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)

[illegible]

OBTAINING EMERGENCY MEDICAL CARE	ADMN. 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 ______________

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:

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

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.

Screening	Result
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:

MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133

PLEASE PRINT

Page ______ of ______

Child's Name: ______________________ Medication: ______________________

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO

If Prescription, Prescriber's Name: ______________________ Telephone: ______________

Dosage Amount: ____________ Time to Administer: ______ a.m. ______ p.m. ______ times/day

Dates for Administration: From ____________ (Date) To ____________ (Date)

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

____

____

I give permission to administer medication to my child as stated above.

______________________________ Parent Signature

______________ Date

FACILITY STAFF COMPLETE THIS SECTION

Date Administered (mm/dd/yyyy)	Time Administered (a.m./p.m.)	Amount of Medication Administered	Comments/Reactions	Staff Initials

This information is confidential and may not be shared or released without the parent's written permission.

Child Pick- up Authorization

I,___________________________authorize___________________________ SACC to release my child(ren) to the person(s) designated. This is in consonance with the _________________________ SACC Emergency Operations Plan.

Student's Name — Designated Custodian (s) Name & Relationship

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

____

Your Signature **Relationship** **Date**

____

Print Name

____

Address

____

Address

________________________ ________________________ ________________________

Home Phone **Work Phone** **Cell Phone**

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

PLEASE PRINT CLEARLY

LEBANON YMCA CHILD CARE GETTING TO KNOW YOU

Child's Name______________________________**Nickname (if any)**______________

Parent Names(s)____

Date________________________**CenterName**________________________________

Family Composition Questions:

1. Please list your child's household members (including relations and ages of siblings).

2. Are there any custody situations that you would like to share with us?

3. Is there any other information about your family's composition that you would like to share?

4. Does your family have any pets? Yes_____ No_____

Child Information:

1. Has your child been in an early learning program or childcare before?

   Yes___ No___

If so, which of the following?

____Family home care ____Relative/neighbor care ____Licensed provider

2. Are there any special concerns we should be aware of?
____Nail biting? ____Thumb Sucking? ____Stuttering?

3. Any special needs (medical, developmental, social, mental health)?

   a. Do any of these special needs require special care by our teachers? If yes, how?

b. Does your child have an IEP (Individualized Education Plan) or ISFP (Individualized Family Service Plan)? ____________

If so, we would like a copy of the plan so we can provide the best possible learning experience for your child.

What program or individuals work with you children in regards to these special needs? Would you sign a release of information with them so they can speak with us about how to provide enhance support to your child?

4. Does your child have any allergies?

____Food Allergies ____Environmental Allergies ____Allergies to medicine

How are your child's allergies treated?

Do you have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.)?

Questions for the Parent:

1. What are your expectations of our program?

2. Is there any information about your family's culture, ethnicity, languages, or religion that is important for us to know?

3. Is there any other information you would like to share about your child or do you have any questions about the program?