TODDLER TOWN ELC LLC
1937-39 W. LEHIGH AVENUE, PHILADELPHIA, PA 19132
(267) 928-3511

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 $	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 $	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 minimum. (§ 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.

Child's Health History

Does child have any known health problems? Yes ( ) No ( ) (If yes, attach documentation)

Check (√) any of the following illnesses the child has had:

□ Asthma	□ Earaches	□ Mumps	□ Whooping Cough	□ Bronchitis
□ Eczema	□ Pneumonia	□ Polio	□ Chicken Pox	□ Frequent Colds
□ Croup	□ Convulsions	□ Measles	□ Influenza	□ Rheumatic Fever
□ Diphtheria	□ Tonsillitis	□ Other_____		

Please list any injuries child has had_____

_____

Does your child have any known allergies? Yes ( ) No ( ) If yes, what are they and what are your child's reactions:_____

_____

Does your child take any medication on a regular basis? Yes ( ) No ( ) If yes, please list the name of the medication(s) and the medical condition for which it is taken:

_____

_____

Do you have any concerns about your child's development? Yes ( ) No ( ) If yes, please comment: _____

_____

Please comment on any other medical information/or special need the child care provider should be aware of: _____

_____

_____

I authorize the child care provider/staff to obtain the following services for this child if necessary: Public Health Nurse, Physician and/or Ambulance in the event of an emergency. (ambulance fees and/or health care cost are the responsibility of the parent/guardian)

_____ _____

(Date) (Signature of parent/guardian)

_____ _____

(Signature of child care provider) (Signature of parent/guardian)

Excursion & Transportation Consent

I hereby give permission to _____
(name of provider or child care)

for my child_____for the following:
(name of child)

□ To participate in excursions not involving transportation such as walks in the neighborhood, walks to the playground, parks and libraries.

□ To participate in excursions involving public or private transportation to location such as, libraries, parks, playgrounds, museums and pet stores.

Comments or Exceptions:

_____

_____

_____

Date:_____ Parent/Guardian signature: _____

Excursion & Transportation Consent

I hereby give permission to _____
(name of provider or child care)

for my child_____for the following:
(name of child)

□ To participate in excursions not involving transportation such as walks in the neighborhood, walks to the playground, parks and libraries.

□ To participate in excursions involving public or private transportation to location such as, libraries, parks, playgrounds, museums and pet stores.

Comments or Exceptions:

_____

_____

_____

Date:_____ Parent/Guardian signature: _____

EMERGENCY – PERMISSION CARD

Provider's Name:_____ Date: _____
Address: _____

Child's Photo

Date:_____
Child's Name_____
Hair Colour: _____
Eye Colour: _____
Birth Date: _____
Address: _____
Home Phone:_____

Mother's Name:_____ Work Phone:_____
Father's Name:_____ Work Phone:_____
Mother's Home Phone:_____ Father's Home Phone:_____
Emergency Contact:_____ Phone:_____
Address:_____
Child's Doctor:_____ Phone:_____
Child's Health #: _____ _____ ID#:_____
Allergies:_____
Medical Condition:_____
Child's Dentist:_____ Phone: _____

It is the child care provider's policy to notify a parent when a child is ill or in need of medical attention. Occasionally we are unable to contact parents, and we need to get immediate help for the child.

Our procedure is to have the child taken to the nearest emergency service by ambulance. (Ambulance fee is the parent's responsibility.)

If an Ambulance is not available the child care provider/staff of the child care will transport the child.

I hereby give permission to the child care provider/staff of _____
(name of child care home)
to make necessary transportation arrangements for my child _____
_____who has become ill or injured.
(name of child)

_____ _____
Signature of parent/guardian Signature of parent/guardian

_____ _____
Date Signature of provider