



A Child's Place

Handbook Signature Page

I/We, _____ the parents of _____, have received, read, had the opportunity to ask questions about, understand and agree to abide by the policies set forth in the A Child's Place parent handbook.

Furthermore, I/We agree to abide by the policies set forth in the manual. I/We understand that the policies described in the Parent Handbook are not conditions of enrollment, and the language does not create a contract between A Child's Place and the parents. ACP reserves the right to alter, amend, or otherwise modify these guidelines, in its sole discretion, without prior notice.

I/We also understand that future questions regarding policies in the parent handbook may be directed to the center Director or corporate office.

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Parent/Guardian Signature

Date

Parent/Guardian Signature Date

Date



A Child's Place

Tuition Agreement

Child's Name _____

Fee Amount: _____ Per Week **Payment Due: Monday before care**
Services to be provided as part of the tuition: (ie: full time or part time childcare)

Child's Arrival Time: _____ **Child's Departure Time:** _____

Late Fee: \$1.00 per minute after 6:00pm and a \$15.00 late fee will be assessed on Tuesday if tuition is not paid by the close of business on Tuesday.

School: (Check One) Warminster Blue Bell

Person(s) designated by parent to whom child may be released:

I, the parent/guardian: (Please initial)

____ received/accessed online A Child's Place Parent Handbook at the time of enrollment

____ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum

____ agree to pay any legal fees incurred by A Child's Place if an attorney or collection agency is required to collect any unpaid tuition. ***By typing your name below, You agree that this is valid as your signature.**

Signature Of Parent Or Guardian

Date

Signature - Operator

Date

PERIODIC REVIEW

Signature Of Parent Or Guardian

Date

<p>FOR OFFICE USE ONLY:</p> <p>Additional services and /or benefits if applicable _____</p> <p>_____</p>
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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

7 < - @ B B 5 A 9		BIRTH DATE
ADDRESS		
A C H < 9 F B B 5 A 9 # @ ; 5 @ ; 1 5 F 8 - 5 B		HOME TELEPHONE NUMBER
E-MAIL ADDRESS		MOBILE TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
: 5 H < 9 F B B 5 A 9 # @ ; 5 @ ; 1 5 F 8 - 5 B		HOME TELEPHONE NUMBER
E-MAIL ADDRESS		MOBILE TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
9 A 9 F ; 9 B 7 M 7 C B H 5 7 H D 9 F G C B F G L	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
D 9 F G C B F G L H C ' K - C A ' 7 < - @ ' A 5 M 6 9 ' F 9 @ 5 G 9 8	NAME	ADDRESS
B 5 A 9 ' C : ' 7 < - @ B B ' D < M G 7 - 5 B # A 9 8 - 7 5 @ 7 5 F 9 ' D F C J - 8 9 F		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)
D 5 F 9 B H G ' G ; B 5 H I F 9 ' G ' F 9 E I - F 9 8 ' : C F ' 9 5 7 < ' H 9 A ' 6 9 @ C K ' H C ' - B 8 - 7 5 H 9 ' D 5 F 9 B H 5 @ 7 C B G 9 B H		
C 6 H 5 - B - B ; ' 9 A 9 F ; 9 B 7 M A 9 8 - 7 5 @ 7 5 F 9		5 8 A - B ' C : ' A - B C F : ' F G H ' 5 - 8 ' D F C 7 9 8 1 F 9 G
WALKS AND TRIPS		SWIMMING
TRANSPORTATION BY THE FACILITY		WADING

D 9 F - C 8 - 7 ' F 9 J - 9 K

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

Child Health Assessment

Parents & Child Care Providers 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:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at <www.aap.org> or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
____ IN/CM % ILE ____	____ LB/KG % ILE ____	(Birth to Age 2) ____ IN/CM % ILE ____	(Beginning at age 3) ____ / ____

PHYSICAL EXAMINATION	<input checked="" type="checkbox"/> = NORMAL	If ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

NONE

NEXT APPOINTMENT - MONTH/YEAR:

Medical care Provider:	Signature of Physician or CPNP:		
Address:			
Phone:	License Number:	Date Form Signed:	

Parents may write immunization dates, health professionals should verify and complete all data.



A Child's Place

Getting to Know You Form

Child's Name: _____

Names of Meeting Attendees: _____

Enrollment: _____ Meeting Date: _____

Attached list of information shared in written form.

5A-@M-B: CFA5HCB

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 that we should know? _____

Does your child have any siblings? _____

7<=@'B: CFA5HCB

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? _____

continued...

Getting to Know You Form

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Does your child have any imaginary friends? _____

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

Does your child have an IEP (Individual Service Plan) or IFSP (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 any 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? _____

Getting to Know You Form

Page 3

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?

D5 F9BH-B: CFA5HCB

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 our 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 _____

Has your child talked to you about his or her experiences in our program so far? _____

Is he/she positive about the program, other children, and the teaching staff? _____

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Signature Of Parent Or Guardian

Date

Signature Of Director

Date



A Child's Place

Individual Education Plans (IEP) & Individual Family Service Plans (IFSP) Information Sheet

Because of the diverse set of needs of the children it is important to gather as much information as possible about each child. If your child has an IEP or an IFSP in place we all benefit from sharing this information so that we may care for your child in the best possible way.

Parent Sign Off Sheet

Child's Name: _____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP or an IFSP, it would be beneficial to share a copy of this plan with us so that we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

- I am providing a copy of my child's IEP or IFSP.
- My child does not have/I am not providing an IEP or IFSP.

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Parent/Guardian Signature

Date



A Child's Place

Go Paperless

Parents,

In an effort to go paperless, we will be using email to communicate on a regular basis throughout the school year. This communication will include monthly newsletters and any non-urgent issues that may arise during the course of the school year. Please provide at least one email address per family. We will add as many email addresses as you like to our database. Thank you for your cooperation.

Child's Name: _____

School Name: _____

Parents Name and assigned email address

1. _____

2. _____

3. _____

Remember to update our records if you email changes over the course of your child's enrollment.

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Parent/Guardian Signature

Date



A Child's Place

Video / Photo Release

I hereby give permission for images of my child, captured at A Child's Place. through video, photo and digital camera, to be used solely for the purposes of ACP's promotional material and publications, and waive any rights to compensation or ownership thereto.

Child's Name: _____

6 mihnd]b['nci f'bUa Y'VY'ck žMci 'U[fYY'h Uih]g']g'j U]X'Ug'nci f'g][bUhi fY"

Parent/Guardian Signature

Date



Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (**Section A**) OR, initiate debit entries to my (our) checking or savings account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name	Phone #
Cardholder Address	City State Zip
Account Number	Expiration Date
Cardholder Signature	Date

SECTION B (Bank Account)

Your Name	Phone #			
Address	City State Zip			
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			

For Official Use Only

Date Received
Employee Signature

John Sample Mary Sample 123 Nice Street Anytown, USA	BANK OF THE WEST 555-555-5555	00226
Pay to the order of: Attach Voided Check Here \$ _____ _____ Dollars Deposit slips not accepted		
123456789	1800338	0226
Routing Number	Account Number	Check Number

A service of

