Springboard
EDUCATE | ENGAGE | EMPOWER

Enrollment Agreement

2019 - 2020 School Year

CHILDS NAME	
PROGRAM PARTICIPATION IE, BEFORECARE, AFTERCARE, FULL DAY, ETC	
ADULTS (OVER 18 YEARS OLD) TO WHOM THE CHILD MAY BE RELEASED	

TO BE COMPLETED BY DIRECTOR

SERVICES PROVIDED IE CHILDCARE, SNACK, TRANSPORTATION, ETC				
ENROLLMENT TYPE CIRCLE SELECTION	FULL-TIME REGULAR		PART-TIME REGULAR	FLEX
DAILY FEE AMOUNT (not all activities available at all locations)	Regular Schedule		Daily Flex	Drop In
	Full Time	Part Time		
After School				
Before School				
Early Release				
Full Day				
REGISTRATION FEE				
LATE FEE	$1.00 per minute			

I, the parent/guardian;

- O received complete written program information at the time of enrollment
- O agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum

Parent Signature - Date

Director Signature - Date

CHILDS ADMISSION	
DATE OF ADMISSION	
DATE OF WITHDRAWAL	

6 MONTH REVIEW
Parent/Guardian Signature - 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	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

6 Month Review:

_____ SIGNATURE OF PARENT or GUARDIAN

_____ DATE

Springboard Authorizations Form 2019-20

Enrollment Information: I have read and understand the enrollment information on admission and tuition. Initial _____

Updated Child's Records: I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status and immunization records, etc. Initial _____

Hospital Transportation: In case of medical emergency I give permission for Springboard to release my child and to be transported to a hospital. My preferred hospital is:
(Name of Hospital) _____

(Hospital Address) _____

(Hospital Phone Number) (_____)_____ or to the nearest hospital by ambulance subject to the EMT's authority once child has been released to their care. Initial _____

First Aid/CPR: I give permission for Springboard staff to administer First Aid & CPR to my child, if necessary. Initial _____

In the event of an emergency: I give Springboard permission to act on my behalf and provide needed medication and assistance. Initial _____

Video/Picture Permission Slip - External: I give permission and consent for Springboard to take pictures/video of my child during program hours and activities. I further give permission and consent that any such photographs/video may be published and used by Springboard Education in America and its agents to illustrate and promote the Springboard experience on **Springboard's website, social media, or for the purpose of brochures and advertisements.** Initial ___

Video/Picture Permission Slip – Internal: I give permission for Springboard to take pictures/video of my child during program hours and activities to be used for **internal purposes posted at Springboard site, Class Dojo and/or Shutterfly.** Initial ___

Release of Records: I authorize Springboard to access and review all health and educational records on file with my child's school, for the purposes of providing a safe, healthy environment that supports my child's academic growth and achievement. This data may include, but is not limited to, an IEP, disability evaluations and test data. Springboard adheres to the highest levels of confidentiality when accessing information contained in these records. Initial _____

Medications: I understand that in order for my child to be given medications (prescriptions and/or over the counter medications), I must provide written authorization by the physician and parent. Medication must be provided in the original bottle with an original label. Initial _____

Sunscreen: I give permission for Springboard to apply sunscreen to my child if assistance is needed. I will supply the sunscreen in its original bottle to you clearly labeled with my child's name. Initial _____

TV/Video: I give permission for my child to use or view TV and or video games during their time at Springboard. I understand that the site coordinator monitors all TV exposure and videos. Initial _____

Parent Agreement: The child named on this form is "awesome," but I understand that children who behave in a "not-so-awesome" way can get sent home from their program without a refund. Initial _____

I have read and initialed the above Authorizations and Policies

Parent Signature _____ Date _____

Print Parent Name _____

Print Child Name _____

All students must have a completed form on file in order to attend the Springboard Program. Please return your completed form to the Springboard Program at your child's school.

5/10/19

Must be completed and signed by a physician, crnp, or pa

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						

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

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

6 Month Review:_____

MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133

PLEASE PRINT

Page _____ of _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____ (Date) To _____ (Date)

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

_____

_____

I give permission to administer medication to my child as stated above.

_____ (Parent Signature) _____ (Date)

FACILITY STAFF COMPLETE THIS SECTION				
Date Administered (mm/dd/yyyy)	Time Administered (a.m. / p.m.)	Amount of Medication Administered	Comments/Reactions	Staff Initials

This information is confidential and may not be shared or released without the parent's written permission.