Bambinou Academy Center

259 W Coulter Street Philadelphia, PA 19144 Tel: 267-766-6260 Fax: 267-766-5141

ENROLLMENT APPLICATION

PRINT CLEARLY

Entrance Date_____**Withdrawal Date**_____

CHILD INFORMATION

Child's Name_____Sex___Age__Date of birth_____Social Sec. # _____

Grade/Class_____Name of Public or Private school child attends, if any:_____

Home Address (Street)_____

City_____State_____Zip_____

Home Phone Number_____

Drop off Time:_____ Pick up Time:_____

FUNDING INFORMATION

Funding Start Date:_____

Currently receiving cash benefit? Y or N

Type: ☐DPW/CCW ☐CCIS ☐Private

Case Record # (DPA):_____

District Office:_____

Case Worker Phone# _____

Case Worker_____

Case Worker Fax#:_____

PROGRAM INFORMATION

Type: ☐DPW/CCIS ☐SCHOOL ☐TRAINING ☐JOB SEARCH CCIS ☐WORKING

Parent/Guardian Signature_____ **Date**_____

CENTER USE ONLY

Received Confirming Call from Worker: YES ☐ ☐NO

PARENT INFORMATION

Father's Name_____Home Phone Number_____

Father's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Father's Place of Employment_____Work Phone _____

Employer's Street Address_____City_____State_____Zip_____

Mother's Name_____Home Phone Number_____

Mother's Home Address (if different from child's) Street_____

City_____State_____Zip_____

Mother's Place of Employment_____Work Phone #_____

Employer's Street Address_____City_____State_____Zip_____

Child's Living Arrangements: (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

Child's Legal Guardian(s): (check one) ( ) Both Parents ( ) Mother ( ) Father ( ) Other

The child may be released to the person(s) signing this agreement or to the following:

*Name_____Address_____

(Street-City-State-Zip)

Telephone Number_____Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

*Name_____Address_____

(Street-City-State-Zip)

Telephone Number_____Relationship to child_____
Relationship to Parent(s) or Guardian_____
Other identifying information (if any)_____

Persons to contact in the case of emergency when parent or guardian cannot be reached:

Name_____Telephone Number_____

Name_____Telephone Number_____

Name_____Telephone Number_____

Child's doctor or clinic name_____

Doctor/clinic phone #_____

_____

_____

My child has the following special needs_____
The following special accommodation(s) may be required to most effectively meet my child's needs while at the center:_____

_____

_____

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns:_____

_____

_____

_____

EMERGENCY MEDICAL AUTHORIZATION

Should (child's name)_____Date of birth_____
suffer an injury or illness while in the care of (Facility name)_____ and the facility is unable to contact me (us) immediately, it shall be authorized to secure such medical attention and care for the child as may be necessary. I (We) shall assume responsibility for payment for services.

Parent/Guardian:_____
Signature

Date:_____

Director/Person-In-Charge_____
Signature

Date:_____

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $	PER MIN-HR	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

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 _____

SCHOOL COPY

Statement Acknowledging Parent's Receipt of Handbook

I/We,_____, hereby acknowledge and
Parent(s) name(s)
agree with the following:

1. I/We have reviewed the Program Handbook ("Handbook") of Bambinou Academy Center, Inc.
2. I/We understand a hard copy of the Program Handbook is available from the school.
3. A staff member of Bambinou Academy Center, Inc. has reviewed the Program Handbook with me/us.
4. I/We have read and agree to comply with the policies contained in the Handbook which govern the terms of the child care contract, and have been given an opportunity to ask questions about the content of the Handbook.
5. I/We understand that the Handbook reflects the current policies and procedures of Bambinou Academy Center, Inc.
6. I/We agree that I/We will conform to these policies and procedures and understand that these policies and benefits may be, amended, modified, terminated or replaced by Bambinou Academy Center, Inc.
7. I/We understand that this Handbook is the property of Bambinou Academy Center, Inc. and must be returned to Bambinou Academy Center, Inc. upon termination of child care services.

This form must be signed and returned to Bambinou Academy Center, Inc. before child may attend the program.

_____ _____
Mother/Guardian Signature Date

_____ _____
Father/Guardian Signature Date

_____ _____
Staff Signature Date

259 W Coulter Street Philadelphia, PA 19144
Phone: (215) 766-6260
Fax: (215) 766-5141

Martine Saint-Vil, Director

Please sign and return

I have read and agree to abide by the Tuition Policy Agreement of Bambinou Academy Center and claim responsibility for the payment of tuition and fees.

Signature _____ **Date** _____

Print Your Name _____

Print Student Name _____ **Grade** _____

Print Student Name _____ **Grade** _____

Print Student Name _____ **Grade** _____

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

Bambinou Academy Center
259 W Coulter Street,
Philadelphia, PA 19454.
Phone: 267-766-6260
Email: bambinouac@gmail.com

Communicable Disease Policy

Parent's will inform the center within 24 hours or the next business day after their child or any member of the immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening disease which must be reported immediately.

_____ **Parent's Signature** **Date**

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

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

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

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

WAIVER

I hereby consent to allow the use of voice, video, image or likeness in photographs and/or video for my child(ren): *(Enter <u>each</u> child's name)*

1. _____
2. _____
3. _____

in connection with **Bambinou Academy Center**

The permission for use of any of the media above is allowed for the following:

- Newsletters
- Business Flyers
- Facebook
- Website
- Photo and video by a third party (such as filming for a television commercial)
- Outgoing messages on answering machines and/or voice mail

I understand this Waiver is in effect until I provide, in writing, a cease order. I also agree to forego any right or entitlement I might have to any compensation or fees.

Finally, I agree that I am the legal guardian of the above named children.

_____	_____	_____
Parent Name	Signature	Date: