

Endless Innovation Academy Enrollment Packet

innovation
cognition learning
play growth skills
development
inspiration socialization
vision knowledge
expression

*motor
imagination*

ENDLESS INNOVATIONS
ACADEMY

PUBLISHED 09/2018

EIA
Behavior policy

At Endless Innovation Academy, we hold each child's safety with the upmost importance. This is our behavior policy and protocol for all students/children in our facility. Incident reports will be written, saved and a copy sent home to parents.

Protocol to Follow

- Verbal and/or Non-verbal redirection in the classroom.
- Cool down area in classroom.
- Cool down area with staff outside the classroom. Then redirected back into classroom setting.
- One-on-one with staff outside classroom for no longer than 1 hour. If student is not able to be reintroduced back into classroom setting within such hour. Parent and/or Guardian is called to have the student picked up with in a timely matter.
- If on-going concern with the students' behavior and/or safety issue a meeting will be scheduled.
- At directors' discretion students may be suspended or disenrolled if behaviors warrant safety concern for students or staff.

Date: _____

Student/Child's Name: _____

Parent Signature: _____

Stakeholders List / Parent Input

1. What school district will your child be attending in the future?

2. Please write the appropriate Elementary/ Middle School your child attends or will be attending.

3. Please share any other possible partner of human service agency that would be responsible for the success of the transition to kindergarten for your child.

6. What are your child's favorite foods? _____

7. What are your child's least favorite foods? _____

8. What (how do you) calms your child down? _____

9. What angers your child? _____

10. Are there any special problems or fears we should know about? _____

11. Does your child have any special needs / medical, developmental, social or mental health?
Yes ___ No ___ Do any of these special needs require special care by our teachers/staff?

12. Is your child potty trained? Yes ___ No ___ Would you like our assistance? Yes ___
No ___

13. Is there any information that will help us make the first few days in our program easier for
your child?

"Getting To Know You"

Child's Name: _____

Name of Meeting Attendees: _____

Meeting Dates: Enrollment: _____ Getting To Know You: _____

If "Getting To Know You" meeting was refused...

Date of refusal by parent: _____ Parent Initials: _____

1. Who lives in the household with your child: (Please list names, relationship & age)

2. Does your child have any parent that does not live in the home? Yes ___ No ___

Does your child visit this parent? Yes ___ No ___ Are there any custody issues we should discuss? Yes ___ No ___

3. Does your child respond to nicknames? _____

4. Is there any information about your family that you would like to share?

5. Has your child been in an early learning program or child care before? If yes please answer the following:

Where: _____ When: _____

How Long: _____ Reason for leaving: _____

Permission to Photograph

I give Endless Innovation Academy LLC, permission to photograph my child/children for the following purposes:

- *Display in facilities scrapbook or bulletin boards shown to current or perspective clients*
- *Display photos on the website*
- *Only first names and last initials In the event of two or more with same 1st name displayed on website.*

This excludes HiMama participation

I understand that it is my responsibility to update this form if I no longer wish to authorize one or more of the above uses. I agree this form will stay in effect until the term of my child's enrollment.

Parent/Guardian Signature

I am declining to have to have my child photographed.

CENTER NAME: _____



Participation Agreement

to email and publish my child's work, photographs or videos via HiMama

To: Parent / Legal Guardian,

Please read this page carefully as it includes information about safety and security issues associated with privacy and behavior.

In the interest of safety and security we require parent permission for the publishing of children's work, photographs or videos through a software program called HiMama (the "Program"). By signing this form you grant permission for us to photograph or video your child for the purposes of sharing this information with you through the Program. You will also receive updates and information about your child through the Program to the email you have provided herein.

Note that sometimes other children in the center may feature in photos, videos or stories of your child. By giving your consent you agree not to share photos or video of any child, other than your own, outside the Program without permission.

To learn more about the Program, please visit www.himama.com. Please complete, sign, and return this form to the center if you wish to participate. We encourage you to contact us if you have any questions.

I hereby acknowledge that I wish to voluntarily participate in the Program:

My Child's Name: _____

My Name: _____

My Email: _____

Signature: _____ Date: _____

Note: Please complete the Participation Agreement for each parent / guardian of the child.

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	Not Applicable
TRANSPORTATION BY THE FACILITY	WADING	Not Applicable

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)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		WORK PHONE:
FACILITY PHONE:	COUNTY:	
<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) <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>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.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
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.

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BUREAU OF HEALTH
Community and
Economic Development
610.437.7760 Fax 610.437.8799

TUBERCULOSIS ASSESSMENT REPORT FOR CHILD CARE FACILITIES

Please return to the child's daycare provider, not the Health Bureau

Age-appropriate tuberculosis assessment should be performed by the healthcare provider as part of the physical exam that is required by the City of Allentown Codified Ordinance for admission to licensed Child Care Facilities.

Age-appropriate tuberculosis assessment may be performed **yearly**, in conjunction with the physical assessment.

Name of Child: _____

Date of Birth: _____

To determine the risk of acquiring Tuberculosis infection, the following questions should be asked of the parent/guardian.

____yes ____no 1. Have you or your child been exposed or had any household contact with someone who has or is suspected to have active tuberculosis?

____yes ____no 2. Are you or your child from a foreign country or have you been outside the U.S. in the last six months?

____yes ____no 3. Are you or your child a household contact with someone who has been in jail or homeless in the last five years?

____yes ____no 4. Do you or your child have cancer, chemotherapy treatments, HIV infection, chronic asthma or long-term steroid use?

____yes ____no 5. Has your child had household contact with someone with a positive Tuberculosis Test?

If "yes" to any of these questions, a tuberculosis skin test, by the Mantoux method and interpretation of results by a health care provider, is recommended. Frequency of testing should be done accordingly to the degree of risk of acquiring Tuberculosis infection.

Date:

_____ Tuberculosis assessment completed - No need for TB testing at this time.

_____ Tuberculosis testing completed by Mantoux method (5Tu).

Date PPD applied: _____

Given by: _____

Results in 48-72 hours: _____ mm

Interpreted by : _____

Date : _____

Physician's Signature: _____ Date: _____

N:\net\rb\assessment.doc



Alliance Hall § 245 North 6th Street § Allentown, PA 18102-4128

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