Getting to Know You Meeting

Child's Name:_____

Names of Meeting Attendees:_____
_____

Enrollment Date:_____ Meeting Date:_____

Family Information

Tell me about the people in your household:_____
_____

Does your child have any parents that do not live in the home?_____

If yes, does your child visit this parent?_____

Are there any custody issues we should know about?_____

Does your child have any siblings?_____

Child Information

What type of pregnancy did you experience? Full-Term__ Premature__
If premature, how many weeks?_____

Were developmental milestones met?_____If yes, are you receiving any early intervention services such as PT or OT?_____

If no, would you be interested in receiving information if services are needed?_____

Has your child been in child care before?_____If yes, would you share information with us? (Where, When, For how long?)_____

What kind of care (family day care home, relative/neighbor care, group, center)?_____

Is there a reason for leaving that program?_____
_____

Are there any special problems or fears that we should know about?_____

Does you child have any imaginary friends?_____

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

Does you r child have an IEP (Individual Service Plan or ISFP (individual 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 your 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 support to your child?_____

Does your child have allergies?_____

~Food Allergies(doctor's documentation should be provided by parent)_____

~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.)?_____
_____

Any other medical or special needs?_____

Describe your child's schedule:
~Normal bedtime, waking time, nap time and duration_____
_____

~Does your child have a different schedule at any other child care setting (babysitter, relative/neighbor care, school)?_____
_____

Is your child toilet trained?_____

Is there information that will help us make the first few days in our program easier for your child?_____
_____

Is there any other information you would like to share that was not addressed?_____
_____

Parent Information

What are your expectations of our program? (explain structural play)_____
_____

Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know? Would you and/or your family like to be a resource for any cultural awareness activities?_____
_____

Are you willing to be a volunteer in a classroom?_____

Are there any other ways you would like to be involved?_____

What times are best for us to reach you and for you to come in for parent conferences?_____
_____

Tell me about your child's:
~Favorite Toys_____

~Other_____

Is your child positive about the program, other children, and teaching staff?_____

_____
Signature of Parent Date

_____
Signature of Director 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.

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 _____

Individual Education Plan (IEP) & Individual Family Service Plans (IFSP)

Due to the diverse set of needs of the children it is important to obtain as much information as possible about each child. At Early Learning Children's Academy your child's growth and development is tracked through developmental assessments and child service reports. If your child has an IEP or an ISFP in place it would be beneficial if we had a copy of this information so that we may best meet the needs of your child. This information will assist us in putting the necessary guidelines into place for your child's daily experience at the center.

Although it is beneficial that you share this information with us, you are not required to provide us with a copy if you do not wish to do so.

Parent Sign Off

Child's Name:_____

□ I am providing a copy of my child's IEP or IFSP.

□ I am not providing a copy of my child's IEP or IFSP and/or this in not applicable to my child.

_____ _____

Parent/Guardian Name (Please Print) Date

_____

Parent/Guardian Signature

Permission for Photography

I allow my child _____ to be photographed and for these photographs to be reproduced for the purpose of Early Learning Children's Academy promotional materials.

Promotional materials will be, but not limited to, brochures, official Early Learning Children's Academy Facebook page(s), mailing materials, bulletin boards, signage, official Early Learning Children's Academy website(s) and any other promotional and marketing materials that may be produced by Early Learning Children's Academy. My child's photography will not be sold or given to any third party or used for any other purpose than what is listed above.

_____ _____

Parent(s) Name Parent(s) Name

_____ _____

Parent(s) Signature Parent(s) Signature

_____ _____

Date Date