does not like:

Describe your child's toileting habits or needs and do they need to be reminded to potty throughout the day?

"About You"

Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know? Would you and/or your family like to be a resource for any cultural awareness activities?

Are you willing or do you have another family member willing to be a volunteer in your child's classroom?

Are there any other ways that you would like to be involved or are there any other talents or interests you would like to share with us?

I would like to have a 45 day "Getting to Know You" Conference:

YES OR NO If YES, date: ________________________

Parents Signature ____Date _________________

Newport Learning Center
Enrollment Form

Child's Name: _________________________Birthdate:____/____/_____ Gender (circle one): M F

Address:____

City: ____State: _____________Zip Code:_______________

School District you reside in: ____

Legal Guardian #1: ___________________________________Relationship:_________________________

Address: ____

Cell: ___________________________ Work: __________________________Hours: ________________

Email: ____

Legal Guardian #2: ____________________________________Relationship: ______________________

Address (If different form above): ____

Cell: ____________________________Work: ________________________Hours: __________________

Email:____

Days / Hours when care is needed: ____

____

Returning Student? Yes or No If yes, Classroom:____________________

Potty Trained? *Yes or *No ***Toddler Rate is charged for 3-5 year-olds not yet potty trained***
(see potty trained definition in handbook)

All enrollments are subject to availability. A $40.00 non-refundable enrollment fee will be payable immediately upon child's registration. Sibling discounts offered for private pay families. Please see Parent Handbook for complete tuition policies. All rates are subject to change with 3 weeks notice.

Legal Guardian's Signature: _______________________________________Date:____________________

Child's Admission Date: _____________________ Child's Withdrawal: ___________________________

Please fill out and return to center's office

Child Care Agreement

I, ________________________, the legal guardian of _________________________ am enrolling my child on:_________________

and agree to the following: ***(Initial all spaces)***

__________ Pay $________________ for days circled. M T W TH F

__________ Pay a yearly $40.00 registration fee per child.

__________ Payment is to be made on Fridays **prior** to the week of service.

__________ I **understand I will owe an additional $15.00 along with any payment 5 days past due**.

__________ I have read and will follow all policies and procedures set in application packet.

__________ Does your child currently have an IEP or IFSP? If so please provide a copy and obtain a *Special Care Plan*. We would like to be part of your meetings setting these up. Services my child currently has:

____

__________ Services to be provided as part of the child care fee are 1 snack in the morning, 1 snack in the afternoon, lunch, transportation to any scheduled outings, and craft or classroom supplies. I understand I am responsible for the cost of anything beyond above listed items.

__________ Child's Arrival time ____________ departure time ________.

__________ Pay $1.00 per minute late after 6 p.m.

__________ Submit a health assessments filled out by child's physician no later than 60 days following the first day of attendance, every six months until the age of two, every 12 months until entering Kindergarten, and a copy of physicals as the school requires thereafter.

__________I understand that there are 11 holidays throughout the year in which child care will be closed. If my child normally attends on this day of the week, I will still be charged for this day.

__________ Notify the teacher 2 days in advance if I plan a special birthday treat for my child and his/her class. (You must contact teacher ahead to discuss any food allergy precautions.)

__________ Notify the staff when my child is ill or any family member has a contagious disease.

__________ I will contact the center via Brighthwheel if my child is not coming by 9 am on any given day.

__________ Complete a medication consent form when requesting medication administration.

__________ I will provide the program staff with a sleeping bag, blanket, pillow, or comfort items for rest time and will take said items home to be laundered weekly. I will also check child's basket to change out clothes due to seasonal changes and size changes.

__________ Provide information on how to contact me in an emergency situation which I will notify the center upon any changes and/or every 6 months. (*Emergency Contact / Parental Contact Form)*

__________ Notify a teacher every time my child arrives, and notify a teacher and sign my child out every time my child departs with a pre-designated person or me.

__________ Everyone Listed on my child's emergency contact sheet is allowed to pick up my child.

Parent or Legal Guardian's Signature____ Date______________________

Directors Signature ____ Date ______________________

PERIODIC REVIEW (EVERY 6 MONTHS)- This information is still correct or corrected.

Parent or Legal Guardian's Signature____ Date______________________

Emergency Contact / Parental Consent Form

CHILD'S NAME:	**DOB**
Home Address	
MOTHER'S NAME/LEGAL GUARDIAN	Home Phone
Home Address	
Business Name	Business Phone
Business Address	
Email	Cell Phone
FATHER'S NAME/LEGAL GUARDIAN	Home Phone
Home Address	
Business Name	Business Phone
Business Address	
Email	Cell Phone

EMERGENCY CONTACT PERSON(S)	Name	Address	Phone # when child is in care
1.			
2.			

PERSON(S) TO WHOM CHILD MAY BE RELEASED	Name	Address	Phone # when child is in care
1.			
2.			

NAME OF CHILD'S PHYSICAN/MEDICAL CARE PROVIDER	Phone number
Address of Physician	
Special Disabilities (if any)	Allergies (including meds)
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)
PARENTS INITIALS ARE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT	
OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST-AID PROCEDURES**
WALKS AND TRIPS	PHOTOGRAPHED
TRANSPORTATION BY FACILITY	WADING/WATER PLAY

Yes No I WOULD LIKE TO HAVE A 45 DAY GETTING TO KNOW YOU MEETING WITH MY CHILD'S TEACHER
Please Circle one

PERIODIC REVIEW (EVERY 6 MONTHS-JANUARY)- (Below)

P

SIGNATURE OF PARENT / GUARDIAN DATE

SIGNATURE OF PARENT / GUARDIAN DATE

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

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

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: