Enrollment Form

Enrollment Date ____________
Child's Name ________________________________
Nickname __________________________________
Age ___________ Child's DOB __________________________
Address ____
City ____________________________________ State ____ Zip ____________

Contact Info:
Mom's Name ____
Mom's Drivers License # _______________________________ State ___________
Mom's Social Security # ____
Mom's Email address: ____

Dad's Name ____
Dad's Drivers License # ________________________________State ___________
Dad's Social Security # ____
Dad's Email address: ____

Phone Info:

Mom Home ___________________________ Dad Home ___________________________

Mom Work ___________________________ Dad Work ___________________________

Mom Cell ____________________________ Dad Cell ____________________________

Emergency Contact Person ____

Contact's Phone ____

Emergency Contact Person ____

Contact's Phone ____

Do you have a backup care provider? ____

Service Info

Beginning date needing care ____

Indicate hours Mon ________ Tues _______ Wed _______ Thurs _______ Fri _______

YOUR 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 ________________________

Dentist's name ____________________________ Dentist's phone ________________________

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 known allergies?____

Are you concerned that your child may be prone to any type of allergies? ________ If so, please describe ____

____

Does your child have any medical conditions which I should be made aware of?_______ If so, please explain____

____

Does your child have any medications which I should be made aware of? __________________

____

Does your child have any problems with any of these? (circle all that apply)

Asthma	Bronchitis	Chicken Pox	Diabetes	Heart Disease
Hepatitis	Frequent Sore Throat	Lice	Ringworm	Skin Rash
Soiling	Stomach Upsets	Urinary Problem	Worms	Impetigo
Measles	Mumps	German Measles	Polio	
Scarlet Fever	Tuberculosis	Whooping Cough		

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

Are 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 recent traumatic situations the child has been exposed to such as a death in the family, divorce, new sibling, etc? ____

What is your normal method of discipline? ____

What is your child's temperament? Are they easy going, hard to please, demanding, aggressive?

____

Are there any food/dietary restrictions? ____

Can your child be relied upon to indicate bathroom wishes? ______________________________

What words does your child use for bowel movements or urination? _______________________

____

What time does your child awaken?____

What time does your child go to sleep at night? ______________________________________

Do they sleep through the night?____

Does your child sleep in a bed, crib or other? _______________________________________

Are there any siblings? Please name them and specify ages and gender

Name ________________________age _______ 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? ___________________________

____

In the event of an emergency involving my child, and Big Leaps Learning Center cannot reach me for whatever reason, I hereby authorize any necessary medical care. I will also agree to be fully responsible for any and all medical expenses relating to the treatment of my child.

Parent's signature _____________________________________ Date _____________________

I give express permission for Big Leaps Learning Center to use any photographs or video recordings of my child on their website and Facebook page. These pictures and videos will not be used for any other reasons.

Parent's signature _____________________________________ Date ______________________

Is there any other 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 (examples: transportation, care, meals, etc)

Services include the care and supervision of the child. An indoor and outdoor play area and nap/rest time is also provided for each child. Except for infants, meals and snacks are provided. In addition, an age appropriate curriculum will be provided in a positive and secure learning environment to develop overall skills.

Child's Arrival Time	Child's Departure Time	Person(s) designated by parent to whom child may be released
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 (§ 3270.124,3280.124,3290.124)
- ☐ Agree to update the emergency contact/parental 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

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

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: