

# 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

<b>CHILD'S NAME</b>		<b>BIRTHDATE</b>
<b>ADDRESS</b>		
<b>MOTHER'S NAME/LEGAL GUARDIAN</b>		<b>HOME TELEPHONE NUMBER</b>
<b>ADDRESS</b>		
<b>BUSINESS NAME</b>		<b>BUSINESS TELEPHONE NUMBER</b>
<b>ADDRESS</b>		
<b>FATHER'S NAME/LEGAL GUARDIAN</b>		<b>HOME TELEPHONE NUMBER</b>
<b>ADDRESS</b>		
<b>BUSINESS NAME</b>		<b>BUSINESS TELEPHONE NUMBER</b>
<b>ADDRESS</b>		
<b>EMERGENCY CONTACT PERSON(S)</b>	<b>NAME</b>	<b>TELEPHONE NUMBER WHEN CHILD IS IN CARE</b>
<b>PERSON(S) TO WHOM CHILD MAY BE RELEASED</b>	<b>NAME</b>	<b>ADDRESS</b>
		<b>TELEPHONE NUMBER WHEN CHILD IS IN CARE</b>
<b>NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER</b>		<b>TELEPHONE NUMBER</b>
<b>ADDRESS</b>		
<b>SPECIAL DISABILITIES (IF ANY)</b>	<b>ALLERGIES (INCLUDING MEDICATION REACTION)</b>	
<b>MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION</b>	<b>MEDICATION, SPECIAL CONDITIONS</b>	
<b>ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD</b>		
<b>HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS</b>		<b>POLICY NUMBER (REQUIRED)</b>
<b>PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT</b>		
<b>OBTAINING EMERGENCY MEDICAL CARE</b>	<b>ADMIN. OF MINOR FIRST - AID PROCEDURES</b>	
<b>WALKS AND TRIPS</b>	<b>SWIMMING</b>	
<b>TRANSPORTATION BY THE FACILITY</b>	<b>WADING</b>	

**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

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Signature of Parent and/or Guardian

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Date



To all Today's Child Parents and Guardians:

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](http://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
Columbus	Rooms 421, 422, 423	hallway	parking lot	501 W. 9 <sup>th</sup> St., Chester
CUSA	Rooms 101 and 102	hallway	parking lot	320 W. 10 <sup>th</sup> St., Chester
Main Street	Rooms 5, 6, 7	hallway	parking lot	201 Bridgewater Rd., Brookhaven
Stetser	Rooms B and C	hallway	parking lot	704 Main St., Upland
Toby Farms	Rooms A4 and A5	hallway	parking lot	704 Main St., Upland
Village	Room 103 and 113	hallway	parking lot	704 Main St., Upland

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: \_\_\_\_\_

<b>Child</b> _____ Address _____ _____ Birth date _____	<b>Parent/Guardian</b> _____ Address _____ _____ Telephone (home) _____ (work) _____
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<b>Sponsoring Organization:</b> Today's Child Learning Centers, Inc. Address: 1016 Maple Avenue, Sharon Hill, PA 19079	<b>Center</b> _____ 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

<b>Part 1. All Household Members</b>				
<b>Name of Enrolled Child(ren):</b>				
<b>Names of all household members</b> (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"/>
<b>Part 2. Benefits:</b> 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. <b>If no one receives these benefits, skip to part 3.</b> NAME: _____ CASE NUMBER: _____ - _____				
<b>Part 3.</b> If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call <b>[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]</b> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/>				
<b>Part 4. Total Household Gross Income—You must tell us how much and how often</b>				
<b>A. Name</b> (List <b>only</b> household members with income) <i>(Example)</i> <i>Jane Smith</i>	<b>B. Gross income and how often it was received</b>			
	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 _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
<b>Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)</b> An adult household member must sign this form. <b>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.</b> (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."



Dear Parents:

Today's Child Learning Center's School Age Enrichment Program in the Penn Delco School District incorporates time each afternoon for the completion of homework. We believe completing homework in a structured environment with staff on hand to help and guide the students strengthens the learning process.

As a parent, you have the choice to have your child participate in the homework program or save their homework to complete at home. Please indicate your choice at the bottom of this letter and return it to the Curriculum Director. If at any time during the school year you wish to change your choice, please notify the Director in writing.

Thank you.

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Child's name \_\_\_\_\_ School \_\_\_\_\_

Homeroom Teacher \_\_\_\_\_ Grade \_\_\_\_\_ Room # \_\_\_\_\_

Please check the appropriate box to indicate your preference

**I WANT** my child to complete homework during Today's Child's Enrichment Program

**I DO NOT WANT** my child to complete homework during Today's Child's Enrichment Program

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Parent's Signature

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Date