**Name
Birth DateBUILDERS
Formula or Breastmilk
How many ounces of milk?
How often?
Does your baby normally burp?
How do you heat the bottle?
D
Does your baby eat baby food?
How eften?
How often?
Does your baby eat finger foods?
What kinds of finger foods?
Sleeping Hints:
Special Instructions:
Parent's Signature Date
**DO NOT release this baby to anyone unless prior

\*\*DO NOT release this baby to anyone unless prior permission from the parents!



I hereby give Faith E	Builders Day Care p	permission to use	e a breathable l	olanket with my	/ child
while they are in the	ir cribs.				

Parent signature	Date		
Staff signature	Date		

Any parental instructions:



## **Permission Slip**

### SunScreen & Insect Repellant

I give my permission for the Faith Builders staff to apply sunscreen/block or insect repellant to my child. I realize that I am required to apply both before daycare, but the staff will apply sunscreen/block and/or insect repellant.

Date

Walking Excursions,Transportation	,Swimming, and Wading
	o on walking excursions, be transported, swimming, tih Builders staff will be responsible for guidance and de of the facility.
Parent Signature	Date

Parent Signature\_\_\_\_\_



# **Photo Release Form**

I,, the parent of child/children	at			
Faith Builders Day Care agree to the following:				
I understand that my child(ren) whose name(s) are listed below may be photographed at the daycare during normal daycare hours, field trips, of activities. I understand that these photographs may be used in promo- child care services, either in print or on the Internet	r			
The child(ren) names are				
With my signature below I grant permission for my child(ren) to be photographed, or their images recorded for print electronic use in promoting the daycare's services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.				
Parent/Guardian SignatureDate				
Relationship to the child				

# Parent/Provider fill in this part.

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

# **CHILD HEALTH REPORT**

		(55 PA COD	E §§3270.13	31, 3280.13	1 AND 3290.	131)		
CHILD'S NAME: (LAST)	klymiya en adal mus myi mar yar meneledi sidan.	(FIRST)	ческий и українстви за посторії відні Атталук <b>а</b> доліл	PARENT/G	UARDIAN:			
DATE OF BIRTH:		HOME PHONE:		ADDRESS:				
	annant Hardente material and a special							
CHILD CARE FACILITY NAME:								
FACILITY PHONE:		COUNTY:		WORK PHO	ONE:			
	The second control of			ena levianiera anuariera anni-				
☐ I authorize the child care staff and my chi	ld's health pro	ofessional to c	ommunicate d	lirectly if need	ded to clarify	information on this form about my child.		
PARENT'S SIGNATURE:	nga panasang anjawa anga anga panasan ng	and the fight of the section of the	THATTE TITLE OF SALES	pour principal and a source of the source	SOCIETY BEAUTY OF FRANCO SOCIETY OF SOCIETY AND			
PRODUCTION BOX OTHER WEST COORDING AS BOTH BACK AND COMPANIES OF COMPA	A PARTICULAR VALUE OF THE PARTIES.	DO N	TIMO TO	NY INFOR	RMATION			
			WARTED COLUMN THE PROPERTY OF THE PARTY OF T	ALL CONTRACTOR OF THE PARTY OF		child care facility needs a copy of the form.		
NONE NONE	AIION PERI	INENT TO R	DUTINE CHI	LD CARE AN	ID DIAGNOS	SIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):		
	hill a naisteach an hair ann an ghiù an air ann ang a		noutrype recension and an action and a contract of the contrac	chibonomic common communication and				
						MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A ICAL CARE, ATTACH ADDITIONAL SHEETS IF NECESSARY.		
□ NONE					02,101 1,20	Test a state of the state of th		
CHILD'S ALLERGIES (DESCRIBE, IF ANY	):	aki ki mahar ambundan kabu magang diapang mangan pilip ay son	ONE TOO BETTER CHARLEST COMMENTER CONTROL OF THE COMMENT		**************************************			
□ NONE								
LIST ANY HEALTH PROBLEMS OR SPECIA	AL NEEDS A	ND RECOM	MENDED TRI	-ATMENT/S	ERVICES A	TTACH ADDITIONAL SHEETS IF NECESSARY TO		
DESCRIBE THE PLAN FOR CARE THAT SI	HOULD BE F					CATION OF SPECIAL TRAINING REQUIRED FOR STAFF,		
EQUIPMENT AND PROVISION FOR EMER NONE	GENCIES.							
		<del>andyta diggy a a quantipopu</del>			and the second s			
IN YOUR ASSESSMENT, IS THE CHILD A COMMUNICABLE DISEASES?	BLE TO PAR	TICIPATE IN	I CHILD CAF	RE AND DO	ES THE CHI	LD APPEAR TO BE FREE FROM CONTAGIOUS OR		
☐ YES ☐ NO IF NO, PLEASE EXPL	AIN YOUR	ANSWER:						
HAS THE CHILD RECEIVED ALL AGE APPRO	OPRIATE	TNOTE BEL	OW IF THE	RESULTS O	F VISION. H	HEARING OR LEAD SCREENINGS WERE ABNORMAL, IF		
SCREENINGS LISTED IN THE ROUTINE PRI HEALTH CARE SERVICES CURRENTLY RECO	EVENTIVE	THE SCRE	ENING WAS	<b>ABNORMA</b>	L, PROVIDE	THE DATE THE SCREENING WAS COMPLETED AND ATIONS OR ACTIONS RECOMMENDED FOR THE CHILD		
BY THE AMERICAN ACADEMY OF PEDIATRI		CARE FAC		I KEFEKKA	LS, INFLICE	ATIONS OR ACTIONS RECOMMENDED FOR THE CHIED		
SCHEDULE AT <u>WWW.AAP.ORG</u> )		VISION (subjective until age 3)			)			
□ YES □ NO		HEARING	(subjectiv	e until age	e 4)	AND AND ADDRESS OF THE PROPERTY OF THE PROPERT		
		LEAD	Linguise Str. anni Arraya (pri frança na carray pri esta	commenced that Tomore on A policy blood by the built	iyaray kahista sa istab dayar dan maddi istamayid indovidda			
RECORD DATES OF IMMI	UNIZATIO	NS BELOW	OR ATTACI	н а рното	COPY OF	THE CHILD'S IMMUNIZATION RECORD		
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS		
HEP-B	B. 5695		5715	- 20/5 <sub>10</sub>				
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MENINGOCOCCAL	a) haqqarik aygʻangarik qari san ) an		· · · · · · · · · · · · · · · · · · ·	**************************************				
OTHER								
MEDICAL CARE PROVIDER:	de la companya de la	Mark Annual Annu	A CONTRACTOR OF THE PROPERTY O	A THE PARTY OF THE	SIGNATURE	OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT		
ADDRESS:					TITLE:			
PHONE:			LICENSE NUMBER: DATE FORM SIGNED:					

## **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				
MOTHED'S NAME / FOAL CHARDIAN	<u> </u>			
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) NAM	E	TELI	EPHONE NUMBER WHEN CHILD IS IN CARE	
		· ·		
PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME	E ADD	RESS TELI	PHONE NUMBER WHEN CHILD IS IN CARE	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER			TELEPHONE NUMBER	
ADDRESS	-			
SPECIAL DISABILITIES (IF ANY)		Laurence (Marie		
		ALLEHGIES (INCLUD	ING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION MEDICATION, SPE			
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		<u> </u>		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFIT	POLICY NUMBER (R	EQUIRED)		
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO	O INDICATE F	PARENTAL CONSE	NT	
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF	MINOR FIRST - AI	D PROCEDURES	
WALKS AND TRIPS	SWIMMING			
TRANSPORTATION BY THE FACILITY	WADING			
PERIODIC REVIEW				
	·			
SIGNATURE OF PARENT or GUARDIAN			DATE	
	· .			
SIGNATURE OF PARENT or GUARDIAN			DATE	

03891A