Lighting the way to a brighter future...
the Learning Lamp

United Way

PANO
STANDARDS FOR EXCELLENCE

GuideStar Exchange GOLD PARTICIPANT

We're lighting the way to a brighter future!

2025 Bedford Street · Johnstown, PA 15904 · (814) 262-0732 · Fax: (814) 262-0837 · www.thelearninglamp.org

CHILD CARE SERVICES AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(c); 3290.123 & 181(c)

NAME OF CHILD		
FEE AMOUNT	**PER-DAY WEEK**	**DAY PAYMENT TO BE MADE** **Weekly**
Services to be provided as part of the child care fee (examples: transportation, care, meals, etc.)		
CHILD'S ARRIVAL TIME	**CHILD'S DEPARTURE TIME**	**PERSON(S) DESIGNAED BY PARENT TO WHOM CHILD MAY BE RELEASED**
LATE FEE $10 will be charged after 6 p.m.	**PER MIN-HR** 15 minutes	

I, THE PARENT/GUARDIAN;

☐ **RECEIVED COMPLETE WRITTEN PROGRAM INFORMATION AT THE TINE OF ENROLLEMNT (PA DPW Code 3270.121, 3290.121, 3290.121)**

☐ **AGREE TO UPDATE THIS EMERGENCY CONTACT/PARENTAL CONSENT FORM INFORMATION WHENEVER CHANGES OCCUR OR EVERY 6 MONTHS AT A MINIMUM. (PA DPW Code 3270.124, 3280.124, 3290.124)**

_____ _____

SIGNATURE - OPERATOR **DATE** **SIGNATURE - PARENT OR GUARDIAN** **DATE**

DATE OF CHILD'S ADMISSION	**PERIODIC REVIEW – sign every 6 months** _____ _____ **SIGNATURE - PARENT OR GUARDIAN** **DATE**
DATE OF WITHDRAWAL	_____ _____ **SIGNATURE – PARENT OR GUARDIAN** **DATE**

CHILD HEALTH REPORT
(55 PA CODE ss3270.131, 3280.131 and 290.131)

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.**

Parents 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 sheet 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:**