# ALGEN HOLDING COMPANY

www.TheAlGenHoldingCo.org


The Harvard Children's Academy
4900 Baltimore Avenue
Philadelphia, PA 19143
Ph.: (215) 729-9900
Fax: (215) 729-9901
***Email: hca@thealgenholdingco.org***

Franklin Day Nursery
719 Jackson Street
Philadelphia, PA 19148
Ph.: (215) 389-2991
Fax: (215) 389-2323
***Email: fdns@thealgenholdingco.org***

Franklin Day Nursery Northeast
5416 Rising Sun Avenue
Philadelphia, PA 19120
Ph.: (267) 428-5814
Fax: (267) 428-5847
***Email: fdnne@thealgenholdingco.org***


# Preschool Application

*For*

*Academic Year*

# 2024-2025

**AlGen Holding Company Partners**

Full Day Pre-K!

**Ages: 3-5 years old**

3 yrs. old before Sept 1st, 2024

5 yrs. old after Sept 1st, 2024

**Program Benefits**

Free Nutritious Meals
High-Quality Curriculum
Access to Nurses
Special Needs Support
Parent Participation

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Thank you for your interest in AlGen Holding Company's preschool program! Completing and submitting a Preschool Application does not guarantee that your child will be accepted to our preschool program. For your best chance at acceptance, please submit your child's completed application ***AS SOON AS POSSIBLE***.

**1. Complete ALL necessary steps below.** As you collect each item, check off the box.

*Applications will not be accepted without all supporting documentation.*

- ☐ **I have filled out the entire application**
- ☐ **I have proof of child's date of birth** (Birth certificate, health insurance card, etc.)
- ☐ **I have documentation of family income** (Tax forms, 4 consecutive paystubs, or financial support letter)
- ☐ **I have proof of Philadelphia residency** (bill, driver's license, lease, etc.)
- ☐ **I have my child's health insurance card**
- ☐ **I have my child's physical** (health assessment within the year) **and immunizations**
- ☐ **I have proof of child's dental visit (within the year)**
- ☐ **I have picture identification of parent/guardian** (Current State or Federal Photo ID)
- ☐ I have proof of TANF (DPW) cash, SNAP/food stamps, medical assistance *(if applies to you)*
- ☐ I have a custody order *(if applies to you)*
- ☐ I have a foster letter *(if applies to you)*
- ☐ I have a homeless verification letter/shelter letter *(if applies to you)*

Free preschool programming is offered at all of AlGen Holding Company's sites (based on your family's program eligibility) beginning July 1st. **TO APPLY PLEASE HAND-DELIVER OR EMAIL YOUR CHILD'S APPLICATION DIRECTLY TO THE SITE OF YOUR CHOICE LISTED BELOW.**

| AlGen Holding Company Site Name: | Site Address | Zip | Phone # | Program | Offering Virtual Option | Before/After Care (Fees Apply) |
|---|---|---|---|---|---|---|
| **SITE#1:** THE HARVARD CHILDREN'S ACADEMY | 4900 BALTIMORE AVENUE PHILADELPHIA, PA | 19143 | (215) 729-9900 | FEDERAL HEAD START | YES | YES |
| DIRECTOR: MARIA SANTOS | **EMAIL ADDRESS:** hca@thealgenholdingco.org **WEBSITE:** www.TheAlGenHoldingCo.org | | Fax#: (215) 729-9901 | | | |
| **SITE#3:** FRANKLIN DAY NURSERY | 719 JACKSON STREET PHILADELPHIA, PA | 19148 | (215) 389-2991 | FEDERAL HEAD START | YES | YES |
| DIRECTOR: ZAKIA ROYSTER | **EMAIL ADDRESS:** fdns@thealgenholdingco.org **WEBSITE:** www.TheAlGenHoldingCo.org | | Fax#: (215) 389-2323 | | | |
| **SITE#3:** FRANKLIN DAY NURSERY NORTHEAST | 5416 RISING SUN AVENUE PHILADELPHIA, PA | 19120 | (267) 428-5814 | FEDERAL HEAD START | YES | YES |
| DIRECTOR: LISA OLIVER | **EMAIL ADDRESS:** fdnne@thealgenholdingco.org **WEBSITE:** www.TheAlGenHoldingCo.org | | Fax#: (267) 428-5847 | | | |

## PRIMARY PARENT

**The adult who is primarily responsible for the care and well-being of the child.**

| | | | |
|---|---|---|---|
| **First Name:** | | **Last Name:** | |
| **Date of Birth:** | | **Gender:** O Male O Female | |
| **Primary language:** | | **Other language(s):** | |
| **Home Address:** | | | |
| **Apt./Unit #:** | **City:** | **State**: | **Zip Code:** |
| **Phone #:** | | **Email Address:** | |
| **# of People in household** | | **# of People in family** | |

| | | | | |
|---|---|---|---|---|
| **Marital Status** Select one | O Married | O Single | O Widowed | O Separated/Divorced |
| **Relationship to Child** Select one | O Parent/Step-Parent | | O Grandparent | |
| | O Foster/Kinship Parent, related to child | | O Foster Parent, not related to child | |
| | O Guardian, related to child | | O Guardian, not related to child | |
| | O Other (specify): | | O Teen Parent – parent was under the age of 18 when child was born | |
| **Race/Ethnicity** Select all that applies | O Hispanic or Latino/a | O American Indian | | O Asian |
| | O Black or African American | O Multi-Racial or Bi-Racial | | O Native Hawaiian |
| | O Pacific Islander | O White | | O Other (specify): |
| **Education** Select highest Diploma/Degree earned or highest Grade Level completed | O High School Diploma | O GED | | O ESL – English as a Second |
| | O Some college/Vocational/Associates | | O Bachelors/Advanced degree | |
| | O 11th Grade | O 10th Grade | | O 9th Grade or lower |
| **Employment, School, Job Training** Select all that applies | O Employed/Self-Employed | O Unemployed/Not Employed | | O Disabled |
| | O Member of the U.S. military on active duty | | O Veteran of the U.S. military | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Do you have health insurance?** *If 'Yes', name of health insurance provider:* | | | | | O Yes | O No |
| **Are you pregnant?** | O Yes | O No | **Are you receiving mental health treatment?** | | O Yes | O No |
| **Do you receive benefits?** | O WIC | O SNAP | O Medical | O TANF Cash | O SSI | |

## SECONDARY PARENT

**An adult who shares in the care of the child.**

| | | | |
|---|---|---|---|
| **First Name:** | | **Last Name:** | |
| **Date of Birth:** | | **Gender:** O Male O Female | |
| **Employment, School, Job Training** Select all that applies | O Employed/Self-Employed | O Unemployed/Not Employed | O Disabled |
| | O Member of the U.S. military on active duty | O Veteran of the U.S. military | |

## OPTIONS

**CHOOSE THE OPTION OF SERVICES YOU WOULD LIKE:** Your child may be selected for your second choice, if there is no available Face to Face spaces. Please do not pick Virtual services, if your child is not willing or able to participate 5-days a week. Laptops will be provided for Virtual services.

| | |
|---|---|
| **Site Choice for FACE TO FACE (M-F):** | **Site Choice for VIRTUAL (M-F):** |

| PREK CHILD | | | |
|---|---|---|---|
| **First Name:** | | **Last Name:** | |
| **Date of Birth:** | | **Gender:** O Male O Female | |
| **Race/Ethnicity** Select all that applies | O Hispanic or Latino/a | O American Indian | O Asian |
| | O Black or African American | O Multi-Racial or Bi-Racial | O Native Hawaiian |
| | O Pacific Islander | O White | O Other (specify): |
| **Primary language:** | | **Other language(s):** | |

| | | | | |
|---|---|---|---|---|
| **Child is receiving Early Intervention services:** | O IEP | O EFSP | O ER | O Suspected |
| **Child's mother and/or father is currently incarcerated:** | | | O Yes | O No |

| HOUSING | | | |
|---|---|---|---|
| **Housing Information** Select your current situation | O Own | O Rent | O Transitional housing – Since what date? |
| | O Shelter – Since what date? | | O Train or bus station, park or in car – Since what date? |
| | O Living with relatives or others to due to lack of alternative, adequate housing or due to the loss of housing – Since what date? | | O Hotel/Motel, camping ground or other similar situation due to lack of alternative, adequate housing or due to the loss of housing– Since what date? |
| | O Temporary housing situation due to emergency: eviction, flood, fire, hurricane, etc. | | O Abandoned apartment building |
| | O Other _____ | | |

| | | | |
|---|---|---|---|
| **Optional Information** | New to the country? | O Yes | O No |
| | Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you? | O Yes | O No |

**FAMILY INCOME**

| Primary Caregiver Income | | | Secondary Caregiver Income | | |
|---|---|---|---|---|---|
| **Employment Type** | **Amount** | **Frequency** | **Employment Type** | **Amount** | **Frequency** |
| O Employment | | | O Employment | | |
| O SSI/ TANF CASH | | | O SSI/ TANF CASH | | |
| O Unemployment | | | O Unemployment | | |
| O Other:_____ | | | O Other:_____ | | |

*I understand that this information will be used to create my Parent Portal COPA account, and I will receive an email with my sign-in information at the email given on this form. I understand that my application is not complete until I sign in and upload my all supporting documentation.*

*Completing a Parent Portal COPA Account and submitting and finalizing an application does NOT guarantee that my child will be accepted to a preschool program.*

Parent Signature:_____ Date:_____

Staff Signature:_____ Date:_____

**Permission Form for Use of Student Picture, Voice, Video, Work and/or Full Name by the AlGen Holding Company d/b/a Franklin Day Nursery, Franklin Day Nursery Northeast, and The Harvard Children's Academy.**

This letter is to request permission for your child's picture, voice, video, work and/or full name to be used for the purposes stated below.

**Please read the options below and mark those that apply.**

I/We GRANT permission for any photo/image, voice, video, work and/or full name of this student to be:

☐ Published on the AlGen Holding Company's website and/or individual center's Social Media page in order to promote our programs and celebrate student work.

☐ Published in recruitment flyers, pamphlets and videos for potential students, parents, teachers, and staff.

☐ Used in presentations, manuals, and handouts for professional development for teachers, directors, and other staff.

☐ Used during information sessions for students and families.

☐ Published in an album/collection of student work to be distributed to students, parents, teachers, directors, staff, and/or other employees.

**OR**

☐ I/We DO NOT GRANT permission for any photo/image, voice, video, work and/or full name of this student to be used for any of the purposes stated above.

---

Student's Name: _____

Center Name: _____

Print name of Parent/Legal Guardian: (print) _____

Signature of Parent/Legal Guardian: (sign) _____

Date Signed: _____

*Please return this form to your Center Director as soon as possible. Thank you.*

# #2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

| Child's Name (Last): | Child's Name (First): | Child's Date of Birth: |
|---|---|---|
| Parent/Guardian Name: | Address: | Contact Phone #: |

PA child care providers must document that enrolled children have received age-appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007. The schedule is available at www.aap.org or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

| Health history and medical information pertinent to routine care and emergencies (describe, if any):<br>❑ **NONE** | **DATE OF MOST RECENT WELL-CHILD/PHYSICAL EXAM:** |
|---|---|
| Allergies to food or medicine (describe, if any):<br>❑ **NONE** | Do not omit any information. This form may be updated by health professional (initial and date new data). |

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:

| **LENGTH/HEIGHT** | **WEIGHT** | **BLOOD PRESSURE** |
|---|---|---|
| _____IN/CM %ILE_____ | _____LB/KG %ILE_____ | (BEGINNING AT AGE 3)<br>_____/_____ |

| **PHYSICAL EXAMINATION** | **☑ = NORMAL** | **IF ABNORMAL - COMMENTS** |
|---|---|---|
| HEAD/EYES/EARS/NOSE/THROAT | | |
| TEETH | | |
| CARDIORESPIRATORY | | |
| ABDOMEN/GI | | |
| GENITALIA/BREASTS | | |
| EXTREMETIES/JOINTS/BACK/CHEST | | |
| SKIN/LYMPH NODES | | |
| NEUROLOGIC & DEVELOPMENTAL | | |

| **IMMUNIZATIONS** | **DATE** | **DATE** | **DATE** | **DATE** | **DATE** | **COMMENTS** |
|---|---|---|---|---|---|---|
| DTap/DTP/Td | | | | | | |
| POLIO | | | | | | |
| HIB | | | | | | |
| HEP B | | | | | | |
| MMR | | | | | | |
| VARICELLA | | | | | | |
| MENINGOCOCCAL | | | | | | |
| PNEUMOCOCCAL | | | | | | |
| INFLUENZA | | | | | | |
| HEP A | | | | | | |
| ROTAVIRUS | | | | | | |
| OTHER/TB | | | | | | |

| **SCREENING TESTS** | **DATE OF TEST** | **NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL** |
|---|---|---|
| LEAD | | |
| ANEMIA (HGB/HCT) | | |
| URINALYSIS (UA) at age 5 | | |
| HEARING (subjective until age 4) | | |
| VISION (subjective until age 3) | | |
| PROFESSIONAL DENTAL EXAM | | |

**HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE** (attach additional sheets if necessary)

❑ **NONE**

**NEXT APPOINTMENT – MONTH/YEAR:**

| MEDICAL CARE PROVIDER: | | SIGNATURE OF PHYSICIAN OR CRNP: | |
|---|---|---|---|
| ADDRESS: | | | |
| ZIP CODE: | PHONE: | LICENSE NUMBER: | DATE FORM SIGNED: |

# REQUEST FOR ADMINISTRATION OF MEDICATION

**(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)**

**PHYSICIAN, PLEASE NOTE:** Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication / treatment. A separate request is needed for each medication.

| NAME OF PATIENT/STUDENT | ADDRESS/ZIP | ROOM/BOOK NO. |
|---|---|---|
| | | |

| DATE OF BIRTH | SCHOOL/ORG.# | REGIONAL OFFICE | PID |
|---|---|---|---|
| | | | |

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN WHILE IN CARE:

| NAME OF MEDICATION/EQUIPMENT/TREATMENT: | DOSE: |
|---|---|
| | |

| TIME(S) TO BE GIVEN WHILE IN CARE: | TOTAL DOSAGE PER 24 HRS: |
|---|---|
| | |

| DATE BEGIN: | DATE END: |
|---|---|
| | |

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS: _____

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN: _____

IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES ☐ NO ☐

IF YES, DESCRIBE: _____

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS: _____

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES ☐ NO ☐

| PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS | TELEPHONE |
|---|---|
| | |

| ADDRESS | EMERGENCY NUMBER |
|---|---|
| | |

| SIGNATURE OF HEALTH CARE PROVIDER | DATE SIGNED |
|---|---|
| | |

**I**

To The Director

I authorize selected Assistant Group Supervisors/Staff or the Director of the child care facility my child is **currently enrolled** in to administer the indicated medication as prescribed by my child's health care provider, whose signature appears on this form.

I authorize the Director where my child is **currently enrolled** in to communicate with my child's health care provider, and my health care provider to reply, as needed regarding this medication and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

**II**

**IN ACCORDANCE WITH OCDEL/DHS AND THE CENTERS CURRENT PROCEDURES, THE ADMINISTRATION OF THIS MEDICATION WAS APPROVED ON**

_____

DATE

**(RETAIN IN SCHOOL)**

SIGNATURE OF CENTER DIRECTOR _____

TELEPHONE NUMBER OF CENTER _____

**TO THE PHYSICIAN:**
Your patient has requested that medication be utilized while **currently enrolled** in our child care facility. Ideally, the administration of medication takes place at home. However, for children who require medication/treatment while **currently enrolled** in our child care facility in order to function in the classroom, our policy does permit selected Assistant Group Supervisors/Staff or the Director of the child care facility to administer medication.

**(IF YOUR PATIENT'S MEDICATION OR TREATMENT SCHEDULE CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE PAGE 1 - A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT).**

When the medication/treatment prescribed exceeds or differs from that approved by the FDA or recommended by the manufacturer, you and the child's parent will be required to submit written detailed information to the Director of the child care facility. This must include a list of side effects and confirmation that all side-effects have been explained to and are understood by the parent. Any particularly dangerous conditions being experienced by the child should be spelled out in detail, with the procedure to follow should a reaction occur.

Please fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment.

Thank you.

Child Care Center Director

---

**DEAR PARENT/GUARDIAN:**

Some children need the administration of medication in order to function while **currently enrolled** in our child care facility. Ideally, this should take place at home. If your child's medication/equipment schedule cannot be altered so that everything can be administered at home, you can request that they be given medication while in our care by seeing the Director of the child care facility.

When the medication/treatment prescribed for your child exceeds or differs from that approved by the FDA or the manufacturer, you and your health care provider will be required to submit additional written information to the Center Director prior to approval.

Once the request has been approved by the Director of the child care facility, you will be required to bring the medication to the center properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T-Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

This procedure must be repeated **annually and/or each time there is a change in dosage**. Parents/Guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days of the expiration date, or by the last day of enrollment in our child care program, will be destroyed/discarded.

If you have any questions on this procedure, please contact the Director of the child care facility.

Thank you .

**#3: CHILD DENTAL HEALTH/DENTAL EXAM FORM**

Child's Name_____ Date of Birth _____

**SECTION 1: Completed by parent/guardian**

1. Has your child been to the dentist? ☐ No ☐ Yes – if 'Yes', date of child's last dental visit _____
2. Does your child have (or had) cavities or caries? ☐ No ☐ Yes – If 'Yes', how many? _____
3. Does your child have any problems with his/her teeth, gums, or mouth? ☐ No ☐ Yes
   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth? _____

**SECTION 2: Completed by child's Dentist**

1. Date of child's most recent:
   Dental Examination_____Teeth Cleaning_____Fluoride Treatment _____
2. Has child ever needed dental treatment? ☐ No ☐ Yes
   If Yes, type of dental treatment _____
   Has dental treatment been completed? ☐ No ☐ Yes – if 'Yes', date of completion _____
3. Date of child's next dental visit_____

---

Dental Office Stamp

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

# IT'S TIME TO GO TO THE DENTIST!

**Please Note:**

- Addresses and phone numbers may change over time; call before visiting any of the providers listed below.
- For additional dental providers and/or information, please refer to the following:
  - 1-800-DENTIST (Toll-free, nationwide)
  - 215-925-6050 – Philadelphia County Dental Society (for private dentists in your area)
  - American Academy of Pediatric Dentistry - www.aapd.org
  - American Dental Association - www.mouthhealthy.org
  - PCCY (Public Citizens for Children and Youth) - 215-563-5848 - www.pccy.org/issues/child-health/dental
  - Philadelphia Department of Public Health - www.phila.gov/health/services/Serv_DentalCare.html

## PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH – CITY HEALTH CENTERS

**HEALTH CENTER #2**
1930 S. Broad St., Unit #14, 19145
215 - 685 - 1822

**HEALTH CENTER #3**
555 S. 43rd St., 19104
215 - 685 - 7506

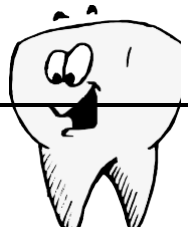
**HEALTH CENTER #4**
4400 Haverford Ave., 19104
215 - 685 - 7605

**HEALTH CENTER #5**
1900 N. 20th St., 19121
215 - 685 - 2938

**HEALTH CENTER #6**
301 W. Girard Ave., 19123
215 - 685 - 3816

**HEALTH CENTER #9**
131 E. Chelten Ave., 19144
215 - 685 - 5738

**HEALTH CENTER #10**
2230 Cottman Ave., 19149
215 - 685 - 0608



## FEDERALLY QUALIFIED HEALTH CENTERS

**ESPERANZA HEALTH CENTER**
3156 Kensington Ave., 19134
215 - 302 - 3156

**FAIRMOUNT HEALTH CENTER**
1412 Fairmount Ave., 19130
215 - 684 - 5349

**MARIA DE LOS SANTOS**
401 W. Allegheny Ave., 19133
215 - 291 - 2509

**ABBOTTSFORD-FALLS**
4700WissahickonAve.,Suite110,19144
215 - 843 - 9720

**HEALTH ANNEX**
6120-B Woodland Ave., 19142
215 - 727 - 4721

**STEPHEN & SANDRA SHELLER (11TH ST. FAMILY HEALTH)**
850 N. 11th St., 19123
215 - 769 - 1100

**ST. CHRISTOPHER'S**
Pediatric Dentistry
3601 A. St., 19134
215 - 427 - 5065

**TEMPLE**
School of Dentistry
3223 N. Broad St., 19140
215 - 707 - 2863

**PENN DENTAL MEDICINE**
Pediatric Dentistry
240 S. 40th St., 19104
215 - 898 - 8965

**CAVITY BUSTERS**
- 240 Geiger Rd., 19115 — 215 - 677 - 0380
- 6801 Ridge Ave., 19128 — 215 - 483 - 6633
- 330 W Oregon Ave - 19148 — 215 - 467 - 6000

**PEDIATRIC DENTAL ASSOCIATES**
- 6404 E. Roosevelt Blvd., 19149 — 215-743 -3700
- 2301 E. Allegheny Ave., 19134 — 215-282 -8000
- 3509 N. Broad St., 19140 - within Temple Hospital, Boyer Pavilion, 6th Floor — 215 - 707 - 6411

**DENTAL DREAMS**
- 2107-B Cottman Ave., 19149 — 215 - 235 - 4060
- 5675 N. Front St., 19120 — 215 - 224 - 0440
- 2459 Aramingo Ave., 19125 — 215 - 427 - 2800

**KIDS SMILES**
- 5828 Market St., 19139 Entrance B — 215 - 747 - 6901
- 2821 Island Ave., 19153 Suite 210 — 215 - 492 - 9291

**DOUGLAS R. REICH, DMD**
- 7122 Rising Sun Ave., 19111 — 215 - 725 - 8300

*job 08/2015 rev.*

# MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133

**PLEASE PRINT**

Page _____ of _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____ (Date) To _____ (Date)

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

_____

_____

**I give permission to administer medication to my child as stated above.**

_____ (Parent Signature) _____ (Date)

| FACILITY STAFF COMPLETE THIS SECTION | | | | |
|---|---|---|---|---|
| **Date Administered (mm/dd/yyyy)** | **Time Administered (a.m. / p.m.)** | **Amount of Medication Administered** | **Comments/Reactions** | **Staff Initials** |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

**This information is confidential and may not be shared or released without the parent's written permission.**

# 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 | Email Address: |
| BUSINESS NAME | BUSINESS TELEPHONE NUMBER |
| ADDRESS | |
| **FATHER'S NAME/LEGAL GUARDIAN** | HOME TELEPHONE NUMBER |
| ADDRESS | Email Address: |
| BUSINESS NAME | BUSINESS TELEPHONE NUMBER |
| ADDRESS | |

| **EMERGENCY CONTACT PERSON(S)** | NAME | ADDRESS | 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** | **VIDEOS** |
| **TRANSPORTATION BY THE FACILITY** | **PHOTOS** |

**PERIODIC REVIEW**

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

**THE SCHOOL DISTRICT OF PHILADELPHIA**
**OFFICE OF EARLY CHILDHOOD EDUCATION**
*440 N. BROAD STREET*
*PHILADELPHIA, PENNSYLVANIA 19130-4015*

## #4: POLICIES and CONSENT for EMERGENCY MEDICAL CARE and OTHER HEALTH SERVICES FORM

*This form will be taken with your child when emergency medical care is needed.*

*Child's Name* _____ *Date of Birth* _____

**EMERGENCY MEDICAL CARE POLICIES**

*Parents, You are responsible for making arrangements for alternate care for your child if he is ill, needs close supervision or has a contagious condition and cannot attend preschool. You are also responsible for transportation if your child has an illness or minor injury while at preschool, not sufficiently severe to warrant emergency medical transportation.*

*In the event your child becomes seriously ill or injured and requires immediate medical attention, s/he will be accompanied by staff and taken to the nearest hospital emergency room in an emergency medical vehicle. We will attempt to notify you at once. Under the Medical Services/Minor Act, immediateemergency treatment will be initiated at the hospital. However, your child's teacher and the hospital must be able to locate you as soon as possible, to give either written or monitored verbal permission for comprehensive treatment. Please be sure to keep your child's teacher informed about how to reach you at all times.*

*You are responsible for the costs of medical treatment if your child is injured. Please contact Early Childhood Health Services if your child needs medical insurance.*

*A Doctor's note is required before your child can return to preschool if s/he has any of the following: an emergency room visit, certain cases of illness (contagious, serious, requires a long absence, surgery, etc), or certain cases of injury (needing doctor's care, cast or brace, special activities, etc.). If you have any doubt, please obtain a Doctor's note whenever your child goes for medical care.*

**CONSENT** *for* **EMERGENCY MEDICAL CARE, PREVENTIVE SCREENINGS, and OTHER HEALTH SERVICES**

*My signature below indicates that I understand the Emergency Medical Care Policies and give consent for:*

1. *The administration of minor first aid to my child by preschool classroom staff;*
2. *The emergency medical and/or dental care which may be necessary to preserve the life of my child or to prevent impairment of his/her health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for ongoing care;*
3. *My child is to participate in the Office of Early Childhood Education's screening program which may include but is not limited to: developmental screening, behavioral screening, vision screening, hearing screening, and dental screening. I understand that as part of the preventive health program, children participating in preschool programs of The School District of Philadelphia receive screenings during the school year;*
4. *The Schoo! District of Philadelphia's Office of Early Childhood Education Program Mental Health Consultation Services provides services on an as needed basis. These services may include:*
    a. *Observation of my/our child in the preschool setting and consult with teaching staff regarding strategies and techniques to support my/our child's healthy social/emotional development;*
    b. *Conduct assessments and behavioral/developmental screenings, using standardized tools, across all domains of my/our child's development;*
    c. *Provide behavioral health consultation services to my/our child and his/her teacher within the early childhood facility;*
    d. *My/Our invitation to participate in team meetings and action plan development for my/our child's social/emotional well-being, where I/we will be provided with information about child-related issues and resources within my/our community that could be helpful.*

*If you have any questions about the above information, please speak with a representative from Early Childhood Health Services.*

*Signature of Parent/Guardian:* _____ *Date:* _____

**Early Childhood Use Only**

Name of Location: _____

Signature of Early Childhood Staff: _____ Date: _____

# ALGEN HOLDING COMPANY

*www.TheAlGenHoldingCo.org*


The Harvard Children's Academy
4900 Baltimore Avenue
Philadelphia, PA 19143
Ph.: (215) 729-9900
Fax: (215) 729-9901
***Email: hca@thealgenholdingco.org***

Franklin Day Nursery
719 Jackson Street
Philadelphia, PA 19148
Ph.: (215) 389-2991
Fax: (215) 389-2323
***Email: fdns@thealgenholdingco.org***

Franklin Day Nursery Northeast
5416 Rising Sun Avenue
Philadelphia, PA 19120
Ph.: (267) 428-5814
Fax: (267) 428-5847
***Email: fdnne@thealgenholdingco.org***


## "Helping Children Grow"

### Child's Social Development

Parent/Guardian: Please complete this form to the best of your knowledge. Your answers will help us to better understand and assist your child while enrolled in preschool.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Today's Date: _____

1. Please list activities your child enjoys: _____.

2. Please list the activities your child does not enjoy: _____.

3. Does your child take a nap? (please check one)___(YES) ___(NO); If yes, what time:_____ and how long is the nap: _____.

4. What time does your child usually go to bed at night? _____ and wake up in the morning _____.

5. Does your child sleep with a light on? (please check one)___(YES) ___(NO).

6. Does your child have a bedtime routine? (please check one)___(YES) ___(NO); If yes, please describe your child's bedtime routine _____.

7. Does your child have trouble sleeping? (please check one)___(YES) ___(NO); If yes, please describe your child's trouble with sleeping _____.

8. What words does your child use to indicate that he/she needs to use the bathroom? _____.

9. How does your child act with children he/she doesn't know? _____.

10. How does your child act with adults he/she doesn't know? _____.

11. Please tell us what your child is afraid of: _____.

12. How do your comfort your child? _____.

13. Does your child have difficulty expressing what he/she wants? (please check one)___(YES) ___(NO)

14. Do you have difficulty understanding your child? (please check one)___(YES) ___(NO); If yes, please explain how you communicate with your child _____.

15. Have there been a big change(s) in your child's life within the past 6 months? (please check one) __(YES) ___(NO)

16. Children learn to do things at different ages. So that we can better fit our program to meet your child's needs, please tell us, as best as you can remember, at what age your child began doing the following tasks:

| TASK | AGE | | TASK | AGE |
|---|---|---|---|---|
| Sitting Up Without Help? | | | Use the Toilet? | |
| Crawl? | | | Respond to Directions? | |
| Walk? | | | Play with Toys? | |
| Talk? | | | Use Crayons? | |

**THE SCHOOL DISTRICT OF PHILADELPHIA**
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET
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## #2: CHILD'S MEDICAL CONCERNS FORM

Child's Name _____ Date of Birth _____

Dear Parent/Guardian,

The Office of Early Childhood Education recognizes the fact that some children have a medical condition that requires prescribed medication. When the prescribed medication is to be administered during preschool hours, a representative from Early Childhood Health Services, with written permission, will train the staff at your child's preschool to administer the medication to your child. Written permission is given by submitting form MED-1: Request for Administration of Medication, completed by you and your child's health care provider for each medication. **At no time will medication be given to your child without a completed MED-1.**

Please check one box and complete as necessary – use additional paper if needed:

☐ At this time, my child does not have a medical condition.

☐ My child has the following medical condition(s):
A representative from Early Childhood Health Services may contact you for more information.

1. Diagnosis or medical condition: _____
   - ☐ Does not require medication to be administered
   - ☐ Requires medication to be administered **DAILY**
     Medication name, dose and times _____
   - ☐ Requires medication to be administered **AS NEEDED**
     Medication name and dose _____

2. Diagnosis or medical condition: _____
   - ☐ Does not require medication to be administered
   - ☐ Requires medication to be administered **DAILY**
     Medication name, dose and times _____
   - ☐ Requires medication to be administered **AS NEEDED**
     Medication name and dose _____

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to immediately inform my child's teacher or Early Childhood Health Services if there is a change to the information indicated above.

_____ _____
Signature of Parent/Guardian Date

**Early Childhood Use Only**

Name of Location: _____

Signature of Early Childhood Staff: _____ Date: _____

## DIETARY RESTRICTIONS

Center _____

Child's Name _____ Date of Birth_____

Dear Parent/Guardian,

The Child and Adult Care Food Program (CACFP) provides a daily nutritional breakfast, lunch and snack for your child. A monthly menu, posted in each center, lists the foods and beverages that your child is offered at each meal component. The Office of Early Childhood recognizes the fact that certain foods, due to religious, medical or other reasons, are restricted from some children's diets. Please tell us about your child. This information will be shared with your child's nutritional, health and instructional staff. In order to ensure that your child is receiving an age appropriate, nutritionally sound diet, **requests for food restrictions must be verified by a note from your child's health care provider or religious leader.** If your child has a dietary restriction, efforts will be made to provide your child with an allowable substitution.

If your child has a significant food allergy which requires the administration of an **EPI-PEN, Benadryl or other medication,** please let us know immediately so that we can begin the process required to train the center staff.

Please check one box and complete as necessary:

☐ At this time, my child does not have a dietary food restriction.

☐ My child has the following dietary food restriction(s):

1. Name of restricted food: _____

Reason for restriction: Religious _____

Other (please specify)_____

Medical _____ Please indicate reaction and treatment: _____

_____

2. Name of restricted food: _____

Reason for restriction: Religious _____

Other (please specify) _____

Medical _____ Please indicate reaction and treatment: _____

_____

3. Name of restricted food: _____

Reason for restriction: Religious ____

Other (please specify) _____

Medical _____ Please indicate reaction and treatment_____

_____

The information on this form is true to the best of my knowledge. I will inform my child's teacher if any of this information changes.

_____ _____

Signature of Parent/Guardian Date

# ALGEN HOLDING COMPANY

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Franklin Day Nursery Northeast
5416 Rising Sun Avenue
Philadelphia, PA 19120
Phone: (267) 428-5814
***Email: fdnne@thealgenholdingco.org***


## *"Helping Children Grow"*

### *Child's Nutrition History*

Parent/Guardian: Please complete both sides of this form to the best of your knowledge.
Child's Name: _____Today's Date: _____

1. What foods does your child like? _____
2. What foods does your child dislike? _____
3. Place a ***CHECKMARK*** in the **NO** or **YES** column next to each question:

| | **YES** | **NO** |
|---|---|---|
| Does your child take vitamins? | | |
| Do the vitamins contain iron? | | |
| Do the vitamins contain fluoride? | | |
| Are the vitamins prescribed by a doctor? | | |
| Is your child on a special diet? | | |
| Is the diet recommended by a doctor? | | |
| Has there been a noticeable change in your child's appetite in the last month? | | |
| Does your child eat or chew things that aren't food? | | |
| Does your child have a problem chewing or swallowing? | | |
| Does your child drink from a bottle? | | |
| Does your child often have diarrhea? | | |
| Does your child often have constipation? | | |
| Do you have any concerns about what your child eats? | | |
| Are you receiving WIC? | | |
| Are you receiving Food Stamps (SNAP)? | | |

4. Place a ***CHECKMARK*** under the column that indicates the approximate number of times a week your child eats the following food:

| | **0** | **1** | **2** | ***3*** | **4** | ***5*** | **6** | **7** | **7+** |
|---|---|---|---|---|---|---|---|---|---|
| Milk (Whole, Skim, Low Fat, Lactose Free) | | | | | | | | | |
| Cheese, Yogurt, and/or Eggs | | | | | | | | | |
| Peanut Butter | | | | | | | | | |
| Dried Beans, Peanuts, and/or Seeds | | | | | | | | | |
| Beef, Poultry, Chicken, and/or Fish | | | | | | | | | |
| Rice, Grits, Bread (any type), Cereal, and/or Tortillas | | | | | | | | | |
| Green Vegetables, Carrots, and/or Broccoli | | | | | | | | | |
| Winter Squash, Pumpkin, and/or Sweet Potatoes | | | | | | | | | |
| Oranges, Grapefruit, Tomatoes, and/or Fruit Juice | | | | | | | | | |
| Other Fruit and/or Vegetables | | | | | | | | | |
| Oil, Butter, Margarine, Jam, Jellies, and/or Olive Oil | | | | | | | | | |
| Cakes, Cookies, Soda, Fruit Drinks, and/or Candy | | | | | | | | | |

# THE SCHOOL DISTRICT OF PHILADELPHIA

OFICE OF EARLY CHILDHOOD EDCUATION
440 N. BROAD STREET
PHILADELPHIA, PENNSYLVANIA, 19130

## FAMILY STRENGTH ASSESSMENT

Dear Parent/Guardian

The Head Start Performance Standards requires each program to assess the strengths of each family it enrolls. The purpose of the Family Assessment is to enable the program staff to assist and support you and your family as you move toward accomplishing your goals. Please complete the Family Profile so that we may provide you the necessary information and referrals in order to help you achieve the mutual goals you develop.

| FAMILY PROFILE | |
|---|---|
| CENTER: | DATE: |
| Child's Name: | Parent's Name |
| Address: | |
| Phone Number: | Cell Number: |

**Ethnicity:**

Hispanic or Latin Origin  American Indian or Alaskan Native  Asian  White

Black or African American  Biracial/Multiracial  Native Hawaiian or Pacific Islander

Other  Unspecified

**Primary Language:**

English____  Spanish____  Native Central/South American and Mexican ____  African___

Caribbean____  Middle East/South Asian____  East Asian____  Pacific Island_____

European/Slavic____  Native North American/Alaskan____  Other (specify)_____

Unspecified

| Number of adults in household over 18 years of age | # |
|---|---|
| Other children under 18 years of age | Date of Birth |
| | |
| | |
| | |
| | |
| | |

| Family Profile Questions | Yes | No |
|---|---|---|
| Are you the parent or guardian of the child? | | |
| Are you the child's grandparent/relative? | | |
| Is your family involved in Foster Care? | | |
| Is this child in Foster Care? | | |
| Is your family currently receiving services from DHS? | | |
| Is your family currently receiving SCOH services?<br><br>If yes, what is the name of the agency: _____ | | |
| Where you referred by an agency?<br><br>If yes, what is the name of the agency? _____ | | |
| Are you a United States Citizen? | | |
| How long have you lived in the United States? | | |
| Do you have any disabilities or other physical/mental concerns that prevent you from caring for your family? | | |
| Does your child have any disabilities? | | |
| Are you currently seeking other housing arrangements? | | |
| Do you live in a shelter or transitional housing? | | |
| Do you feel safe in the place you are currently living? | | |
| Have you been displaced due to a hardship?<br><br>If yes, please check or explain. | | |

| | |
|---|---|
| | Displaced by fire. |
| | Displaced due to domestic violence. |
| | Displaced due to loss of income. |
| | Displaced due to an eviction/put out of home. |
| | Displaced due to flood/housing beyond repair. |
| | Other _____ |
| | How many times have you moved in the past year? |

| Educational Profile | | |
|---|---|---|
| Do you have a High School Diploma? | | |

| | | |
|---|---|---|
| Do you have a GED? | | |
| Do you have some College Credits? | | |
| Do you have a College Degree?<br><br>If yes, check appropriate<br><br>Master Doctorate | | |
| Are you currently enrolled in school/college?<br><br>If yes, full time_____ part time_____<br><br>Where? _____<br><br>Length of program _____ | | |
| Are you interested in additional information for continuing education opportunities for yourself or family member? | | |
| What type of information?<br><br>GED _____ Trade School _____ College _____ Financial Aid _____ | | |
| What Skills or talents do you bring to the Head Start Program<br><br>Secretarial_____ Technical_____ Health _____ Arts/Crafts _____<br><br>Sewing_____ Child Care _____ Other (specify) _____ | | |
| **Child Care Survey** | | |
| Do you need before and after school for your child? | | |
| Does/Will your child attend a child care facility or child care home after the Head Start day? | | |
| **Employment and Training** | Yes | No |
| Employed<br><br>If yes, Employer Name _____<br><br>Employer Address _____<br><br>Employer Phone Number _____ | | |
| Are you working part time? | | |
| Are you working full time (35 hrs/week or more) | | |
| Unemployed, seeking work | | |

| | | |
|---|---|---|
| Homemaker | | |
| Student | | |

# AGREEMENT

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

| NAME OF CHILD | | |
|---|---|---|
| FEE AMOUNT<br>$ | PER-DAY-WEEK | DAY PAYMENT TO BE MADE |

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

Head Start

Meals: Breakfast, Lunch, and Snack

| CHILD'S ARRIVAL TIME | CHILD'S DEPARTURE TIME | PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED |
|---|---|---|
| 8:30 am | 2:30 pm | |
| LATE FEE<br>$ $1.00 | PER MIN-HR<br>Per Min. After 3:00 pm | |

**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 | PERIODIC REVIEW |
|---|---|
| DATE OF WITHDRAWAL | SIGNATURE-PARENT OR GUARDIAN DATE |

# ALGEN HOLDING COMPANY

www.TheAlGenHoldingCompany.org


FRANKLIN DAY NURSERY
719 JACKSON STREET
PHILADELPHIA, PA 19148
(215) 389-2991
fdns@thealgenholdingco.org

FRANKLIN DAY NURSERY NORTHEAST
5416 RISING SUN AVENUE
PHILADELPHIA, PA 19120
(267) 428-5814
fdnne@thealgenholdingco.org

THE HARVARD CHILDREN'S ACADEMY
4900 BALTIMORE AVENUE
PHILADELPHIA, PA 19143
(215) 729-9900
hca@thealgenholdingco.org


## CIVIL RIGHTS COMPLIANCE
Parent/Guardians

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

To file a complaint of discriminated against on the basis of our race, color, religious creed, disability, ancestry, national origin, age, or sex. Complaints of discrimination may be filed with any of the following:

Franklin Day Nursery
719 Jackson Street
Philadelphia, PA 19148

Franklin Day Nursery Northeast
5416 Rising Sun Avenue
Philadelphia, PA 19120

The Harvard Children's Academy
4900 Baltimore Avenue
Philadelphia, PA 19143

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105

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

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

_____
Parent Signature Date

_____
Director Signature Date

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(215) 729-9900
hca@thealgenholdingco.org


To: Parent/Guardian
From: Lisa Oliver, Executive Director
Maria Santos, Director
Zakia Royster, Director
Re: Nondiscrimination in Services

Admission, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, age, sex, national origin Limited English Proficiency (LEP).

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with:

Franklin Day Nursery
719 Jackson Street
Philadelphia, PA 19148

Franklin Day Nursery Northeast
5416 Rising Sun Avenue
Philadelphia, PA 19120

The Harvard Children's Academy
4900 Baltimore Avenue
Philadelphia, PA 19143

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105

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

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

_____

Parent Signature Date

_____

Director Signature Date

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RE: PARENT/GUARDIAN AGREEMENT and ACKNOWLEDGMENT OF HANDBOOK

8. I/ We (used for Parent(s)/Guardian(s)) agree to comply with the rules and regulations of this center.

9. I will timely notify this center if my child is absent or tardy.

10. I agree to give two weeks written notice to this center if my child will be withdrawing for any reason.

11. I agree to pick up my child at the agreed upon dismissal time or risk paying a late fee and possible termination from the program.

12. I agree to make tuition and co-pay payments in advance, on the Friday before the week due, o·rrisk paying a late fee and possible termination from the program.

13. I agree to cooperate with the staff at this center to ensure the safety, health and well-being of my child and so that my child will have a rewarding learning experience.

14. I have received and reviewed the Parent/Guardian Handbook for this center. It is my responsibility to read it and to ask questions. I will read the updates and Parent/Guardian memos that are sent home daily and/or weekly, so that I can stay informed about this center and my child's learning experience.

I understand that failure to comply with the above statements could jeopardize my child's enrollment at this center.

Name of all children: _____
_____
_____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Director/Director's Designee Signature: _____ Date: _____

**Copy kept in each child's file