

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

CHILD ALLERGY INFORMATION

You have indicated on your child's Emergency Contact / Parental Consent form that your child suffers from an allergy and/or allergic reaction. Please complete this form based on your child's individual needs. Please make sure that an adequate and up-to-date supply of all allergy medication is on hand at the center at all times in case your child has an allergic reaction while in our care.

Name of Child: _____

Type of Allergy: _____

Symptoms of an Allergic Reaction (hives, vomiting, swelling, etc.) _____

Medication and dosage amount to be given in case of an allergic reaction:

Medication _____ Dosage _____

Emergency Procedures to be taken (call parents, 911, doctor, etc.) _____

Emergency numbers to be used:

Mother: Home _____

Father: Home _____

Work _____

Work _____

Cell _____

Cell _____

Alternative Emergency Contact:

Name: _____

Relationship: _____

Home: _____

Work: _____

Cell: _____

I hereby give permission for Today's Child Learning Centers, Inc. to post my child's allergy information in the center.

Parent's Signature

Date



DISTANT EMERGENCY CONTACT & RELEASE FORM

I, _____ authorize Today's Child Learning Center to contact and release my child _____, to the person(s) designated below in case of an emergency in which I cannot be contacted or located.

This is in consonance with Today's Child Learning Center's Emergency Preparedness Plan.

Please indicate a custodian who lives at least five miles away from our child care center and is not listed on your emergency contact form.

Designated Custodian: _____

Address _____

Phone Number: _____

E-Mail: _____

Relationship to child: _____

I do not have an emergency contact out of the state and/or immediate area.

Parent/Guardian Signature

Date

Parent Address: _____

Parent Home Phone: _____ Parent Work Phone: _____

Parent Cell Phone: _____ Parent E-Mail: _____



INDIVIDUALIZED EDUCATION PLAN STATEMENT

Today's Child works in cooperation with families and outside agencies to facilitate the provision of Early Intervention services for children in need. If your child does have an IEP or EISP we would appreciate receiving a copy in order to more effectively meet your child's needs. Updated versions should be submitted as necessary.

- My child does not have an IEP or EISP currently in place.
 My child has an IEP My child has an EISP

My child is currently receiving:	Agency providing service	Service provided
<input type="checkbox"/> Speech therapy	_____	<input type="checkbox"/> On site <input type="checkbox"/> Off site
<input type="checkbox"/> Physical therapy	_____	<input type="checkbox"/> On site <input type="checkbox"/> Off site
<input type="checkbox"/> Occupational therapy	_____	<input type="checkbox"/> On site <input type="checkbox"/> Off site
<input type="checkbox"/> Behavioral services	_____	<input type="checkbox"/> On site <input type="checkbox"/> Off site
<input type="checkbox"/> _____	_____	<input type="checkbox"/> On site <input type="checkbox"/> Off site
<input type="checkbox"/> _____	_____	<input type="checkbox"/> On site <input type="checkbox"/> Off site

If services are to be provided off-site during the school day, who will be the transporting agency?

What day of the week will this take place? Mon Tue Wed Thur Fri

What time will your child be picked up? _____ What time will your child return? _____

Child's Name

Parent's Signature

Date



VIDEO AND PHOTOGRAPHIC PERMISSION FORM

Child's Name _____ Date _____

Today's Child Learning Centers, Inc. has my permission to videotape and/or photograph my child for the purposes of

- Educational projects by the staff
- Staff training
- Newsletters
- Calendars
- Special Event postings at the center or on our website

Signature of Parent and/or Guardian

Date



To all Today's Child Parents and Guardians:

2011-2012 SY

This letter is to reiterate to you our concern for the safety and welfare of children attending Today's Child Learning Centers and to inform you that we have Emergency Preparedness Plans in place for response to all types of situations. Depending on the circumstance of the emergency, we will use one of the following protective actions:

Immediate Evacuation and Assembly – Students are evacuated to an area that is a safe distance from the building.

In-place Sheltering – Sudden occurrences, such as weather or those related to hazardous materials, may dictate that taking cover inside the building is the best immediate response.

Evacuation – Total evacuation of the facility may become necessary. In this case, children will be taken to a relocation facility.

Modified Operation – May include cancellation/postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems (such as utility disruptions) that make it unsafe for children but may be necessary in a variety of situations.

Method to Contact Parents – In the event of an emergency, parents will be called, a note will be placed on the door, and radio/tv stations will be alerted to provide more specific information. Details will be posted and parents can check our website at www.todayschild.us for up to the minute announcements.

Emergency ends/reuniting with children – When the emergency ends, parents will be informed and reunited with their children as soon as possible. The contact methods listed above will be used to inform parents. We ask that you not call during an emergency. This will keep the main telephone line free to make emergency calls and relay information.

The form designating persons to whom your child may be released will be used in situations such as those noted above. Please ensure that only those persons you list on the form can pick up your child. I specifically urge you not to make different arrangements during an emergency as it could create confusion and divert staff from their assigned emergency duties. A full copy of our Emergency Plan is located in the Parent Information area of the center. Please feel free to familiarize yourself with the document. Should you have any additional questions regarding our emergency operations please speak with the Director at your child's center. Listed below is a breakdown of the shelters and evacuation facilities for all our locations.

CENTER	LOCKED SHELTER	INTERIOR SHELTER	ASSEMBLY AREA	OFF-SITE EVAC FACILITY
Clifton Heights	All classrooms	main hallway	parking lot in rear	300 E. Berkley Ave., Clifton Heights
Colwyn	1 st floor storage room	main hallway	parking lot behind church	235 Sharon Ave., Sharon Hill
Main Campus	staff room & office	downstairs classes	Pine St. & Maple Ave.	250 Sharon Ave., Sharon Hill
Media	pastor's off. & music rm.	upstairs hallway	State St. & Lemon St.	4 th & Monroe Sts., Media
Springfield	All classrooms	sanctuary/auditorium	parking lot on side	300 W. Sproul Road, Springfield
Head Start	Classroom	gymnasium	parking lot on side	235 Sharon Ave., Sharon Hill
Darby Twp.	Room A4	stage	field	1 School Lane, Glenolden
Delcroft	Room 202	hallway outside of class	parking lot on side	235 Sharon Ave., Sharon Hill
Harris	Guidance Office	interior hall/guidance	Collingdale Park	800 MacDade Blvd., Collingdale
K Center	Faculty lounge	interior hall/faculty Inge	parking lot in front	801 Ashland Ave., Glenolden
Sharon Hill	Closet next to stage	closet next to stage	parking lot in back	235 Sharon Ave., Sharon Hill
Aston	Room 103	library/faculty lounge	parking lot on side	1 Neumann Drive, Aston
Coebourn	Room 12	kitchen	parking lot on side	2 Cambridge Road, Brookhaven
Pennell	Room 106	library	parking lot near field	1 Neumann Drive, Aston

CHILD'S NAME: _____

I acknowledge receipt of info regarding the center's Emergency Preparedness Plan.

Please print name here

Please sign here

Date

Child and Adult Care Food Program -- Child Enrollment Form

Enrollment Date: _____

Child _____ Address _____ _____ Birth date _____	Parent/Guardian _____ Address _____ _____ Telephone (home) _____ (work) _____
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Sponsoring Organization: Today's Child Learning Centers, Inc. Address: 1016 Maple Avenue, Sharon Hill, PA 19079	Center _____ Address _____ _____
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Normal Hours of Care: (write in times*)

Monday	Tuesday	Wednesday	Thursday	Friday
Start: _____	Start: _____	Start: _____	Start: _____	Start: _____
End: _____	End: _____	End: _____	End: _____	End: _____

*If more than 8 hours of care per day, please provide an explanation.

- Work schedule, along with travel time, requires over eight hours of care
- School schedule, along with travel time, requires over eight hours of care
- Other _____

Daily Expected Meal Service Participation (please check box)

Breakfast	Lunch	PM Snack

Is this child of school age? ___Yes ___No If yes, will additional meals be provided when school is not in session? ___Yes ___No
 If yes, please specify the meal: ___Breakfast ___Lunch ___Snack ___Supper

Household Contacts: This child care facility participates in the Child and Adult Care Food Program. In order to receive federal funds, representatives of the sponsoring organization or the State Agency may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

Day _____	Evening _____	Time _____	Letter _____	Telephone: _____ (home) _____ (work)
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Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ **Date** _____

Signature Center Administrator/Home Provider _____ **Date** _____

"In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). " "To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

For Sponsor Use Only

Child withdrew on _____

Child and Adult Care Food Program Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members				
Name of Enrolled Child(ren):				
Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.			CHECK IF NO INCOME
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3. NAME: _____ CASE NUMBER: _____ - _____				
Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call [Your center director, Homeless Liaison, Migrant Coordinator at Phone #] Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/>				
Part 4. Total Household Gross Income—You must tell us how much and how often				
A. Name (List only household members with income) <i>(Example)</i> <i>Jane Smith</i>	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
	\$200/weekly _____	\$150/twice a month _____	\$100/monthly _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign) An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) <i>I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.</i>				
Sign Here: _____		Print Name: _____		
Date: _____				
Address: _____		Phone Number: _____		
City: _____		State: _____		Zip Code: _____
Last four digits of Social Security Number: * * * - * * - _____ <input type="checkbox"/> I do not have a Social Security Number				

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> Black or African American	

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year Household size: _____

Categorical Eligibility: _____ Eligibility: Free _____ Reduced _____ Denied (Paid) _____ Date Withdrawn: _____

Reason for Denied: _____

Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	\$20,147
2	\$27,214
3	\$34,281
4	\$41,348
5	\$48,415
6	\$55,482
7	\$62,549
8	\$69,616
Each additional person:	+\$7,067

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

MUST BE COMPLETED FOR ALL CHILDREN UNDER ONE YEAR OF AGE

**CHILD and ADULT CARE FOOD PROGRAM
ENROLLMENT SUPPLEMENT for INFANTS**

This enrollment supplement must be completed for all infants in care at the time of enrollment to determine responsibility for providing infant formula as part of the Child and Adult Care Food Program (CACFP). Please have the parent sign and date two forms. Send one to your sponsoring organization and keep the other as part of the infant's enrollment file.

INFANT NAME: _____ DATE OF BIRTH: _____

CENTER: _____

PARENT CHOICE: (Please check one)

- The Center will furnish infant's formula. Today's Child provides Similac Advanced.
- The Parent will furnish the infant's: Formula Breast Milk

Please indicate type of formula to be provided by parent

If the above type formula does not meet CACFP requirements, please attach a copy of the Physician's medical statement recommending this type of formula.

As the parent of the above-named child, I understand I may change my decision regarding furnishing infant formula with proper notice.

Parent/Guardian Signature

Date

Center Director's Signature

Date

MUST BE COMPLETED FOR ALL CHILDREN TWO THROUGH FIVE YEARS OF AGE

PA PRE-K COUNTS APPLICATION

This information is confidential to the PA Pre-K Counts program.

Date form Completed:

Last Name (Child)	First Name (Child)	Middle Initial

Child's Date of Birth	Age	Household (Family) size
/ /	2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	

Primary Language	Family Type
<input type="checkbox"/> English	<input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent
<input type="checkbox"/> Spanish	<input type="checkbox"/> Foster <input type="checkbox"/> Child living with Relative
<input type="checkbox"/> Other _____ (Please specify)	<input type="checkbox"/> Other _____ (Please specify)

Street Address	County	
City	State PA	Zip Code
Home Telephone:	Work Phone:	Email Address:

Household Income (required) check box:

- Less than \$5,000 \$5,001 - \$10,000 \$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 More than \$100,000

Actual Annual Verified Gross Household (Family) Income: _____
(Attach copies of documents used to verify income prior to enrollment)

- Family income is **at or below 300% of federal poverty level** (Required Risk factor). Consider all sources of income. See end of document for income chart relative to family size. (Must be verified prior to enrollment)

Other Child Eligibility Risk Factor Criterion (Must check all that apply)

- Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
- Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services
- Education level of guardian:** does not have a high school diploma or GED or post-secondary degree.
- English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
- Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following:
- A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
 - B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
 - C. Children who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.
- Incarcerated Parent:** A child for whom one of the child's parents is currently in prison
- Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
- Migrant (non-immigrant)/Seasonal Student.** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
- Teen mother:** A child whose mother was under the age of 18 when the child was born

To the best of my knowledge, the information provided is accurate. I understand that I may be asked to verify or substantiate information provided.

Parent/Guardian Signature

Date

Parent/Guardian Name – Please Print

Staff Verifying Income and Risk Factors Signature

Date

Staff Verifying Income - Please Print

See Announcement ELS/PAPKC #1 for further definitions of Risk Factors and steps to verify income.

Federal Income Guidelines for 2009

<http://aspe.hhs.gov/poverty/09poverty.shtml>

[*Federal Register Notice, January 23, 2009*](#) (Volume 74, Number 14)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary
Annual Update of the HHS Poverty Guidelines
AGENCY: Department of Health and Human Services.
ACTION: Notice.

SUMMARY: This notice provides an update of the HHS poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: Effective Date: Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia			
Persons in family	100% of Poverty	200% of Poverty	300% of Poverty
1	\$ 10,830	\$ 21,660	\$ 32, 490
2	\$ 14,570	\$ 29,140	\$ 43,710
3	\$ 18,310	\$ 36,620	\$ 54,930
4	\$ 22,050	\$ 44,100	\$ 66,150
5	\$ 25,790	\$ 51,580	\$ 77,370

For families with more than 5 persons, add \$3,740 for each additional person.