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 _____

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "**Sources of Income for Children**" chart will help you with the Child Income section.

The "**Sources of Income for Adults**" chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

How often?

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/Social Security/SSI/VA Benefits	Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

How often?

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - _ _ _ _

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Address

City

State

Zip

Phone/Email

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Dear Parents:

A component of our education program includes screenings in the following areas of development: cognitive, motor, social-emotional, speech/language, and hearing. These screenings must be completed within 45 days of your child's initial entry into the program. The assessment is done thru the Ages and Stages.

Information about the screening tools we use is on the back of this letter. You will receive a "results" letter after each screening is completed.

I give permission for my child, _____, to be screened in the following areas:

☐ **All 4 areas of development (Cognitive, Speech& Language, Social-Emotional, and Hearing)**

☐ Overall Development (cognitive, motor, and language) ONLY
☐ Speech & Language Development ONLY
☐ Social-Emotional Development ONLY
☐ Hearing ONLY *Does your child have tubes? ☐ YES ☐ NO

☐ I do NOT want my child to receive ANY developmental screenings

☐ **My child has a current IEP through Pittsburgh Public Schools, Early Intervention Program or Allegheny Intermediate Unit/DART.**

Parent/Guardian Signature: _____

Screening tools briefly look at children's skills in comparison to other children, their own age, nationwide. These tools give us a snapshot of where a child is at one particular moment in time. Some children demonstrate skills in everyday situations that are not exhibited during the screening process. Other children may make accurate guesses that give misleading scores. If you have any concerns about your child's development that are not indicated on the screening, please call us and we can discuss your concerns and resources that may be available. Please remember to keep the lines of communication open with your child's classroom teachers. Throughout the year they will be identifying individual goals for your child to work on to build his/her skills.

If you have any questions about the screening process, your child's results, or the agencies we collaborate with, please call us. Also, please feel free to contact us at anytime if you need assistance with referrals for evaluations or additional services for your child.

ATTACHMENT 6
CHILD PICK-UP AUTHORIZATION

I, _____ authorize Mt. Washington Children's Center to release my child(ren) to the person(s) designated. This is consonance with the Mt.Washington Children's Center Emergency Operations Plan.

Child's Name	**Designated Custodian Name and Relationship**
_____	_____
_____	_____
_____	_____

_____

Your Signature Relationship Date

_____

Print Name

_____

Address

(Home Phone) (Work) (Cell)

NOTE: Parents and guardians should designate themselves as designated custodians. Friends, neighbors and other relatives may also be designated.
PLEASE PRINT CLEARLY.

MOUNT WASHINGTON CHILDREN'S CENTER
200 Southern Avenue, Pittsburgh, PA 15211

Childcare Information Service (CCIS)

These policies and regulations are written by CCIS. The center must adhere to these policies, as we have a signed contract with CCIS. We are required to adhere to the below stated regulations and appreciate your cooperation with contract compliance. Any deviation will jeopardize not only your child's enrollment, but all the children enrolled through CCIS.

There is a deposit or one week's tuition due upon entry, along with one week's tuition. (E.g. if your tuition is $20.00 per week, you will need $40.00 to enroll your child.) The $20.00 deposit will be used as your last week's payment, or refunded to you when you leave the program. This deposit is not credited toward tuition until your last week of service.

All tuition payments are due each **MONDAY by 6:00 p.m**. You may count the Mondays in the month and pay for the entire month if you so desire. However, you cannot be late with a payment and must always pay in advance.

FAILURE TO PAY ON TIME WILL RESULT IN:

1. The center reporting to CCIS that the payment has not been received.

2. CCIS issuing a termination notice even if your payment is received the next day, and the notice will be recorded. After four notices, your child will not be permitted to return to the program.

Any child absent for **FIVE** consecutive days (for whatever reason—illness, vacation, etc.) must be reported to CCIS. After those five days, CCIS will issue a termination notice. Children enrolled in the CCIS program are only permitted to miss 25 days per year.

CCIS will review certain circumstances on an as needed basis.

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Overall Developmental (Cognitive, Motor, and Language)
We use the Speed DIAL 4 (a Shorter version of the *Developmental Indicators for the Assessment of Learning-Third Addition)* and/or the ESI-R (Early Screening Inventory, Revised) for our developmental screening. These screenings give information about developmental skills such as how your child uses his/her body (motor skills), knowledge of basic concepts like colors (conceptual skills), and use of her language. The skills listed above have proved important in predicting a child's success in a classroom. These screening tools can help identify if your child's skills are appropriate for his/her age or if further testing may be appropriate.

Speech & Language
We have two contracted agencies to provide the speech/language screenings to Head Start Children in accordance to the Head Start Performance Standards. Rehabilitation Specialists, Inc. will be providing these screenings at the following sites: Overbrook, Hazelwood, Loreto, Rochelle St, and all ECE sites. River Speech and Educational Services will be providing these screenings at the Dorseyville site.

Social-Emotional Development
For our social-emotional screening we use the Preschool and Kindergarten Behavior Scale, Second Edition, also known as the PKBS-2. This screening tool looks at social skills, such as how he/she gets along with the teachers, other children, and how independent he/she is, and problem behaviors, such as acting out behaviors (kicking, hitting, biting, etc.) and/or internal behaviors (excessive shyness, separation anxiety, etc.). This is a checklist that is completed by your child's teachers based on their observations of your child in the classroom. The results allow the teachers to plan activities according to each child's strengths and weaknesses, as well as determine whether or not extra assistance may be needed in the classroom.

Hearing Screenings
A hearing screening has two parts. Tympanometry is a measure of your child's middle ear that can indicate fluid build-up, ear infection, and/or ear wax. Pure tone screening is a measure of how your child hears sounds of different frequencies.

If your child has allergies, tubes in his/her ear, or a cold, it can cause him/her to fail the hearing screening. A failed hearing screening can also mean that your child has an ear infection or possible hearing loss. If your child pulls on his/her ear, runs a fever, complains of ear pain, or doesn't seem to hear you on a frequent basis, please call your doctor.

Rehabilitation Specialists, Inc. will be providing the hearing screenings for all sites.

Mt. Washington Children's Center has prepared an emergency evacuation plan for our facility. The plan outlines procedures for site evacuation, severe weather, and security incidents. This plan is posted in each classroom if you would like to read it in its completed form. Below is an outline of how the MWCC children will follow the plan for the defined emergencies:

Site Evacuation- The Center is evacuated in the event of a fire, gas leak etc. either at the site or in its close proximity to the site which require evacuation of our site.

- We evacuate to the St. Justin's Plaza 120 Boggs Avenue
- Children will walk to the site. The Director will coordinate that portion of the evacuation.
- Attendance records will accompany the class and head counts will be taken prior to leaving the site and upon relocation.
- Parents will be notified as soon as the children have been safely relocated

Severe Weather- In the event that a Sever Weather /Tornado Warning is broadcast as an imminent danger to the MWCC the following action will be taken:

- All personnel will be notified to take shelter in the designated area. Our designated area is the hallway, bathrooms, and Directors office. All doors will be closed and areas of the doors kept clear to prevent injury
- A weather radio will be relocated to the safe area
- Classroom flashlight and current attendance roster will accompany the teacher to the safe area
- Head count will be taken to ensure all children are present in the safe area and then reported to the Director
- When the storm has passed, and clear has been given, the building will be inspected for damage. If damage is present there will be restricted access to the damaged area and arrangements will be made to get the children home. If no damage is present everyone may return to normal activities.

Security Incidents-These are procedures for increased security at MWCC when advised by local law enforcement or emergency management agencies. When an alert message is received by the Center to increase security or lock down the following will occur:

- All staff will be notified that a lock down is in effect
- All children and staff will be recalled from outside activity to the security of the building
- All outside doors will be locked
- All windows will be closed and locked
- A head count will betaken to ensure all children are present and information will be given to the Director
- Parents/Guardians will be notified of the situation and advised on how to proceed
- When lock down is in effect no one may enter or exit the building except law enforcement agents until all clear has been given
- Parents will not be able to pick up their children until law enforcement has given the clear.

Hopefully we will never have to use any of these plans, but they are in place to keep your child safe. If you have any questions please ask the Director at drop-off or pick-up or call on the telephone.

PARENT HANDBOOK CONFIRMATION FORM

I, the undersigned, understand what I have read and agree to the policies and procedures as written in the Mt. Washington Children's Center Parent Handbook to ensure the health and wellbeing of my child(ren), other children in care, and those responsible for their childcare.

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

THIS FORM MUST BE SIGNED IN ORDER TO ENTER THE PROGRAM.

MOUNT WASHINGTON CHILDREN'S CENTER
200 Southern Avenue
Pittsburgh, PA 15211
Ph. 412-381-1515

MT. WASHINGTON CHILDREN'S CENTER
200 SOUTHERN AVENUE
PITTSBURGH, PA. 15211

I give my permission to the Mt. Washington Children's Center staff to apply

Sunscreen ☐
Lotion ☐
Diaper Cream ☐

To: _____
Child's Name

Items must be supplied by parents.

_____ _____
Signature Date

In response to the growing focus on child care issues, specifically concerning the liability and insurance, the Board of Directors of Mt. Washington Children's Center has expanded the Department of Public Welfare's policy concerning the release of children to parents or other designated adults who appear to the center's staff to be in an impaired condition.

An impaired condition specifically relates to alcohol, mind-altering chemicals or other medical conditions that render a person unable to operate a motor vehicle and thereby endanger the safety of the child who would be transported by the impaired person.

If, in the judgment of the responsible personnel at the center, a parent or designated person appears to be unable to safely transport a child, the center personnel will ask the parent or designated person to arrange for alternative transportation. If the person is unwilling to provide such alternative transportation, the matter will be referred to the Pittsburgh Police before the child is released for transport.

The board recognizes that this is a stringent policy, but we are morally and perhaps could be even legally responsible if we would release a child to an impaired person.

Hopefully, the necessity to implement the policy will not arise, but should it, cthe parents/designated person must be apprised of the policy.

This will be an addendum to the Policy and Practice of the Mt. Washington Children's Center which is in your child's school file.

Please sign and return this paper to the center as soon as possible to avoid misplacing it.

_____
Mother 's Signature

_____
Father's Signature

_____
Guardian Signature

MOUNT WASHINGTON CHILDREN'S CENTER
200 Southern Avenue, Pittsburgh, PA 15211
412-381-1515
mwcc15@yahoo.com

ELN Child & Family Information

Child Demographics

Child's First, Middle, and Last Name:_____

Ethnicity:☐ Hispanic ☐ Non Hispanic ☐ Other

Race: Please check all that apply
☐ American Indian/Alaskan Native ☐ Asian ☐ White
☐ AfricanAmerican/Black ☐ Native Hawaiian/Pacific Islander
☐ Other
Gender: ☐ Female ☐ Male

Date of Birth: ___/___/_____

Last 5 digits of Social Security Number:_____
Is English the first language of the child ☐ Yes ☐ No

Parent/Legal Guardian Information

Mother/Legal Gaurdian's First, Middle, and Last Name_____
Date of Birth:_____

Relationship to child: ☐ Biological ☐ Adoptive ☐ Foster ☐ Stepparent ☐ Other ☐
Does mother/legal guardian have custody of the child? Y N (please circle)

Does child live with mother/legal guardian? Y N Part of the time

Mother/legal guardian street address:_____

City:_____State:_____Zip Code:_____

County:_____School District:_____

Phone Number:_____Email Address:_____

Child Health Information:

Child's birth weight: ☐ Normal (5.8 lbs. or greater) ☐ Low (between 3.4/5.7 lbs.)
Very low (less than 3.4 lbs.) ☐ ☐ Unknown

What type of insurance does the child currently have? ☐ CHIP ☐ Medical Assistance ☐ Private Insurance ☐ None ☐ Unknown

Has a doctor diagnosed the child with any of the following? ☐ Anemia ☐ Asthma ☐ Diabetes ☐ Obesity ☐ None

Based on the American Academy of Pediatric Standards, are the child's immunization up to date? Y N (please circle)

Does the child see a physician regularly? Y N
Does the child see a dentist regularly ? Y N

Household Information

How often do the members of the household read to the child? ☐ At least once a day ☐ At least once a week ☐ At least once a month ☐ Less than once a month

How many children's books are in the home (may include library books)? ☐ fewer than 5 ☐ 5-10 ☐ 11-20 ☐ More than 20

Is the child homeless? Y N
Is the child adopted ? Y N

How many siblings (related by blood, marriage, or adoption) reside in the child's household?_____

Including the child, how many people live in the household?_____

In the household, how many people are over the age of 18?_____

Language(s) spoken in the home:_____/_____/_____

What is the annual household income level? ☐ $5,000 or less

☐ 10,001-15,000 ☐ 15,001-20,000 ☐ 20,001-25,000 ☐ 25,001-30,000

☐ 30,001-$35,000 ☐ 35,001-40,000 ☐ 40,001-45,000 ☐ 45,001-50,000

☐ 50,001-60,000 ☐ 60,001-70,000 ☐ 70,001-100,000 ☐ over 100,000

Mother/legal guardian's highest level of education:
☐ Up to 8th. Grade ☐ 9th-11th grade ☐ High School Diploma/GED/Vocation Tech Program after high school ☐ Some College ☐ Associates Degree ☐ Bachelors Degree ☐ Graduate/Professional degree

Mother/Legal guardian employment status: (please check all that apply)

☐ Full Time (30 hrs/week and over) ☐ Part time (fewer than 30 hrs/week)

☐ More than one part time ☐ Seasonal ☐ Full time Student ☐ Part time Student

☐ Unemployed

Father/Legal Gaurdian's First, Middle, and Last Name_____
Date of Birth:_____

Relationship to child: ☐ Biological ☐ Adoptive ☐ Foster ☐ Stepparen ☐ Othe ☐
Does mother/legal guardian have custody of the child? Y N (please circle)

Does child live with mother/legal guardian? Y N Part of the time

Mother/legal guardian street address:_____

City:_____State:_____Zip Code:_____

County:_____School District:_____

Phone Number:_____Email Address:_____

Father/legal guardian's highest level of education:
☐ Up to 8th. Grade ☐ 9th-11th grade ☐ High School Diploma/GED/Vocation Tech Program after high school ☐ Some College ☐ Associates Degree ☐ Bachelors Degree ☐ Graduate/Professional degree

Father/Legal guardian employment status: (please check all that apply)

☐ Full Time (30 hrs/week and over) ☐ Part time (fewer than 30 hrs/week)

☐ More than one part time ☐ Seasonal ☐ Full time Student ☐ Part time Student

☐ Unemployed

Which of the following outreach activities has any member of the household received in the last year? *Please check all that apply*

☐ Emergency/Crisis Intervention ☐ Housing Assistance (subsidies, utilities, etc)

☐ Transportation Assistance ☐ Mental Health Services ☐ English as a Second Language ☐ Job Training ☐ Substance Abuse Prevention or Treatment

☐ Domestic Violence Services ☐ Health Education ☐ Marriage Education

☐ Child Abuse and Neglect ☐ Parenting Education ☐ Assistance to Families of

Incarcerated Individuals ☐ Assistance in obtaining health insurance ☐ Assistance

In identifying health care providers ☐ Unknown ☐ None ☐ Child Support

Child and Adult Care Food Program
Child Enrollment Form (Sample)

Sponsor:_____
Center:_____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIMEOUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD NAME BIRTH DATE AGE	☐ Same as Above ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIMEOUT**			**TIME CHILD ATTENDS SCHOOL**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ **MONDAY** ☐ **TUESDAY** ☐ **WEDNESDAY** ☐ **THURSDAY** ☐ **FRIDAY** ☐ **SATURDAY** ☐ **SUNDAY**									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIME OUT**			**TIME CHILD ATTENDS SCHOOL**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIMEOUT**			**TIME CHILD ATTENDS SCHOOL**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FOURTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M.SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		TIME-IN			**TIMEOUT**			**TIME CHILD ATTENDS SCHOOL**		
	☐ *Same Times as Above*	**AM**	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FIFTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours Other: **Enrollment Date:** **Withdrawal Date:**										

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Application

Child's Name:_____ _____
First Middle Last Nickname

Birth date:____/___/____ Sex: ☐ Male ☐ Female

Home Address:_____Zip:_____ Phone:_____

Mother's Name:_____

Home Address:_____Zip:_____Phone( )_____

Work Address:_____Zi:_____Phone:_____

Occupation:_____Marital Status: ☐ M ☐ S

Father's Name:_____

Home Address:_____Zip:_____Phone( )_____

Work Address:_____Zi:_____Phone:_____

Occupation:_____Marital Status: ☐ M ☐ S

PERSONS TO BE CALLED IN CASE OF EMERGENCY:

NAME:_____RELATIONSHIP TO CHILD:_____

ADDRESS:_____ZIP:_____PHONE:_____

NAME:_____RELATIONSHIP TO CHILD:_____

ADDRESS:_____ZIP:_____PHONE:_____

CHILD'S PHYSICIAN: DR._____PHONE: _____

HEALTH INSURANCE COVERAGE:_____POLICY/ID NO._____

Please list any allergies, medications, handicaps or other notes that staff should be made aware of:_____

Application Date:__/__/__ Enrollment Date:__/__/__ Withdrawal Date:__/__/__

Parent's Signature:_____ (over please)

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Application

PARENT PERMISSION

I Hereby grant permission for my child, _____to use all the play equipment and participate in all of the activities of the school. I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks, or for field trips in an authorized vehicle.

Does your child require any special care while being transported (i.e. seizures, motion sickness)? Please give instructions for special care:

_____

_____

_____

I hereby grant permission for the Director, or Acting Director to take whatever steps are necessary to obtain emergency medical care if warranted.

Signed:_____, Mother Date:___/___/_____

Signed:_____, Father Date:_____/____/____

The Mt. Washington Children's Center admits students of any race, color, national and ethic origin to all the rights, privileges, programs

Mount Washington Children's Center
"Getting to Know You"

Child's name: _____ Age: _____ Today's date: _____
Mother's name: _____
Father's name: _____
Sibling(s) name and age: _____
Child lives with: _____

In what language do you and your child communicate at home?

_____

Has your child attend preschool before? If yes, where?

_____

How does your child react to other children and adults?

_____
_____
_____

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

_____
_____

Does your child have allergies? If yes, please explain:

_____
_____

Are there any medical or special needs (diet, etc.)?

_____
_____

Does your child have an IFSP or IEP? If yes, please discuss:

_____
_____

Describe your child's normal daily schedule (include toileting and napping behaviors):

_____
_____
_____
_____

Tell me about your child's favorite toys:

_____
_____
_____

Likes and dislikes (include foods, etc):

_____
_____

Are there cultural or religious holidays that your family observes that you would like to share with the program?

Any other information you would like to share about your child, you, or your family?

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.