CDD PRESCHOOL / SCHOOL AGE APPLICATION

** Date Completed: _____

Last Name (Child)	First Name (Child)	Sex
		☐ Male ☐ Female

Child's Date of Birth	Current Age	Birthplace	Phone Number
/ /	☐ 3 ☐ 4 ☐ 5		- -

Street Address:		County:
City:	State:	Zip Code:
Child Lives With: ☐ One Parent ☐ Both Parents ☐ Foster ☐ Other (Please Specify): _____		
Names and ages of siblings: _____		

Parent/Guardian Information	
Mothers Name: _____ Address: _____ City/State/Zip: _____	Fathers Name: _____ Address: _____ City/State/Zip: _____
Phone (Home if different plus alternate i.e. cell, work):	Phone (Home if different plus alternate i.e. cell, work):
Email Address:	Email Address:

Childcare, Preschool or Playgroups Attended			
Program/Caregiver:	When (from/to):	Location:	Days and Hours:
Any Comments:			
Does your child have opportunities to play with children his/her own age? If yes, describe.			

Provide a brief account of any evaluations, agencies or services for your family or child (i.e. Early Intervention, private therapies, WIC, C&Y, Provider 50, CCIS, ets.):

Describe your child's strengths and things he/she likes to do:

Do you have any concerns about your child's development?

Can your child:

Take turns while playing a game?	☐ Yes	☐ No	☐ Sometimes	
Follow one-step directives (i.e. go find your shoes)?	☐ Yes	☐ No	☐ Sometimes	
Listen to a short story (2-3 minutes)?	☐ Yes	☐ No	☐ Sometimes	
Assist in getting him/herself dressed?	☐ Yes	☐ No	☐ Sometimes	
Eat and drink independently?	☐ Yes	☐ No	☐ Sometimes	
Toilet Independently?	☐ Yes	☐ No	☐ Sometimes	

When your child is:

Happy, he/she will: _____

Unhappy, he/she will: _____

Frustrated, he/she will: _____

Afraid, he/she will: _____

My favorite:

Toys are: _____

Books are: _____

Foods are: _____

Activities are: _____

TV shows/Movies are: _____

Is there any information about your child that you would like to share with CDD staff to help support him/her in our program? Include unique family customs or traditions, languages besides English spoken in the home, etc.

Things your child likes to do with family or friends?

CDD Developmental History

Name of Child:_____ Birthdate: _____

A child's development since birth influences his/her total health and growth. Please answer the following questions:

History of Birth:

1. Mother's age at child's birth: _____
2. Were there any unusual conditions during pregnancy (i.e. bleeding, infection German Measles, medication, high blood pressure? _____ If yes, which illness and when did illness occur?
   _____
3. Was the baby premature? _____ at what month was baby delivered? _____
4. What was the baby's weight at time of birth? _____
5. Was delivery normal? _____ Forceps delivery? _____ C-Section? _____ If C-Section, why?
   _____
6. Were there any conditions or problems in the child after birth (i.e. jaundice, need for oxygen, birth injuries, or birth defect? _____ Comment _____

History of Infancy and Childbirth:

Has your child shown any of the following? (Answer Yes or No)

1. Extreme Activity _____ Comment:_____
2. Extremely Tired/Sleepy _____ Comment:_____
3. Frequent Headaches _____ Comment:_____
4. Temper Tantrums _____ Comment:_____
5. High Fevers _____ Comment:_____
6. Fainting _____ Comment:_____
7. Convulsions/Seizures _____ Comment:_____
8. Feeding Problems _____ Comment:_____
9. Bowel/Bladder Problems _____ Comment:_____
10. Allergies _____ Comment:_____
11. Frequent Stumbling/Falling _____ Comment:_____
12. Poor Coordination _____ Comment:_____
13. Nail Biting _____ Comment:_____
14. Eye Blinking _____ Comment:_____
15. Stuttering _____ Comment:_____
16. Bed Wetting _____ Comment:_____
17. Thumb Sucking _____ Comment:_____
18. Other Habits/Problems _____ Comment:_____
19. Any Injury to Eyes/Head/Neck _____ Comment:_____
20. Any Hospitalizations _____ Comment:_____
21. Any family history of birth defects, convulsive disorders, heart disease, diabetes, TB? _____ Comment:_____
22. Has your child been to any clinics or other agencies? _____ Comment:_____
23. At what age did your child first sit alone _____, walk alone _____, crawl _____, said single words _____, talk in sentences _____, first tooth _____, bowel trained _____, bladder trained _____
24. Is there any other pertinent health information we should be advised of?
    _____

Child's Name:	Date of Birth:

MEDICAL INFORMATION
Child's physician, address, and phone number:
Date of most recent Health Assessment:
Are immunizations up to date? ☐ Yes ☐ No, if no reason:
List any allergies?
List any medications your child is currently taking and dosage:
Any other medical conditions or concerns?
Any special diet or food concerns/choices?

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 _____

CHILD PICK-UP AUTHORIZATION FORM

Child's name: _____

Main pick-up person:

Name: _____

Address: _____

Relationship: _____

Phone: _____

Additional persons who may pick up child/children on a less frequent basis:

Name: _____

Address: _____

Relationship: _____

Phone: _____

Name: _____

Address: _____

Relationship: _____

Phone: _____

any person(s) NOT authorized to pick up my child/children:

_____

_____

Note: Any person unfamiliar to me will be required to show proof of identification. Under NO circumstances will the child be released to anyone other than those listed above without WRITTEN permission from the parent.

Mother's/Guardian's Signature: _____ Date: _____
and / or
Father's/Guardians 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

Date: September 1, 2016
Subject: Nondiscrimination in Services
To: Families and Community Stakeholders
From: Lisa Randazzo, Executive Director

Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

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

Center for Developmental Disabilities of Pike County, Ltd.
Lisa Randazzo, Executive Director
101 Pocono Drive
Milford, PA 18337
Tel. (570) 296-3992
Fax (570) 296-4919

Department Human Services
Bureau of Equal Opportunity
Room 223 Health & Welfare Bldg.
P.O. Box 2675
Harrisburg, PA 17105-2675
Tel. (570) 717-787-1127
Fax (570) 717-772-4366

PA Human Relations Commission
Harrisburg Regional Office
333 Market Street, 8th Floor
Harrisburg, PA 17104

U.S. Dept. of Health & Human Services
Office of Civil Rights
Suite 372, Public Ledger Bldg
150 S. Independence Mall West
Philadelphia, PA 19106-1911

X_____
Parent/Guardian Signature

APPENDIX "FEE SCHEDULE"

CDD is pleased to provide your child with quality programs and services. Our fee schedule varies according to the amount of program time you choose that best fits your needs and the needs of your child.

There is an initial non-refundable $50 registration fee due immediately to hold your child's spot in the schedule of your choice.

Invoices are generated by our Fiscal Manager monthly and payments are due one month in advance of care, any payment that is not received by the 5th business day of the month will incur a $5 per day late fee until received. If your payment is more than 2 weeks overdue, CDD reserves the right to discontinue programs and services to your child until payment is received.

Please note CDD allows for one week of vacation exempt from your payment agreement whereas a one month written notice is required for any scheduled family vacation time during our fiscal year **July 1st – June 30th**. CDD does not have a sick day allocation as our staffing is scheduled according to the number of regularly scheduled students requiring care. Snow Days are built into our School Calendar and are counted as scheduled program days. Please note that CDD follows the DVSD Snow Closings & Delay announcements.

All questions in regards to payments please contact CDD at 570-296-3992 or email lrandazzo@cddkids.org.

As space permits we do accommodate additional care please contact our Family Support Specialist to inquire at 570-296-3992 x226 or vmccabe@cddkids.org.

FEE SCHEDULE:

$22 per day under 4 hours of care per day
$35 per day for 4 hours and over of care per day

APPENDIX "FEE SCHEDULE"

I/We _____ the parent or guardian of _____ understand and do hereby agree to the above outlined fee schedule for my/our child while attending CDD for programs and services as well as the below identified days & times of scheduled care and the above outlined payment terms:

Days of Care: M T W R F

Times of Care: **(care is available 7am-6pm):**

_____

_____

Parent or Guardian's Signature(s):

_____

Date: _____ **Phone Number:** _____

For CDD Staff Use Only

_____

_____

_____

_____

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						

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.

Information Release Form

Parents and Guardians,

In an effort to meet Federal privacy laws, we are asking that you complete the form below with names of individuals with whom our staff may communicate regarding your child's program. Please include physicians, therapists, childcare providers, Provider 50 agencies, county agencies (i.e. C&Y, CCIS), grandparents and any friends or family who may be participating in your child's program.

Name: Address: Phone:

_____

_____

_____

_____

_____

Parent/Guardian Signature_____ Date_____

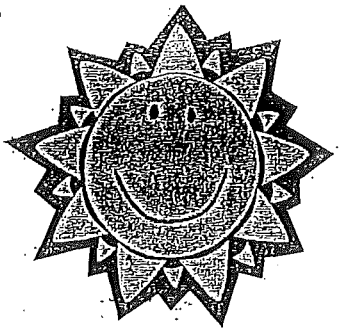
Publicity Permission

Child's Name _____

I grant to CDD, its representatives and employees the right to take photographs of my child in connection with his/her Early Intervention or Early Childhood Education program. I authorize CDD, to use and publish the same in print and/or electronically. I agree that CDD may use such photographs as well as photos provided by me with or without my name and for any lawful purpose such as publicity, fundraising, advertising, and Web content.

I have read and understand the above:
Parent's Name _____
Signature _____
Address _____
Date _____

101 Pocono Drive, Suites 2 & 3 | Milford, Pennsylvania 18337
Tel (570) 296-3992 | Fax (570) 296-4919



Sunscreen Permission Form

Dear Parents/Guardians,

As part of our curriculum, children who attend CDD spend time outside each day, weather permitting. Therefore, we are requesting you complete the enclosed Sunscreen Permission Form in order for staff members to apply/or not apply sunscreen to your child.

Please complete and return to Vicki or Donna

Yes. I give permission for CDD staff to apply sunscreen to my child while at school. I will provide the sunscreen in a plastic bag with my child's name on it.

Child's name: _____

Parent's Signature: _____

Date: _____

OR

No. I would prefer to put sunscreen on my child prior to coming to school each day.

Childs Name: _____

Parent's Name: _____

Date: _____

CDD 

VISION/HEARING SCREENING CONSENT FORM
Please Fill out In Full.....Please Print

Child's Name_____

Date of Birth:_____Age:_____Sex: M___F___

Address_____

City/State_____Zip Code_____

Home Phone_____Cell Phone_____Email_____

As the undersigned parent/guardian, I hereby grant permission to CDD to screen the hearing of the above named child.

Parent/guardian Signature:_____Date:_____

Thank you,

Lisa Randazzo,
Executive Director