

Application for Child Care Services

Name of child: _____ Birthdate: _____ Male/Female: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Legal Guardian #1: _____ Relationship: _____

Home Address: _____ Work Address: _____

Phone (Home): _____ Business: _____ Business Hours: _____

Parent/Legal Guardian #2: _____ Relationship: _____

Home Address (If different from above): _____ Work Address: _____

Phone (Home): _____ Business: _____ Business Hours: _____

Days/Hours when care is needed: _____ Reason for entry into child care: _____

Transportation arrangement to and from program: _____

Composition of family: _____

Legal guardian's formal education (#1): _____ (#2): _____
(highest grade completed) (highest grade completed)

Any previous child care experience: _____

Our program does not exclude children with special needs if we can provide a safe environment. The following information is requested to help us plan care for your child.

Special needs of parents (e.g., inability to climb stairs, difficulty lifting child, etc.): _____

Disability or special needs of child (medications, treatments, allergies, food intolerance, conditions, behaviors, etc.) no yes
(Complete Special Care Plan and Authorization for Release of Information Form)

Usual eating schedule: _____

Foods child likes: _____ dislikes: _____

Elimination Patterns (Toileting/Diapering): _____

Things that comfort child: _____ scare child: _____

Cultural habits/home issues that may affect the child's behavior: _____

Who is authorized to pick up this child from child care? _____

Who will care for child when he/she is sick: _____
(Complete the Child Care Emergency Contact Information Form)

Legal Guardian's Signature: _____ Date: _____

Enrollment Date: _____

From the Pennsylvania chapter of the American Academy of Pediatrics, prepared by S.S. Aronson, *Model Child Care Health Policies*, 4th ed., (Washington, DC: NAEYC, 2002), Appendix A.

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): <input type="checkbox"/> NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): <input type="checkbox"/> 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.

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

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:

From the Pennsylvania chapter of the American Academy of Pediatrics, prepared by S.S. Aronson, *Model Child Care Health Policies*, 4th ed., (Washington, DC: NAEYC, 2002), Appendix B.

Child Care Emergency Information

Child's Name: _____ Birthdate: _____

Legal Guardian #1 Name: _____

Telephone Numbers: Home: _____ Work: _____

Legal Guardian #2 Name: _____

Telephone Numbers: Home: _____ Work: _____

Emergency Contacts (to whom child may be released if legal guardian is unavailable)

Name #1: _____

Address: _____

Telephone Numbers: Home: _____ Work: _____

Name #2: _____

Address: _____

Telephone Numbers: Home: _____ Work: _____

Child's Usual Source of Medical Care

Name: _____

Address: _____

Telephone Number: _____

Child's Usual Source of Dental Care

Name: _____

Address: _____

Telephone Number: _____

Child's Health Insurance

Name of Insurance Plan: _____ ID # _____

Subscriber's Name (on insurance card): _____

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations

Transport Arrangement in an Emergency Situation

Ambulance service: _____ Child will be taken to: _____

(Parents/guardians are responsible for all emergency transportation charges)

Parent/Legal Guardian Consent and Agreement for Emergencies

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, including administration of Syrup of IPECAC if staff are so instructed by emergency medical service personnel, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above **to act on my behalf** until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: _____ Parent/Legal Guardian's Signature #1: _____

Date: _____ Parent/Legal Guardian's Signature #2: _____

From the Pennsylvania chapter of the American Academy of Pediatrics, prepared by S.S. Aronson, *Model Child Care Health Policies*, 4th ed., (Washington, DC: NAEYC, 2002), Appendix C.

Special Care Plan

Facility Name: _____

Facility Address: _____

Child's Name: _____

Date of Birth: _____ Times and Days in Child Care: _____

1. Describe the child's special need during group care: _____

2. Child's present functional level and skills: _____

3. What emergency or unusual episode might arise while the child is in care? How should the situation be handled? _____

(Prepare and maintain information on the "Emergency Form for Children with Special Needs" available from the American Academy of Pediatrics, www.aap.org)

4. Accommodation which the facility must provide for this child: _____

a) Are there particular instructions for sleeping, toileting, diapering, or feeding? _____

b) Will the child require medication while in care? If so, attach the physician's instructions for use of the child's medication. _____

c) Are special emergency and/or medical procedures required? If so, what procedures are required? _____

d) What special training, if any, must staff have to provide that care? _____

e) Are special materials/equipment needed? _____

5. Other specialists working with the child (e.g., occupational therapist, physical therapist): _____

Primary Case Manager: _____ Phone: _____
(usually the doctor in charge)

Address: _____

On-site child care facility case manager: _____ Phone: _____

From the Pennsylvania chapter of the American Academy of Pediatrics, prepared by S.S. Aronson, *Model Child Care Health Policies*, 4th ed., (Washington, DC: NAEYC, 2002), Appendix D.

Authorization for Release of Information

I, _____ give permission for
(parent or legal guardian)

_____ (professional/facility)

to release to _____ the following information
(child care program)

_____ (screenings, tests, diagnoses and treatment, or recommendations)

The information will be used solely to plan and coordinate the care of my child and will be kept confidential and may only be shared with _____
(staff title/name)

Name of Child: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Parent/Legal Guardian Signature Date

Witness Signature Date

Staff member to be contacted for additional information

From the Pennsylvania chapter of the American Academy of Pediatrics, prepared by S.S. Aronson, *Model Child Care Health Policies*, 4th ed., (Washington, DC: NAEYC, 2002), Appendix D.

Child Care Agreement

I, _____, the legal guardian of _____
agree to the following: (Initial all that apply)

_____ Pay fee per day/per week of _____.

_____ Volunteer to work _____ hours a week with the program.

_____ Follow the procedures in the program handbook.

_____ Obtain a Special Care Plan if applicable.

_____ Day payment to be made is _____.

_____ Services to be provided as part of the child care fee (transportation, meals, etc.) are:

_____.

_____ Child's arrival time _____ Child's departure time _____.

_____ Late fee \$ _____.

_____ Obtain health assessments for my child according to the schedule recommended by the American Academy of Pediatrics.

_____ Notify _____ when my child is scheduled for routine health visits, and obtain a form to complete and return.

_____ Cooperate with _____ in the follow up of any medical, dental, or developmental needs of my child.

_____ Complete a daily admission form and have my child observed by a member of the staff before I leave each day.

_____ Notify the teacher _____ in advance if I plan a birthday celebration for my child.
(specify time)

_____ Notify the staff when my child is ill or any family member has a contagious disease.

_____ Complete a medication consent form when requesting medication administration.

_____ Provide the program staff with _____ necessary for my child's care.
(linens, clothing, toothbrush)

_____ Provide information on how to contact me in an emergency situation which I will update when changes occur and every 6 months.

_____ Agree to discuss my concerns with _____.
(staff member's name)

_____ Notify a teacher and sign my child in and out every time my child arrives and departs with me or a person I authorize.

_____ Designated persons to whom child may be released are: _____.

_____.

Legal Guardian Signature

Date

This agreement should be reviewed by the legal counsel for your facility. Contracts usually include more information than present on this form.

From the Pennsylvania chapter of the American Academy of Pediatrics, prepared by S.S. Aronson, *Model Child Care Health Policies*, 4th ed., (Washington, DC: NAEYC, 2002), Appendix F.

Special Care Plan for a Child with Asthma

Child's name _____		Date of birth _____	
Parent or guardian's name(s) _____			
Emergency phone: Mother _____		Father _____	
<i>(see emergency contact information for alternate contacts if parents are unavailable)</i>			
Primary health provider _____		Emergency phone _____	
Asthma specialist _____		Emergency phone _____	
Known triggers for this child's asthma (circle all that apply)			
animals	flowers	grass	smoke
colds	foods (specify) _____	house dust	strong odors
excitement	_____	mold	tree pollens
exercise	_____	room deodorizers	weather changes
other (specify) _____			
Activities for which this child has needed special attention in the past (circle all that apply)			
<i>outdoors</i>		<i>indoors</i>	
field trip to see animals	running hard	art projects with chalk, glues, fumes	pet care
gardening	outdoors on cold or windy days	kerosene/wood stove heated rooms	recent pesticide application in facility
jumping in leaves	playing in freshly cut grass	painting or renovation in facility	sitting on carpets
other (specify) _____		_____	
Can this child use a flowmeter to monitor need for medication in child care? NO YES			
Personal best reading _____		Reading to give extra dose of medicine _____	
Reading to get medical help _____			
How often has this child needed urgent care from a doctor for an attack of asthma			
in the past 12 months? _____		in the past 3 months? _____	
Typical signs and symptoms of the child's asthma episodes (circle all that apply)			
breathing faster	difficulty playing, eating, drinking, talking	flaring nostrils, mouth open (panting)	persistent coughing
complaints of chest pain/tightness	face red, pale or swollen	gray or blue lips or fingernails	restlessness, agitation
dark circles under eyes	fatigue	grunting	wheezing sucking in chest/neck
Reminders			
1. Notify parents immediately if emergency medication is required.			
2. Get emergency medical help if			
— the child does not improve 15 minutes after treatment and family cannot be reached			
— after receiving a treatment for wheezing, the child			
• is working hard to breathe or grunting • is breathing fast at rest (>50/min) • has trouble walking or talking • has nostrils open wider than usual • has sucking in of skin (chest or neck) with breathing • won't play • has gray or blue lips or fingernails • cries more softly and briefly • is hunched over to breathe • is extremely agitated or sleepy			
3. Child's doctor and child care facility should keep a current copy of this form in child's record.			
<i>Adapted from the American Academy of Pediatrics.</i>			

Adapted from Karen Sokal-Gutierrez, *Child Care and Children with Special Needs: A Training Manual for Early Childhood Professionals*, 2d ed. (Wilmington, DE: Video Active Productions, 2001).