

## 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
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)
<b>PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT</b>		
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 HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> 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](http://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**

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:

ADDRESS:

PHONE:

SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT

TITLE:

LICENSE NUMBER:

DATE FORM SIGNED:

**CIVIL RIGHTS COMPLIANCE  
PARENT AWARENESS**

In accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as a resident of this agency, have the right:

to be provided services at this agency and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, age or sex.

to file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, disability, ancestry, national origin, age or sex.

Complaints of discrimination may be filed with any of the following:

Provider's Name: **Old Union Nursery School**  
**PO Box 114**  
**Wallingford, PA 19086**

Department of Public Welfare  
Bureau of Equal Opportunity  
Room 223, Health & Welfare Building  
P.O. Box 2675  
Harrisburg, PA 17105

PA Human Relations Commission  
Philadelphia Regional Office  
110 N. 8th Street  
Suite 501  
Philadelphia, PA 19107

U.S. Department of Health and Human Services  
Office for Civil Rights  
Suite 372, Public Ledger Building  
150 South Independence Mall West  
Philadelphia, PA 19106-9111

Commonwealth of Pennsylvania  
DPW Bureau of Equal Opportunity  
Southeast Regional Office  
801 Market Street, Suite 5034  
Philadelphia, PA 19107

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Staff Signature