# 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.

# 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** | BIRTH DATE |
| ADDRESS | |
| **MOTHER'S NAME/LEGAL GUARDIAN** | HOME TELEPHONE NUMBER |
| E-MAIL ADDRESS | MOBILE TELEPHONE NUMBER |
| ADDRESS | |
| BUSINESS NAME | BUSINESS TELEPHONE NUMBER |
| ADDRESS | |
| **FATHER'S NAME/LEGAL GUARDIAN** | HOME TELEPHONE NUMBER |
| E-MAIL ADDRESS | MOBILE 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 REACTIONS) |
| 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 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 _____

# 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<br>Mondays |

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

Child-Care Services
CACFP (Food Program: Breakfast-Lunch-PM Snack Mon-Fri)
Child Service Report (semi-annually)
Child-Centered Curriculum

| CHILD'S ARRIVAL TIME | CHILD'S DEPARTURE TIME | PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED<br>Name, address & Phone # |
|---|---|---|
| LATE FEE<br>$ 1.00/xx | PER MIN-HR | |

**Extra services to be provided at an additional fee if applicable**

N/A

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

# APPLICATION FOR DAY CARE SERVICES AT THANKFUL LEARNING CENTER, INC.

| | |
|---|---|
| NAME OF CHILD | BIRTH DATE |
| ADDRESS | |
| MOTHER'S NAME OR LEGAL GUARDIAN | FATHER'S NAME OR LEGAL GUARDIAN |
| MOTHER'S HOME ADDRESS | TELEPHONE NO – HOME |
| MOTHER'S BUSINESS ADDRESS | TELEPHONE NO - BUSINESS |
| FATHER'S HOME ADDRESS | TELEPHONE NO – HOME |
| FATHER'S BUSINESS ADDRESS | TELEPHONE NO - BUSINESS |
| NAME AND ADDRESS OF PERSON TO BE CONTACTED IN EMERGENCY (if parents not available) | TELEPHONE NO |
| NAME AND ADDRESS OF CHILD'S PHYSICIAN OR SOURCE OF MEDICAL CARE | TELEPHONE NO |
| SPECIAL DISABILITIES (IF ANY) | |
| ANY SPECIAL MEDICAL OR DIETARY INFORMATION NECESSARY FOR MANAGEMENT IN AN EMERGENCY SITUATION ALLERGIES, MEDICATIONS, OR SPECIAL CONDITIONS | |
| ANY ADDITIONAL INFORMATINO ON SPECIAL NEEDS OF THIS CHILD | |
| HEALTH INSURANCE COVERAGE FOR CHILD UNDER FAMILY INSURANCE POLICR OR MEDICAL ASSISTANCE BENEFITS (IF APPLICABLE) | |
| SIGNATURE OF PARENT OR GUARDIAN | DATE OF APPLICATION |
| PARENT OR GUARDIAN EMAIL ADDRESS | |

# Child and Adult Care Food Program
# Child Care Center Meal Benefit Income Eligibility Form

**Part 1. All Household Members**

**Name of Enrolled Child(ren):**

| **Names of all household members** (First, Middle Initial, Last) | CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM. | CHECK IF NO INCOME |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

**Part 2. Benefits:** If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

**Part 3.** If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless ☐ Migrant ☐ Runaway☐

**Part 4. Total Household Gross Income—You must tell us how much and how often**

| **A. Name** (List **only** household members with income) | **B. Gross income and how often it was received** | | | |
|---|---|---|---|---|
| | 1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Pensions, retirement, Social Security, SSI, VA benefits | 4. All Other Income |
| *(Example)* *Jane Smith* | $200/weekly | $150/twice a month | $100/monthly | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |
| | $_____/_____ | $_____/_____ | $_____/_____ | $_____/_____ |

**Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)**

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign Here: _____ Print Name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _ _ _ - _ _ - _ _ _ _ ☐ I do not have a Social Security Number

**Part 6. Participant's ethnic and racial identities (optional)**

| Mark one ethnic identity: | Mark one or more racial identities: |
|---|---|

## Child and Adult Care Food Program
## Child Enrollment Form (Sample)

Sponsor/Center Name: _____

Agreement #: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

| FULL NAME OF ENROLLED CHILD (Include Birth Date/Age | DAYS OF WEEK IN ATTENDANCE | TIMES CHILD NORMALLY ATTENDS DURING WEEK: TIME IN AM | TIME IN PM | TIME IN TIME | TIME OUT AM | TIME OUT PM | TIME OUT TIME | TIME CHILD ATTENDS SCHOOL: LEAVES CENTER | TIME CHILD ATTENDS SCHOOL: RETURNS TO CENTER | MEALS RECEIVED |
|---|---|---|---|---|---|---|---|---|---|---|
| FIRST CHILD<br>NAME<br>BIRTH DATE<br>AGE | ☐ MONDAY<br>☐ TUESDAY<br>☐ WEDNESDAY<br>☐ THURSDAY<br>☐ FRIDAY<br>☐ SATURDAY<br>☐ SUNDAY | | | | | | | | | ☐ BREAKFAST<br>☐ A.M. SNACK<br>☐ LUNCH<br>☐ P.M. SNACK<br>☐ SUPPER<br>☐ EVENING SNACK |
| ☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours<br>Other:<br>Enrollment Date: Withdrawal Date: | | | | | | | | | | |
| SECOND CHILD<br>NAME<br>BIRTH DATE<br>AGE | ☐ Same as Above<br>☐ MONDAY<br>☐ TUESDAY<br>☐ WEDNESDAY<br>☐ THURSDAY<br>☐ FRIDAY<br>☐ SATURDAY<br>☐ SUNDAY | | | | | | | | | ☐ Same Meals as Above<br>☐ BREAKFAST<br>☐ A.M. SNACK<br>☐ LUNCH<br>☐ P.M. SNACK<br>☐ SUPPER<br>☐ EVENING SNACK |
| ☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours<br>Other:<br>Enrollment Date: Withdrawal Date: | | | | | | | | | | |
| THIRD CHILD<br>NAME<br>BIRTH DATE<br>AGE | ☐ Same as Above<br>☐ MONDAY<br>☐ TUESDAY<br>☐ WEDNESDAY<br>☐ THURSDAY<br>☐ FRIDAY<br>☐ SATURDAY<br>☐ SUNDAY | | | | | | | | | ☐ Same Meals as Above<br>☐ BREAKFAST<br>☐ A.M. SNACK<br>☐ LUNCH<br>☐ P.M. SNACK<br>☐ SUPPER<br>☐ EVENING SNACK |
| ☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours<br>Other:<br>Enrollment Date: Withdrawal Date: | | | | | | | | | | |

Signature _____ _____ _____

*Signature of Parent or Guardian* *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

*Name of Representative/Signature* *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

**********

*In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.*

*Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.*

*To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:*

*(1) mail: U.S. Department of Agriculture*
*Office of the Assistant Secretary for Civil Rights*
*1400 Independence Avenue, SW*
*Washington, D.C. 20250-9410;*

*(2) fax: (202) 690-7442; or*

*(3) email: program.intake@usda.gov.*

*This institution is an equal opportunity provider.*

THANKFUL LEARNING CENTER, INC.
3200-02 N. 17th Street
Philadelphia, PA 19140
(215)226-5544
(215)226-2558( Fax)

# CIVIL RIGHTS COMPLIANCE
## PARENT AWARENESS

**In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your child(ren), as a client of this facility, have the right:**

- **To be provided services at this facility and to be referred for services at other facilities without regard to your race, color, religious creed, disability, ancestry, national origin, age, or sex.**

- **To file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, disability, ancestry, national origin, age, or sex.**

**Complaints of discrimination may be filed with any of the following locations:**

**City of Philadelphia**
**Department of Health**
**and Human Services**
**821 Market Street**
**Philadelphia, PA 19107**

**PA Human Relations Commission**
**Philadelphia Regional Office**
**110 N.8th Street**
**Suite 501**
**Philadelphia, PA 19107**

**Department of Public Welfare**
**Bureau of Equal Opportunity**
**Room 223, Health & Welfare Building**
**P.O. Box 2675**
**Harrisburg, PA 17105**

**Bureau of Equal Opportunity**
**Southeastern Regional Office**
**801 Market Street, Suite 5034**
**Philadelphia, PA 19107**

**Thankful Learning Center, Inc.**
**3200-02 N. 17th Street**
**Philadelphia, PA 19140**

_____
**Parent/Guardian Signature** **Date**

_____
**Director/Administrator Signature** **Date**

## AGREEMENT to TERMS of CONTRACT

I _____ have received a copy of the Parent/Guardian – Please print

Thankful Learning Center, Inc. handbook on _____ and
Date

Agree to the terms and conditions as stated within the guidelines.

_____ _____
Parent/Guardian Director



**Please Detach and Sign**

# Thankful Learning Center, Inc.

3200-02 North 17th Street
Philadelphia, PA 19140
(215) 226-5544

Thankful Learning Center
3200-02 N. 17th Street
Philadelphia, PA 19140
Telephone: (215) 226-5544
Fax: (215) 226-2558

February 15, 2016

ATTN: Parents of Enrolled Child at Thankful Learning Center

RE: Use of Vaseline

Dear Parents;

The Thankful Learning Center (TLC) would like parents to sign the consent form below allowing the staff at Thankful Learning center to apply Vaseline on your child skin when needed. The reason for TLC doing this is because many children come to the center each day with extremely dry skin; Dry skin can cause children to sometime scratch the area of the skin which may cause more irritation or possible infection. Vaseline is a safe lubricant that can be applied to the skin of children of all ages without causing irritation or any reaction to the skin. If your child requires anything else other than Vaseline to be applied to your child's skin, the center will need documentation from your child's Pediatrician on file. Again TLC thanks you for your ongoing support and please gives the consent form to the staff members in the office.

Sincerely,

Mrs. Johnnie Lee Williams, M. Ed.
Administrator

.....

I, (Print Name) _____ give TLC staff the permission to apply Vaseline to (Print Name) my child _____ skin when needed.

Signature _____ Date _____