# AGREEMENT

**55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)**

| NAME OF CHILD | | |
|---|---|---|
| FEE AMOUNT<br>$ | 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<br>$ | 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 |
|---|
| DATE OF WITHDRAWAL |

**PERIODIC REVIEW**

SIGNATURE-PARENT OR 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

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.**

513 Montgomery Avenue
Merion Station, PA 19066-1298
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WALDRON MERCY ACADEMY

610-664-2829
www.waldronmercy.org

# Child Care
# Child Information

*Tell us a little about your family. (brothers, sisters, special people)*

Do you have a pet? ❒ Yes ❒ No

If yes, what kind of pet and what its name? _____

Your child's favorite food(s) (if applicable) _____

Your child's favorite toy(s)? _____

Your child's favorite book(s)?_____

Your child's favorite snuggle object(s)? _____

Additional information: _____

_____

_____

_____

_____

_____

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# Child Care Center Arrival/Departure Times

*Please indicate the approximate arrival and departure times for your child/children.*

| DAY | ARRIVAL TIME | DEPARTURE TIME |
|---|---|---|
| Monday | _____ | _____ |
| Tuesday | _____ | _____ |
| Wednesday | _____ | _____ |
| Thursday | _____ | _____ |
| Friday | _____ | _____ |

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# Child Care
# Diaper Cream and Sunscreen Permission

Do we have your permission to:

| | Yes | No |
|---|---|---|
| Apply diaper cream when we change your child's diaper and deem it necessary? | ❒ | ❒ |
| Apply sunscreen? | ❒ | ❒ |

Be sure your child's name is on the diaper cream and sunscreen jar/tube.

# 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 _____

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# Handbook Acknowledgement

We encourage a spirit of cooperation and working together to give your child/children the best we can.

Please carefully review the online *Parent Handbook,* and sign and return this form to Louise Fry, director, Waldron Mercy Child Care.

Name of Child:_____

Date of Birth:_____

Your signature indicates that you have read and agree to comply with Waldron Mercy Child Care's policies.

Signature of Parent:_____ Date:_____

Signature of Parent:_____ Date:_____

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WALDRON MERCY ACADEMY

# Child Care
# Nondiscrimination in Services

To: Parents/Guardians/Students

From: Louise Fry, Director of Waldron Mercy Child Care

Admission, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age, or sex.

Program services shall be made accessible to eligible handicapped persons through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any parent/guardian/student who believes that he or she has been discriminated against may file a complaint of discrimination with any of the following:

Mercy Child Care Center
515 Montgomery Avenue
Merion, PA 19066

Department of Public Welfare
Bureau Of Equal Opportunity
Room 223, Health & Welfare Bldg.
PO Box 2675
Harrisburg, PA 17105

U.S. Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

Pennsylvania Human Relations Commission
Harrisburg Regional Office
1101 S. Front Street, Fifth Floor
Harrisburg, PA 17104

Commonwealth of Pennsylvania
DPW Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

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# Child Care Permission

Do we have your permission to:

| | Yes | No |
|---|---|---|
| have first aid administered by a qualified person? *It is understood that you will be informed when any such treatment is given.* | ❒ | ❒ |
| have your child be included in photographs/video which will be used for marketing and advertising purposes for the Center? | ❒ | ❒ |
| have your child observed in the Center and to have all required screenings? *These may include developmental, speech and language, vision, and/or hearing. You will be informed about the need for any screenings and will receive a consent form prior to evaluation* | ❒ | ❒ |

Parent/Guardian Signature:_____
Date:_____

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# Child Care
# Policy and Fee Acknowledgement Form

This will acknowledge receipt and acceptance of Waldron Mercy Child Care's rules and regulations regarding the scheduling and tuition policies, a listing of the fees, registration fee and withdrawal requirements.

I agree to abide by the stated rules and regulations and further agree to be liable for payment of the current fees charged for providing our service.

Signature of Parent/Guardian:_____

Date:_____