Sun Bright Application set for upto 2 Children.

Documents Needed for Student Enrollment to Sun Bright

1. Parent ID
2. Person Authorized to Pick ups ID
3. Health Insurance Card- for each child
4. Health Forms - Filled by Doctor for Each Child
5. Custody Court Order - if Applicable
6. Allergy Documentation provided by Doctor- if Applicable
7. IEP- if Applicable

Following Documents Needed FOR PHL- PreK Enrollments

8. Evidence of Residence- PHL PreK
9. Evidence of Age- Phl PreK

Parents Please bring the following

- ❑ 2 sets of clothing for child in clear bag
- ❑ Pair of closed toe shoe
- ❑ Blanket
- ❑ Please bring ID each time you come to pick up child
- ❑ Laptop- for your school ager child to attend school

Sun Bright Student Enrollment Application

Childs Name: (Office Use Only)	DOB: (Office Use Only)

PARENT'S INFORMATION		PARENT WORK SCHEDULE	
Mother's Name / Legal Guardian:	Father's Name / Legal Guardian:	DAYS OF WEEK	TIME OF DAY Arrival Departure
Street Address:	Street Address:	Monday	
City/State/Zip:	City/State/Zip:	Tuesday	
Cell phone:	Cell phone:	Wednesday	
Cell Phone Carrier: T-Mobile / Cricket / Metro / Sprint / Verizon / Other (If 'other', please specify):	Cell Phone Carrier: T-Mobile / Cricket / Metro / Sprint / Verizon / Other (If 'other', please specify):	Thursday	
Work Name & Address:	Work Name & Address:	Friday	
Work phone:	Work phone:	Saturday	
Email address:	Email address:	Sunday	

Emergency Contact Name	Emergency Contact Address	Telephone	Is this Person to Whom Child may be released to?	Sign for Parental Consents:
			YES ☐ NO ☐	Obtain Emergency Medical Care: Sign X:
			YES ☐ NO ☐	Admin of Minor First Aid Procedures: Sign X:
			YES ☐ NO ☐	Walks and Trips: Sign X:
Parent Signature Date		Parent Signature: Date: Swimming: N/A Music lessons: N/A		Transportation By Sun Bright: Sign X:

CHILD INFORMATION	CHILD INFORMATION
Name: DOB	Name DOB
Days:(Please circle): M T W Th F S Su	Days:(Please circle): M T W Th F S Su
Services: ☐ Care ☐ Meal ☐ Summer Camp ☐ Homework Help ☐ School Transportation - Pickup ☐ School Transportation - Drop Off ☐ PHL-PreK	Services: ☐ Care ☐ Meal ☐ Summer Camp ☐ Homework Help ☐ School Transportation - Pickup ☐ School Transportation - Drop Off ☐ PHL-PreK
School Name:	School Name:
IEP, IFSP or Behavior Plan in place - Yes _ No Plan Provide to Sun Bright - Yes - No	IEP, IFSP or Behavior Plan in place - Yes _ No Plan Provide to Sun Bright - Yes - No
Allergies:	Allergies:
Medical Conditions:	Medical Conditions:
Speech, Hearing or Visual Impairment?	Speech, Hearing or Visual Impairment?
Health Insurance: Policy Number:	Health Insurance: Policy Number:
Enrollment Date Withdrawal Date Admission	Enrollment Date Withdrawal Date Admission
RACE: ☐ Hispanic of Latino ☐ Not Hispanic or Latino ☐Asian ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Black or African American	RACE ☐ Hispanic of Latino ☐ Not Hispanic or Latino ☐Asian ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Black or African American

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

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

TUITION AND FEE POLICY

Fees and co-payments: All Fees, Transportation Fees and copays must be PREPAID. Fees and co-payments are **due latest by each Monday** of the week care is provided. Full weekly payment is due regardless of the number of days attended. Payment is required for holidays and in-service days. There are no vacation days or weeks permitted.

All Fees are per week: Transportation Fee: $25.00 per Family or $20.00 per Child □ Copay $ □ PHL-PreK $0.00 □ Food $ □ Other Fees $

Non-payment Policy: If paying private, fees must be pre-paid - care will be terminated if the client has not prepaid. Funded or subsidy clients will be reported to their subsidy office for non-payment of weekly co-payments. Pay is based on enrollment, not attendance.

Late fee: A fee $20.00 for 1st minute and $2.00 per minute per child late fee assessed after the designated closing time per child. All late fees must be paid before the child may return for care.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

Cardholder Name Phone #

Cardholder Address City State Zip

Bank Credit Union Name Bank or Credit Union Address City State Zip

Routing Transit Number Account Number □ Checking □ Savings

E-mail Address Authorized Signature Date

POLICIES

Children benefit most from our educational programs if attendance is consistent. Their day at Sun Bright should begin no later than 9:30 a.m.- when we start the day's learning plans. If arriving later than a regularly scheduled time, please contact the daycare to ensure proper staff is kept on site to accommodate your arrival.

Tardiness: Late arrivals are disruptive to the learning process. All instruction begins promptly at 9:30 a.m..

Absences: When your child is absent notify the daycare before 9:00 a.m. Sun Bright Childcare reserves the right to suspend services for absences more than five consecutive days. Maximum absences are governed by the state in which we operate and any absence occurring outside of what is allotted by the state funding agency will be the responsibility of the parent. Pennsylvania Department of Public Welfare, 3041.19 Absence: if a child is absent more than 40 days during the year the parent or caretaker is responsible to pay the provider for each day a child is absent beginning with the 41 day of absence; any absence occurred outside of what is allotted by the state funding agency will be the responsibility of the parent. Sun Bright reserves the right to suspend or terminate services for sporadic attendance incongruent with contracted days.

Vacation: Sun Bright requires that you notify the daycare of vacation dates at least two weeks in advance. Any absence occurred during a 'vacation' is reported to the funding agency as a non-attended day and will count against the allotted absent days governed by the state.

Withdrawal: All clients must give a 10 day advance notice of withdrawal of services or those days will be invoiced as attended

Parent/guardian Acknowledgment: I acknowledge that I understand and agree: I have received a copy of the parent handbook. ____ I received a copy of the attendance policy;____ I have read, understand and agree to comply with said policy;____ I understand that failure to do so may result in termination of my child's eligibility/enrollment.____

Camera and Video Release: I hereby give Sun Bright Childcare, LLC, legal representatives and assigns, those for whom the photographer/videographer/Video Recording Equipment is acting and those acting with permission, or employees, the right and permission to copyright and or use, reuse and/or broadcast and publish photographs/videotape recordings of me or in which I may be distorted in character, or form, in conjunction with my own or fictitious name, on reproductions thereof in color, or black and white made through any media by the photographer/videographer in studio or elsewhere, for any purpose whatsoever, including the use of any printed matter in conjunction herewith. I hereby waive any right to inspect or approve the finished videotape/photograph/image, soundtrack, or advertising copy or printed matter that may be used in conjunction therewith or the eventual use that might be applied. I hereby release discharge and agree so save harmless the photographer/ videographer/ Sun Bright Childcare LLC and affiliates/ Video Recording Company, his representatives, assigns, employees, and any person or persons, corporation or corporations, for whom her might be acting, including any firm publishing and/or distributing the finished product, in whole or in part, from and against any liability as a result of any disorientation, blurring, or alteration, optical illusion, or use in any composite form, either intentionally or otherwise, that may occur or be produced in the taking, processing or reproduction of the finished product, its publication, distribution, or broadcast of the same, even should the same subject me to ridicule, scandal, reproach, scorn or indiginity.

I hereby certify that I am the parent and/or guardian of _____, an infant under the age of twenty-one years, I hereby consent that any video recordings/ photographs which have been, or are about to be made by the Video recordings/ camera/ videographer/ photographer, may be used by him for the purpose set forth in the original release hereinabove, signed by the infant model, with the same for and effect as if executed by me.

Parent Signature X:	**Date**	**Operator Signature**	**Date**
Parent Signature	**Date**	**Operator Signature**	**Date**

Sun Bright Student Getting to Know You Form

ABOUT YOUR CHILD

Child Name: **DOB:**

Has your child ever been in child care before? _____ How long? _____
What type (center, family daycare, grandparents, etc.)?
Was it a positive experience?
Why are you looking for childcare?
How does your child feel about daycare and being left by his/her mommy/daddy?
Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new siblings, etc.?
Would there be any restrictions to play or activities?
What is your child's temperament? Are they easy going, hard to please, demanding, aggressive?
What are your child's favorite foods?
What foods does your child dislike?
Does your child have any known allergies?
Does your child have any speech, hearing or visual problems?
Does your child have an IEP, IFSP or behavioral plan in place? ____Yes ____ No
Does your child have an early intervention or behavioral specialist? ___Yes ___No
Can your child be relied upon to indicate bathroom wishes?
What words does your child use for: Bowel movements_____ Urination _____
Has your child had experience playing with other children?
What language(s) are spoken at home?
Does your child have any security objects such as a blanket, soother, bottle, toy?
What are your child's favorite activities, toys, books, or games?
Are there any siblings? Please name them and specify ages and gender: Name: _____ Age: ____ Gender: _____ Name: _____ Age: ____ Gender: _____ Name: _____ Age: ____ Gender: _____
Are there any other comments or information that you would like to share? Any specific concerns?

Sun Bright Student Getting to Know You Form

ABOUT YOUR CHILD

Child Name: **DOB:**

Has your child ever been in child care before? _____ How long? _____
What type (center, family daycare, grandparents, etc.)?
Was it a positive experience?
Why are you looking for childcare?
How does your child feel about daycare and being left by his/her mommy/daddy?
Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new siblings, etc.?
Would there be any restrictions to play or activities?
What is your child's temperament? Are they easy going, hard to please, demanding, aggressive?
What are your child's favorite foods?
What foods does your child dislike?
Does your child have any known allergies?
Does your child have any speech, hearing or visual problems?
Does your child have an IEP, IFSP or behavioral plan in place? ____Yes ____ No
Does your child have an early intervention or behavioral specialist? ___Yes ___No
Can your child be relied upon to indicate bathroom wishes?
What words does your child use for: Bowel movements_____ Urination _____
Has your child had experience playing with other children?
What language(s) are spoken at home?
Does your child have any security objects such as a blanket, soother, bottle, toy?
What are your child's favorite activities, toys, books, or games?
Are there any siblings? Please name them and specify ages and gender: Name: _____ Age: ____ Gender: _____ Name: _____ Age: ____ Gender: _____ Name: _____ Age: ____ Gender: _____
Are there any other comments or information that you would like to share? Any specific concerns?

Sun Bright COVID-19 PUBLIC HEALTH EMERGENCY SPECIAL PROGRAM ATTENDANCE ACKNOWLEDGMENT AND DISCLOSURE

FAMILY/CHILD VERSION: This should be initialed and signed by BOTH parents.

Please read and initial each statement below.

1. _____I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter the facility beyond the designated drop-off and pick-up area. I understand that during drop-off and pick-up I MUST wear a mask at all times. I understand that this procedure change is for the safety of all persons present in the facility and to limit to the extent possible everyone's risk of exposure. I understand that it is my responsibility to inform any Emergency Contact persons of the information contained herein.

2. _____ I understand that IF there is an emergency requiring me to enter the facility beyond the designated drop-off and pick-up area I MUST wash my hands before entering, remove my shoes and wear a mask. While in the facility I must practice social distancing and remain 6ft from all other people, except for my own child.

3. _____ I understand that to enter upon the facility premises my child must be free from COVID-19 symptoms. If, during the day, any of the following symptoms appear my child will be separated from the rest of the people in the center, I will be contacted, and my child MUST be pick-ed up from the facility within 30 minutes of being notified. If my child, or a member of our household is experiencing any of the following symptoms, my child will be excluded from the program.

   Symptoms include,

   - fever of 100.4 degrees Fahrenheit or higher
   - dry cough
   - Shortness of Breath
   - Chills
   - Loss of taste or smell
   - Sore Throat
   - Muscle aches
   - Diarrhea

   While we understand that many of these symptoms can also be related to non-COVID-19 related issues we must proceed with an abundance of caution during this Public Health Emergency. These symptoms typically appear 2-7 days after being infected so please take them seriously. Your child will need to be symptom free without any medications for 72 hours before returning to the facility.

4. _____ I understand that my child's temperature will be taken every 4-6 hours throughout the day while on facility premises.

5. _____ I understand that my child will be encouraged to wear a mask at all times while in the facility and on facility premises. (Children 2 years of age and under should not wear a mask. Children eating, napping or swimming should not wear masks.)

6. _____ I understand that my child will be required to wash their hands using CDC recommended hand washing procedures throughout the day using warm running water and rubbing with soap for at least 20 seconds.

7. _____I understand that outside of care, in order to control my child's exposure in the community, I will comply with any and all CDC recommendations, state and local restrictions and recommendations regarding limiting/reducing my risk and my child's risk for exposure including wearing a mask in all public areas and remaining 6ft from all other people.

1. _____ When gathering socially with anyone that does not live in our household we will maintain social distance of at least 6 ft and wear a face mask until such time as it is determined by state and local health officials that the COVID-19 Public Health Emergency is over. We will not gather socially with anyone not complying with social distancing and face mask recommendations or who have any of the symptoms listed in number 3 above. We will not gather socially with anyone presumed positive or who has tested positive even with a face mask and/or social distancing.

8. _____ I understand that to limit the exposure risk for everyone in the center my child will be excluded from the program for 14 days upon return if my child or anyone from our household travels to any country, state, county or city that is considered to be a "hot spot" for COVID-19 infections. Further, if travelers from locations considered "hot spots" visit/stay in our home, my child will be excluded from the program for 14 days from the last day of their visit/stay. I further acknowledge that tuition will be due in full during any 14 day period the child is not permitted to attend the program as the child is still enrolled in the program.

9. _____ I will immediately notify Sun Bright Childcare management if I become aware of any person with whom my child or I have had contact exhibits any of the symptoms listed in Number 3 above, is advised to self-isolate, quarantine, has tested positive, or is presumed positive for COVID-19. Further, I will immediately notify Sun Bright Childcare management if anyone from my place of employment is presumed positive or tests positive for COVID-19 whether or not I have had direct contact with that person. *This is not a HIPAA/Privacy violation as we are not requiring you to disclose the identity of the person.

10. _____ I understand that while present in the facility each day my child will be in contact with children, families and other employees who are also at risk of community exposure. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I understand that my family and I play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined

herein. I understand that these guidelines can and will be updated and changed related to developments and updates to the Public Health Emergency on the national, state, and local level and based on best practices, CDC guidance and licensing recommendations and/or requirements. Further, I acknowledge that the center administrators have the right and responsibility to enact and enforce policies and procedures to keep all employees, children and their families as safe as possible.

I certify that I have read, understand, and agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by Sun Bright Childcare will result in termination of services. I acknowledge that care for my child will be terminated if it is determined that my actions, or lack of action unnecessarily exposes another employee, child, or their family member to COVID-19.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Parent/Guardian's Name: _____ Date

_____ _____

Parent/Guardian Signature Date

Parent/Guardian's Name: _____ Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Sun Bright Childcare Date

Child Care Center Meal Benefit Income Eligibility Form

Sun Bright Childcare & Learning Center □3424 N 11th St, Philadelphia, Pennsylvania 19140

Fill out all fields (*) in PRINT with Black ink. If left blank- forms will NOT be processed- Child(ren) will NOT be placed on the roster to receive meals.

Part 1. All household Members			
*Names of **Enrolled** child(ren) in this daycare: **Kids attending THIS location** □ **FIRST and LAST**	CHECK IF A **FOSTER CHILD** (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PARK 5 TO SIGN THIS FORM)	*CHECK IF NO INCOME	*AGE
	□	□	
	□	□	
	□	□	
	□	□	

Names of all Household Members (First, Middle Initial, Last)	Total # of people in your house* : _____		
□*	□	□	
□*	□	□	
□*	□	□	
□*	□	□	
□*	□	□	

***Part 2. Benefits: Do you receive SNAP Benefits? □YES □NO (Check One)**
If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3
***NAME:_____ CASE NUMBER:*___ ___--___ ___ ___ ___ ___ ___ ___ ___**

Part 3. If any child you are applying for is homeless, migrant or a runaway, check the appropriate box and call [Your center director, Homeless Liaison, Migrant Coordinator at Phone #] Homeless □ Migrant □ Runaway □

Part 4. Total Household Gross income and how often it was received e.g. weekly, bi-weekly, monthly

Name (List ONLY household members with income)	Earnings from work before deductions	Welfare, child support, alimony	Pensions, retirement, Social Security, SSI, VA benefits	All other income
(Example) Jane Smith	$ Gross Income/ How often	$ Gross Income/ How often	$ Gross Income/ How often	$*_____/_____
□*	$*_____/_____	$*_____/_____	$*_____/_____	$*_____/_____
□*	$*_____/_____	$*_____/_____	$*_____/_____	$*_____/_____
□*	$*_____/_____	$*_____/_____	$*_____/_____	$*_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult Must Sign)

□***Sign here: _____ * Print Name: _____ *Date _____**

***Address_____ *Phone number _____**

***City_____ *State _____ *Zip Code _____ Last four digits of Social Security Number __ __ __ __**
□ I do not have a Social Security Number

Part 6. Participant's ethnic and racial identities (optional)
□ Hispanic of Latino □ Not Hispanic or Latino □Asian □ White □ American Indian or Alaska Native □ Native Hawaiian or Pacific Islander □ Black or African American

Sun Bright Childcare CACFP Child Enrollment Form

REQUIRED: ⇨ *Signature _____ *Date _____

Parent/Guardian

REQUIRED: ⇨ *Signature _____ *Date _____

Center Administrator/Home Provider

Normal Hours of Care (Write in times)

Monday - Friday Drop off: _____ Pick Up: _____

Saturday Drop Off: _____ Pick Up: _____ Sunday Drop Off: _____ Pick Up: _____

□*** DO NOT LEAVE BLANK! Daily expected Meal service participation**
(Please check box regardless of age- Do not leave blank!)

Breakfast □ □ AM Snack □ □**Lunch** □ □**PM Snack** □ □**Supper** □ □ **Eve Snack** □

Is this child of school ages? ___ Yes ____No If yes, will additional meals be provided by parents when school is not in session? ___Yes ___No
If yes, please specify the meal: __Breakfast __Lunch __Supper

Child's First Name:□ Child's Last Name: □ Child's Date of Birth□

Child's First Name:□ Child's Last Name: □ Child's Date of Birth□

Child's First Name:□ Child's Last Name: □ Child's Date of Birth□

Child's First Name:□ Child's Last Name: □ Child's Date of Birth□

Child's First Name:□ Child's Last Name: □ Child's Date of Birth□

Child's First Name:□ Child's Last Name: □ Child's Date of Birth□

Address□ City □ State □ Zip code □

Parent/Guardian: □

E-mail □

Telephone (home) □ Telephone (work)□

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.

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.

For ELRC 18:

Pelican ID: 9113540030-1
Local ID: 601371
Type of Care: Regulated. Child Care Center (Center)
Legal Name: Sun Bright Child Care
Address: 3424 N 11th Street, Philadelphia, PA 19140 aka 1102 Rising Sun Ave

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To Whom It may Concern:

The parent has decided to send her children to Sun Bright. We have space for the parents children.

We are Open from 6 am to 9 pm. We have rooms that are not being used and we have space available to service additional children.

If you need capacity form to enroll children at our center, we would be happy to send it ASAP.

Should you have additional questions, please feel free to contact us at 215-225-9977.

Respectfully yours,
Poonam Singhal

ELRC Region 18 Contact Info

North Philadelphia (Closest to Sun Bright)

1701 W. Lehigh Ave, Suite 2102-2103 Philadelphia, PA 19132
Tel: 215-382-4762 Fax: 215-382-1199 MWF: 8am - 5:30PM Tu, Th: 8:00am - 7:00pm

Main office:

2361-2373 Welsh Philadelphia, PA 19114
T: 215-382-4762 F: 215-382-1199 **MWF: 8am - 5:30PM Tu, Th: 8:00am - 7:00pm Sat: 8:30am- 5:00pm**

West Philadelphia

5548 Chestnut Street, 2nd Floor Philadelphia, PA 19139
Tel: 215-382-4782 Fax: 215-940-0224 MWF: 8am - 5:30PM Tu, Th: 8:00am - 7:00pm