Enrollment Forms

St. Cyril Academy

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Hatfield PA 19440
StCyrilAcademy@gmail.com

CHILD HEALTH REPORT

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

⑥ 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):
⑥ 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.
⑥ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
⑥ 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.
⑥ 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?
⑥ YES ⑥ 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) ⑥ YES ⑥ 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:

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 _____

VERBAL REQUEST FOR RELEASE OF CHILD

55 PA CODE CHAPTERS 3270.117(c) and 3280.117(c) and 3290.116(c)

THIS FORM MUST BE COMPLETED TO DOCUMENT THE VERBAL REQUEST BY A PARENT FOR THE RELEASE OF A CHILD TO A PERSON(S) NOT INDICATED ON THE AGREEMENT
(CHAPTERS 3270.123(a)(5), 3270.124(b)(7); 3280.123(a)(5), 3280.124(b)(7); 3290.123(a)(5), 3290.124(b)(7)).

NAME OF CHILD	DATE	TIME
NAME OF REQUESTING PARENT	TELEPHONE NO. FROM WHICH PARENT IS CALLING	
NAME OF INDIVIDUAL TO WHOM THE CHILD IS TO BE RELEASED ➤		
NAME OF STAFF PERSON TAKING THE CALL ➤		

CALL THE ENROLLING PARENT BACK TO CONFIRM THE INFORMATION IF POSSIBLE

CONFIRMING PARENT	DATE
NAME OF STAFF PERSON CONFIRMING INFORMATION	TIME

_____ _____
NAME OF STAFF PERSON RELEASING CHILD DATE

BE SURE TO ASK FOR IDENTIFICATION WHEN THE INDIVIDUAL ARRIVES TO PICK UP THE CHILD

Your Child's Health

CHILD'S HEALTH RECORD: (A copy of your child's immunizations and current physical will be needed)

General state of health:

_____

Doctor's name:

_____

Doctor's phone number:

_____

Dentists' name:

_____

Dentists' name:

_____

Are your child's immunizations up to date? _____

(Please attach a copy of immunizations. This should include the signature of nurse or doctor who administered medications.)

Does your child have any known allergies?

_____

Are you concerned that your child may be prone to any type of allergies?

_____

Describe:

_____

Does your child have any medical conditions which I should be made aware of?

_____

Has your child had the following common childhood illnesses? (*please circle*)

Does your child have any problems with any of these?	Has your child had any of these diseases?
Constipation	Asthma
Convulsions	Bronchitis
Diarrhea	Chicken Pox
Fainting Spells	Diabetes
Frequent Colds	Heart Disease
Frequent Ear Infections	Hepatitis
Frequent Sore Throats	Impetigo
Lice	Measles
Ringworm	Mumps
Skin Rash	German Measles
Soiling	Polio
Stomach Upsets	Scarlet Fever
Urinary Problem	Tuberculosis
Worms	Whooping Cough

Does your child have any speech, hearing or visual problems?

_____

_____

Would there be any restrictions to play or activities?

_____

_____

About Your Child

Has your child ever been in child care before?_____ What type (center, family daycare, grandma etc.)_____

Was it a positive experience?

_____

Why are you looking for child care?

_____

Are there any siblings? Please name them and specify ages and gender.
Name _____ age _____ gender _____
Name _____ age _____ gender _____
Name _____ age _____gender _____
Has your child had experience playing with other children?

_____
What language(s) are spoken at home?

_____

Does your child have any security objects such as a blanket, soother, bottle, toy etc?

_____

What are your child's favorite activities, toys, books, or games?

_____
Are there any other comments or information you would like to let me know about?

_____

Any specific concerns?

_____
_____
_____

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	DAY PAYMENT TO BE MADE
Services to be provided as part of the day care fee (example; transportation, care, meals, etc.)		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASE
LATE FEE $	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/parent consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE

Field Trip Permission Slip

I grant St. Cyril Academy Daycare, my child's daycare provider, permission to take my child, _____, on a field trip.

Date:_____

Start time:_____

Return time:_____

Parent's Signature

_____

Date_____