Dear Parent(s)/Guardian(s).

This is a complete Enrollment Packet for Philly KiDZ Initiative.
All the DHS Mandated child care forms are included and need to be filled out, before your child is allowed to attend the After School, AM Care or Summer Camp Program.

1. **Philly KiDZ initiative Parental Guide**
2. **Philly KiDZ After School Registration**
3. **Emergency Contact Information**
4. **Parental Agreement Form**
5. **Child Pick Up Authorization**
6. **Verbal Request For Release of Child (if you wish to add another emergency pick up person)**
7. **Child Health Report (must be completed by a pediatrician and include all inoculations)**
8. **Appendix G: a list of inoculations for the appropriate age**
9. **Immunization Exemption Form: for Religious, Medical, or Philosophical Reasons**
10. **Medication Log (if your child needs to take medications during After School)**
11. **List of Free Clinics in Philadelphia Region**
12. **ELRC/CCIS Change of Provider Application**
13. **Vital Emergency Information Packet**

Upon completion, please return it to Philly KiDZ via email (phillykidzinitiative@gmail.com), fax (215-434-0688) or, bring a copy to your school, and leave it with the administrative secretary, in the office.

We will not accept any unfinished or incomplete forms and your child will not be able to start with Philly KiDZ Initiative.

For any questions, please contact Mark Ingerman @ 215-378-9700.

PHILLY KIDZ REGISTRATION PACKET

Name of CHILD

Birth date and age of CHILD

Address

MOTHER'S FULL NAME, ADDRESS AND TELEPHONE

FATHER'S FULL NAME, ADDRESS AND TELEPHONE

MOTHER'S EMAIL

FATHER'S EMAIL

SCHOOL ATTENDING

GRADE AND ROOM NUMBER

STARTING DATE

IS YOUR CHILD ATTENDING 5 DAYS PER WEEK

WILL YOU BE ATTENDING EARLY DISMISSAL DAYS? NO YES

DO YOU NEED EARLY MORNING CARE? NO YES
($5 extra fee per day)

DO YOU HAVE ELRC/CCIS (circle on choice please) NO YES

EMERGENCY CONTACT INFORMATION FORM

CHILD'S NAME

Address

Mother's Name/ Legal Guardian

Mother's Work Address

Mother's Work Phone

Mother's Cell Phone

Home Phone

Father's Name/ Legal Guardian

Father's Work Address

Father's Work Phone

Father's Cell Phone

Father's Home Phone

NAMES, ADDRESS AND TELEPHONE NUMBERS OF EMERGENCY CONTACTS OTHER THAN GUARDIANS

NAME, ADDRESS AND PHONE NUMBER OF YOUR CHILD'S DOCTOR

HEALTH INSURANCE COVERAGE FOR CHILD

SPECIAL DISABILITIES (IF ANY)

ALLERGIES

MEDICAL OR DIETARY INFORMATION NECESSARY IN EMERGENCY SITUATION

MEDICATION, SPECIAL CONDITIONS

ADDITIONAL INFORMATION ON SPECIAL NEEDS

Obtaining Emergency Medical Care	Parent sign
Administering of Minor First Aid Procedures	Parent sign
Walks and Trips	Parent sign
Transportation by the Facility	Parent sign

GUARDIAN'S SIGNATURE _____ DATE

PERIODIC REVIEW

GUARDIAN'S SIGNATURE _____ DATE

PARENTAL AGREEMENT FORM

I am

I understand that the program costs $15 per day tuition and the services provided by Philly KIdZ Initiative After School will include:
Homework Assistance, Twilight Meals, Science/Math/Reading/Chess, Music, Visual Arts, Drama and Sports Enrichment activities. These Enrichment Activities are available in participating schools only, and may vary according to the School Administration/ Teachers Preference. The teachers will dictate the Curriculum for Enrichment according to the individual needs of each School. I understand and support the Philly KiDZ Initiative in their ideal of "Academics Above All", their support of "Read By Four" PSD Initiative, and the "100 Book Challenge", as well as other Academically Enriched Activities that will further my child's reading and comprehension skills. I understand and support the Philly KiDZ Initiative Math Enrichment through School Based needs, and participate in these activities willingly. The total price for attending the After School Program is $2,340.00 for the Academic Year. I understand that, Philly KiDZ Initiative After School offers a 5 day per week attendance only.

Should I have any questions regarding the After School Program, I will contact Mark Ingerman @2153789700, or Alla Sherman @2678088518.

I understand that the monthly tuition payment will reflect the total number of available attendance days each month, and that my payments will fluctuate monthly based on the total number of days available each month. I understand that a payment schedule by month will be available on the Philly KiDZ Initiative Website where I can reference payment amounts due by month along with due dates. I understand that I will need to pay my tuition in full by the first of every month, with the first payment due by August 30th for September tuition or my child will be dismissed from the program, and I will have to re-register pending space availability.

GUARDIAN INITIALS

I understand that there are a DETERMINED AMOUNT OF Early Dismissal Days during the Academic Year. I understand that on these selected days, my child will be dismissed from school at 11:45 AM, and remain with the Philly KIDZ After School Program from 11:45 AM to 6:00 PM. I understand that there will be no extra charge for the Planned School District Early Dismissal Days.

GUARDIAN INITIALS

I understand that Philly KiDZ Initiative After School Program also offers Early Morning Care (before school) Monday - Friday, at an additional cost of $5 per day. Should I choose to participate in the Early Morning Care option, I will need to indicate which days I will need the care, and Philly KiDZ Initiative will adjust the monthly tuition to reflect the appropriate cost.Available only at

Decatur, Greenberg, Loesche and Fox Chase Locations

GUARDIAN INITIALS

*** I understand that Philly KiDZ After School has a strict NO-REFUND Policy that extends itself to Early Facilities Closings due to inclement weather such as early dismissals due to snow days, heat advisory days, etc... When buildings are set to close prior to the start of the program that day. I understand that I will not receive a Refund due to my child missing the After School program due to illnesses, or family vacations. I understand that Refunds will not be extended or offered, reasons not mentioned and Philly KiDZ reserves the right to keep all monies provided to them for services, and I will not hold Philly KiDZ and it's contractors and employees liable in any way.

I understand that the Program operates until 6:00 PM, Mondays - Fridays. I understand that there will be a late charge of $1.00 per minute, should I be late to pick up my child/children on any given day. The late fee will begin accrual promptly after 6:00 PM. And I will pay that amount at pick up time to the on-site coordinator as I collect my child/children on that same day. A "PARENTAL RULE BOOK" describing all the operational procedures of the Philly KiDZ Initiative After School Program has been provided and explained to me at the time of signing of this contract. A Calendar Schedule of all NON OPERATING DAYS will be provided to me a month in advance to me by the Philly KiDZ Initiative After School Program.

GUARDIAN INITIALS

I understand that a "Late Payment Policy" does not exist through the Philly KiDZ initiative After School Program, and if I do not forward payment in full by the first (1st) of every month, for the month in advance of attendance, Philly KiDZ Initiative has the sole right to terminate my child/children's attendance at that time, and I will need to re-register for the coming month. Should that occur, I understand that my child/children will be able to return to the Philly KiDZ Initiative After School Program pending space availability.

GUARDIAN INITIALS

I have received complete written Program Information at the time of enrollment (3270.121, 3280.121, 3290.212) I agree to update my Emergency Contact/Parental Consent Form Information whenever a change occurs, or every 6 months at a minimum (3270.124, 3280.124, 3290.124) I agree to forward payment by the 1st of every month my child is enrolled in the Philly KiDZ Initiative Program.

GUARDIAN INITIALS

OPERATOR'S SIGNATURE _____ DATE

GUARDIAN'S SIGNATURE _____ DATE

DATE OF ADMISSION DATE OF WITHDRAWAL

PERIODIC REVIEW: GUARDIAN'S SIGNATURE _____ DATE

CHILD PICK UP AUTHORIZATION FORM

I am,

and I authorize Northeast Conservatory Philly KiDZ Initiative After School Program to release my child(ren) to the person(s) designated in this form. This is in consonance with the Northeast Conservatory Emergency Plan.

Child's Name

Designated Custodian Information

Address

Home Phone Number

Work Phone Number

Cell Phone Number

GUARDIAN'S SIGNATURE _____ DATE

PLEASE BE SURE TO PICK UP THE MEDICAL FORM AT THE SCHOOL OFFICE OR PRINT IT OUT ON OUR WEBSITE AND HAVE IT FILLED OUT BY THE CHILD'S DOCTOR.

ALL INOCULATION HISTORY SHOULD BE ATTACHED. WE WILL NOT ADMIT ANY CHILD INTO THE PROGRAM WITHOUT A RECENT PHYSICAL AND A COMPLETED MEDICAL FORM FROM THEIR DOCTOR.

VERBAL REQUEST FOR RELEASE OF CHILD

55 PA CODE CHAPTERS 3270.117(c) and 3280.117(c) and 3290.116(c)

THIS FORM MUST BE COMPLETED TO DOCUMENT THE VERBAL REQUEST BY A PARENT FOR THE RELEASE OF A CHILD TO A PERSON(S) NOT INDICATED ON THE AGREEMENT
(CHAPTERS 3270.123(a)(5), 3270.124(b)(7); 3280.123(a)(5), 3280.124(b)(7); 3290.123(a)(5), 3290.124(b)(7)).

NAME OF CHILD	DATE	TIME
NAME OF REQUESTING PARENT	TELEPHONE NO. FROM WHICH PARENT IS CALLING	
NAME OF INDIVIDUAL TO WHOM THE CHILD IS TO BE RELEASED ➤		
NAME OF STAFF PERSON TAKING THE CALL ➤		

CALL THE ENROLLING PARENT BACK TO CONFIRM THE INFORMATION IF POSSIBLE

CONFIRMING PARENT	DATE
NAME OF STAFF PERSON CONFIRMING INFORMATION	TIME

NAME OF STAFF PERSON RELEASING CHILD _____ DATE _____

BE SURE TO ASK FOR IDENTIFICATION WHEN THE INDIVIDUAL ARRIVES TO PICK UP THE CHILD

PHiLLY KiDZ INITIATIVE After School Program

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	

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

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:

THE SCHOOL DISTRICT OF PHILADELPHIA

Immunization Exemption Form

(Medical/Religious/Philosophical)

For School Immunization Requirements

Student's Full Name:	Birthdate (mm/dd/yyyy):	Grade Level:	Student ID:
Parent or Guardian's Name:		Telephone Number:	
Street Address:	City:	State:	Zip Code:

NOTICE: When a health care practitioner has determined a specific vaccination is not advisable for the child for medical reasons, this form must be completed by a physician and submitted to the student's school at the start of each school year.

Medical Exemption

Children need not be immunized if a physician or the physician's designee provides a written statement that immunization may be detrimental to the health of the child. (Please indicate which vaccine antigen(s) the medical exemption is referring to):

☐ Medical

☐ Diphtheria	☐ Tetanus	☐ Acellular Pertussis	☐ Polio
☐ Hepatitis B	☐ Measles	☐ Mumps	☐ Rubella
☐ Varicella (chickenpox)	☐ Meningococcal		

Physician Declaration

I declare that the physical condition of the above-named child is such that immunization would endanger life or health.

Physician Name (print)	Physician Signature	Date

NOTICE: A parent or guardian may exempt their student from the vaccinations listed below by submitting this completed form to the student's school at the start of each school year.

Personal/Philosophical or Religious Exemption

I am exempting my child from the requirement that my child be vaccinated against the following disease(s) to attend school. (Select an exemption type and the vaccinations you wish to exempt your child from):

☐ Personal/Philosophical ☐ Religious

☐ Diphtheria	☐ Tetanus	☐ Acellular Pertussis	☐ Polio
☐ Hepatitis B	☐ Measles	☐ Mumps	☐ Rubella
☐ Varicella (chickenpox)	☐ Meningococcal		

State your reason for requesting this exemption:

Parent/Guardian Declaration

One or more of the required vaccines are in conflict with my personal, philosophical, or religious beliefs. I understand that if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school for the duration of the outbreak. I affirm that the information on this form is complete and correct.

Parent/Guardian Name (print)	Parent/Guardian Signature	Date

THE SCHOOL DISTRICT OF PHILADELPHIA

Medical Plan

(Medical Certificate)

For School Immunization Requirements

NOTICE: This form must be used when a health care practitioner has determined that an alternative immunization schedule is necessary. This form must be completed and signed by a health care practitioner and submitted to the student's school.

VACCINE Circle appropriate item	Enter month, day and year each immunization **will be given** DOSES				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or measles serology Date	Titer	
Varicella	1 / /	2 / /	Rubella serology Date	Titer	
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Attach EHR of vaccines already given.

Physician Name (print) Physician Signature Date

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, local health department)

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.

FQHCs in Philadelphia

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are "safety net" providers such as community health centers. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved communities.

Any Philadelphia resident is eligible for free or low cost care at the City's AHS Health Centers.

North Philadelphia

Facility	Address	Zip Code	Phone
AHS Health Center #5	1900 N. 20th St	19121	215-685-2933
AHS Health Center #6	301 W. Girard Ave	19123	215-685-3803
Strawberry Mansion Health Center	2840 Dauphin St	19132	215-685-2401
DVCH Fairmount Primary Care Center	1412 Fairmount Ave	19130	215-235-9600
QCHC Cooke Family Health Center	1300 W. Louden St	19141	215-457-6902
QCHC Family Health Center	2501 W. Lehigh Ave	19132	215-227-0300
QCHC Meade Family Health Center	1600 N. 18th St	19121	215-765-9501
GPHA Hunting Park Health Center	1999 W. Hunting Park Ave	19140	215-228-9300
GPHA Medical Suite At Temple	3223 North Broad St	19140	215-226-3789
DVCH Maria De Los Santos Health Center	401 W. Allegheny Ave	19133	215-291-2500
Esperanza Health Center – Kensington	3156 Kensington Ave	19134	215-831-1100
Esperanza Health Center – N. 5th St.	2940 N. 5th St	19133	215-221-6633
Esperanza Health Center – N. 6th St.	4417 N. 6th St	19134	215-302-3600
PHMC Health Connection	1900 N 9th St	19122	215-765-6690
PHMC Health Center at Temple	3401 North Broad St	19140	215-731-7144
PHMC Congreso	412 W. Lehigh Ave	19133	267-765-2272
Project Home-Stephen Klein Wellness Ctr	2144 Cecil B Moore Ave	19121	215-320-6187
Spectrum Broad St Health Center	1415 N. Broad St	19122	215-235-7944

Northeast Philadelphia

Facility	Address	Zip Code	Phone
AHS Health Center #10	2230 Cottman Ave	19149	215-685-0639
GPHA Frankford Ave. Health Center	4510 Frankford Ave	19124	215-744-1302
PHMC Rising Sun Health Center	5675 N. Front St	19120	215-279-9666

FQHCs in Philadelphia

Federally Qualified Health Centers

Northwest Philadelphia

Facility	Address	Zip Code	Phone
AHS Health Center #9	131 E. Chelten Ave	19144	215-685-5701
Covenant House Health Services	251 E. Bringhurst St	19144	215-844-0181
FPCN Abbottsford-Falls Family Practice	4700 Wissahickon Ave	19144	215-843-9720

South Philadelphia

Facility	Address	Zip Code	Phone
AHS Health Center #2	1700 South Broad Street	19145	215-685-1803
GPHA Carl Moore Health Center	1401 South 31st Street	19146	215-755-7700
GPHA Southeast Health Center	800 Washington Ave	19147	215-339-5100

West and Southwest Philadelphia

Facility	Address	Zip Code	Phone
AHS Health Center #3	555 S. 43rd St	19104	215-685-7504
AHS Health Center #4	4400 Haverford Ave	19104	215-685-7601
FPCN Health Annex	6120 Woodland Ave	19142	215-727-4721
GPHA Woodland Ave. Health Center	5000 Woodland Ave	19143	215-726-9807
Sayre Family Health Center	5800 Walnut St	19139	215-474-4444
Spectrum Community Health Center	5201 Haverford Ave	19139	215-471-2761

Center City Philadelphia

Facility	Address	Zip Code	Phone
GPHA Chinatown Medical Services	432 N. 6th St	19123	215-627-8000
FPCN 11th St. Family Health Services	850 N. 11th St	19123	215-769-1100
Philadelphia FIGHT Pediatrics	1207 Chestnut St, 5th Floor	19107	215-525-8600
PHMC Mary Howard Health Center	125 S. 9th St	19107	215-592-4500
PHMC Care Clinic	1200 Callowhill St. Suite 101	19123	215-825-8220
Project Home-Hub of Hope	1404 Arch St, subconcourse	19102	215-309-5225
Y-HEP Health Center	1207 Chestnut St, 5th Floor	19107	215-344-1632

PARENT'S CHANGE OF PROVIDER

PLEASE NOTE: CHANGE WILL NOT TAKE PLACE IF THERE ARE OUTSTANDING CO-PAYS

Parent and Provider cannot reside in the same household under no circumstances and receive payment

WORKER'S NAME: _____

CHILD(REN) NAMES & AGES : _____

PARENT'S NAME: _____

PARENT'S ADDRESS: _____

_____

PARENT'S *Last Four Digits* SOCIAL SECURITY#: _____

PARENT'S TELEPHONE #: _____

OLD PROVIDER'S NAME: _____

OLD PROVIDER'S ADDRESS: _____

_____

OLD PROVIDER'S TELEPHONE #: _____

OLD PROVIDER'S RELATIONSHIP TO THE CHILD(REN): _____

ENDING DATE: _____

NEW PROVIDER'S NAME: _____

NEW PROVIDER'S ADDRESS: _____

_____

NEW PROVIDER'S TELEPHONE #: _____

NEW PROVIDER'S RELATIONSHIP TO THE CHILD(REN): _____

START DATE: _____

SIGNATURE: _____

DATE: _____