Enrollment Application

Print Full Name _____ _____ __Gender _

D.O.B__ _____Age_____Grade _____T-shirt Size _

Address _____ ____City_____ ____State _ Zip_____

Parent/Guardian Contact Information

Parent/Guardian#1

Name_____

Phone _____

Email_____

Parent/Guardian#2

Name_____

Phone_____

Email_____

Please list any medical conditions including allergies and those requiring medication(i.e. Diabetic, Astma, Seizure and Allergies.)

Helping Hands Developmental Learning Academy LLC, will be providing the following:

- Arts and craft
- Math, Reading & Writing(S.T.E.M)
- Age-based curriculums
- Inside & Outside play motor skills
- Computer time
- Music and Dance

I understand and hereby,as the parent/guardian Helping Hands Developmental Learning Academy LLC,and affiliates from all liabilities from any accidents that may occur or injuries sustained while attending (H.H.D.L.A.) I also authorize any medical assistance that may be required during my absence.

Signature of Parent/Guardian **Date**

Please list any siblings your child has who will also be attending below: Sibling(s) Name(s) Age(s)

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*Please drop the application off at the front desk.

*Please make payment by money order; payable to Helping Hands Dev Lrn Acad LLC.

♦Contact ***Mrs. K & Mr. K*** ♦via Email: hhands772@gmail.com

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	DATE OF BIRTH
ADDRESS	
PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
PARENT'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 SITUATION
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 _____

WHITE COPY (Original) **YELLOW COPY** (Child Care Space) **PINK COPY** (Excursion)

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

Parents may write immunization dates; health professional should verify and complete all data.

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:

VERBAL REQUEST FOR RELEASE OF CHILD

55 PA CODE CHAPTERS 3270.117(c) and 3280.117(c) and 3290.116(c)

THIS FORM MUST BE COMPLETED TO DOCUMENT THE VERBAL REQUEST BY A PARENT FOR THE RELEASE OF A CHILD TO A PERSON(S) NOT INDICATED ON THE AGREEMENT
(CHAPTERS 3270.123(a)(5), 3270.124(b)(7); 3280.123(a)(5), 3280.124(b)(7); 3290.123(a)(5), 3290.124(b)(7)).

NAME OF CHILD	DATE	TIME
NAME OF REQUESTING PARENT	TELEPHONE NO. FROM WHICH PARENT IS CALLING	
NAME OF INDIVIDUAL TO WHOM THE CHILD IS TO BE RELEASED ➤		
NAME OF STAFF PERSON TAKING THE CALL ➤		

CALL THE ENROLLING PARENT BACK TO CONFIRM THE INFORMATION IF POSSIBLE

CONFIRMING PARENT	DATE
NAME OF STAFF PERSON CONFIRMING INFORMATION	TIME

_____ NAME OF STAFF PERSON RELEASING CHILD

_____ DATE

BE SURE TO ASK FOR IDENTIFICATION WHEN THE INDIVIDUAL ARRIVES TO PICK UP THE CHILD

PHOTO RELEASE FORM

I, Parent(s)/Guardian(s) (the "Releasor") grant permission and consent to Helping Hands Dev Lrn Acad LLC (the "Releasee") for the use of the following photograph(s) as identified below for presentation under any legal condition, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content:

Description: Images of child/children

Payment

I understand that there shall be no payment for this release.

Royalties

I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

Revocation

I understand that with my authorization below the photograph(s) may never be revoked.

We, the Releasor and Releasee, understand and agree to the aforementioned terms and conditions.

Releasor's Signature: _____ Date _____
Parent(s)/Guardian(s)

Releasee's Signature: _____ Date _____
Helping Hands Dev Lrn Acad LLC