lititz
recCenter

recKids
Child Care

ENROLLMENT

BEFORE YOU BEGIN...

Please have this information handy before you begin completing these ENROLLMENT FORMS.

- Child's prescription info for any medications they take regularly.
- Emergency contact names and phone numbers.
- Name, address and phone number for persons who will pick up your child.
- Child's doctor name, address, phone and medical insurance information.

YOUR PROGRESS CANNOT BE SAVED if you choose to complete the following forms online!

recKids ENROLLMENT CHILD INFORMATION

Child's Name FIRST _____ LAST _____ Birth Date _____ Gender ◯ Fem ◯ Male

School Attending _____ Grade _____ Has your child previously attended a recKids Program? ◯ YES ◯ NO

Which program (s) will your child attend?

SCHOOL YEAR ☐ recKids Preschool ☐ Before School ☐ After School (K-3rd) ☐ After School (4th- 6th) ☐ Snowy/Special Day

PREFERRED SCHOOL YEAR ATTENDANCE DAYS: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri

Drop-Off Time: _____ Pick-Up Time: _____ Requested START DATE: _____

SUMMER *(min 3-week consecutive enrollment)* Grade Completed: ◯ PreK/Kind ◯ 1st-3rd ◯ 4th-6th

PREFERRED SUMMER ATTENDANCE DAYS: ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri

Drop-Off Time: _____ Pick-Up Time: _____ Requested START DATE: _____

Summer T-shirt Size: ◯ YSM ◯ YM ◯ YL ◯ AS ◯ AM ◯ AL

School District Child normally attends: ◯ Warwick SD ◯ Manheim Central SD ◯ Manheim Tsp SD ◯ Other _____

Child Custody, Release and Support:

Does your child have an IEP (Individual Education Program)? ◯ YES ◯ NO

Please Note: *If Applicable, a copy of the full IEP must be turned in at least 5 days prior to your child's first day of attendance and may require meeting with the onsite staff before care begins.*

Does your child require a TSS, classroom aide, behavioral/emotional supports? ◯ YES ◯ NO

Are there person (s) your child MAY NOT BE RELEASED TO? FULL NAME _____

Please Note: *If court documents are available supporting this restriction, please provide these.*

Are there Custody/PFA Court Documents for your child? ◯ YES ◯ NO

Please Note: *If Applicable, all Custody/PFA Court Documents must be turned in prior to your child's first day of attendance (all information is confidential).*

Child's Household Information:

Parent/Guardian Full Name: _____ Parent/Guardian Full Name: _____

Date of Birth: _____ Phone _____ Date of Birth: _____ Phone _____

Relation to Child _____ Relation to Child: _____

Address: _____ Address: _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Email (s) to receive child care communications: _____ _____

Others who reside at the child's home: _____ **Age** _____ **Relation** _____

_____ **Age** _____ **Relation** _____

Does your child currently receive child care subsidy (ELRC)? ◯ YES ◯ NO **Free & Reduced School Lunch?** ◯ YES ◯ NO

Special Dietary, Medical, Physical Needs

Does your child require medication, have allergies, or are there other dietary or medical restrictions or conditions? ◯ **YES** ◯ **NO**

If YES, *please provide details on the following page.*

Child Physical, Medical, Dietary Individual Action Plan

If your child has any **physical, medical, dietary,** or other special needs, please note them on this form. If these needs require specific care, a copy of the script from the doctor's office is required before your child starts a recKids program.

If this form does not pertain to your child, please write "none" under each item and sign & date the bottom of the form.

CHILD'S FULL NAME _____ DATE of BIRTH _____

1. Please state the nature of your child's physical, medical, dietary, or other special need:

2. Please provide signs/symptoms indicating your child's need and explain the course of action to be taken if symptoms are exhibited:

3. In case of an emergency, your child will be transported to the nearest medical facility. If your health insurance requires a specific hospital or provider for treatment, please indicate this in the event that your child can be transported there:

4. Please list medications your child takes on a regular basis. If these need to be administered by our staff, you will need to provide doctor's instructions along with the original container of medication. Any prescribed medications including inhalers and EpiPens, must be turned in to the recKids office prior to the child's first day of attendance, along with a script from the provider who prescribed the medication. ***Staff cannot provide or administer ANY over the counter or prescription medication (including Benadryl, Tylenol, etc.) without a current doctor's script.***

Name of Medication _____ Type _____ (pill, inject, etc)

Prescription Provided ◯ Yes ◯ No Expiration Date _____

Name of Medication _____ Type _____ (pill, inject, etc)

Prescription Provided ◯ Yes ◯ No Expiration Date _____

Name of Medication _____ Type _____ (pill, inject, etc)

Prescription Provided ◯ Yes ◯ No Expiration Date _____

Parent/Guardian _____ Signed 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	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)

LITITZ recKids CHILD CARE

CHILD'S FULL NAME _____

In the course of recKids child care programs your child will have many opportunities for activity. For children to fully participate, parents/guardians are required to provide the following permissions and releases:

- **Photo Release**
- **funZone Permission**
- **Sunscreen Permission**
- **Release of Information**

*Please review the information provided below and indicate your agreement by **initialing and signing below**. Without your agreement, your child might be unable to participate in specific activities.*

☐ **Photo Release:** From time to time Lititz recCenter will take photos or video of children engaged in recKids activity to use for promotional purposes. By signing, I hereby give permission to Lititz recCenter to secure and use photographs and/or video of the minor in my guardianship for use in promotional publications or other communication related to the mission of Lititz recCenter.

☐ **funZone Permission:** If and when my child attends funZone at Lititz recCenter, I agree that my child is responsible to follow safety guidelines and instructions from staff. As required, I will complete a waiver specific to funZone participation indicating specific risks and my release of liability for my child.

☐ **Sunscreen Permission**: I give Lititz recCenter staff permission to allow my child to apply his/her own provided sunscreen as applicable to recKids activities.

☐ **Release of information:** I authorize Lititz recCenter staff to communicate with caregivers and resource providers such as school district or IU personnel in order to create an effective care, behavior, or support plan for my child within the recKids child care program.

I agree to the above and grant permission for my child pertaining to the above outlined activities during their time attending recKids programs:

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

NEXT PAGE

OPTIONS for CHILD HEALTH REPORT:
You can provide the following form to your child's doctor to complete, OR you can provide us with a copy of your child's most recent physical AND an immunization report. These can be requested from your doctor or school nurse.

Child Health Report, Physicals, and Immunizations can be emailed to recKids@lititzrec.com, or faxed to 717-627-3795.

Files can also be attached if you are completing this packet online.

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: Lititz recCenter		
FACILITY PHONE: 717-626-5096 ext 234	COUNTY: Lancaster	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						

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

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

THANK YOU FOR COMPLETING ENROLLMENT INFORMATION FOR YOUR CHILD!

REMINDER:

You might be prompted to verify your email address when you submit these forms online. Don't forget to check your email and click to verify!

Questions? Contact recKids Child Care 717.626.5096, ext 234 or recKids@lititzrec.com

Signature:

Email: gabrielgriffith@lititzrec.com

Signature:

Email: barbfishel@lititzrec.com