INTITIAL CHECKLIST

CHILD'S NAME_____DOB_____

Parents: Please complete all paperwork in FULL. Return this form to the center with your packet at your enrollment meeting. Thank you!

Child Folder Checklist

- **___emergency contact (must be completed in full)**
- **___agreement**
- **___health policy**
- **___health assessment (must be signed by DR. returned within 20 days of enrollment)**
- **___ Flu vaccine**
- **___Consent and release form**
- **___ Hospital consent form**
- **___child enrollment food program & food form application if needed**
- **___Getting to know you for all / infant schedule if under 1 year.**
- **___policy agreement**
- **___All screening and release of information papers for IEP/IFSP**
- **___ Activity releases**
- **___ Waiver if applicable**

For Center Use Only

1. **___enrollment fee paid_____**
2. **___registration fee paid____**
3. **___date of enrollment____**

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	BIRTH DATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE 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 REACTIONS)
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)

PARENTS 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 _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

RELC- G Tuition Agreement

NAME OF CHILD

FEE AMOUNT PER DAY	DAY PAYMENT TO BE MADE
$_____ per week - ELRC co-pay	Friday Prior to Week of Service

Services to be provided as part of the daycare fee (examples: care, meals, etc.)

_____ Room (Days of the Week _____)

Childcare

CACFP Breakfast, Lunch and Snack if child is in attendance during regularly scheduled times

INFANT: Similac Advance w/ Iron and age appropriate meals

School Age: Escorted to and from bus stop

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED (must match emergency contact list)

LATE FEE

$5.00 per 15 minutes <6pm or $25 + $10.00 per 5 min >6pm AND/OR $5.00 per 15 minutes early drop off without permission charges

Extra services to be provided at an additional fee if applicable

Enrollment and tuition deposit as applicable

Additional days may be added if space available with advance notice

I, the parent/guardian acknowledge that I will:

_____ Follow all procedures in the Parent Handbook, which contains written program information, that I received upon enrollment.

_____ Agree to update the emergency contact/parental information whenever changes occur and every 6 months per DHS regulation

_____ Complete a medication consent form when requesting medication administration.

_____ Notify the staff when my child is ill or any family member has a contagious disease.

_____ Obtain health assessments for my child according to the schedule recommended by the American Academy of Pediatrics. 2,4,6,9,12,18, 24 months and yearly thereafter

_____ Provide staff with any extra items necessary for my child's care, (i.e. pull ups, wipes, extra clothes, etc.).

_____ Agree to discuss my concerns that I may have with the Teacher/Program Director.

_____ Agree to pay for all days that my child is enrolled even if he/she does not attend. Schedules are set and not to vary

_____Agree to follow my child's scheduled drop off and pick up times contracted to- I will not bring my child early or pick up late

_____	_____	_____	_____
ADMINISTRATIVE SIGNATURE	DATE	SIGNATURE - PARENT OR GUARDIAN	DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW	
	_____	_____
DATE OF WITHDRAWL	SIGNATURE- PARENT OR GUARDIAN	DATE

12/3/25- LF

Child and Adult Care Food Program
Child Enrollment Form

Sponsor/Center Name: Rainbow's End Learning Center
Agreement #: 300-63-930-0

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD NAME BIRTH DATE AGE	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:			Withdrawal Date:					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
SECOND CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:			Withdrawal Date:					
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
THIRD CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:			Withdrawal Date:					

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

****

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.

The completed AD-3027 form or letter must be submitted to USDA by:

1. *mail:* *U.S. Department of Agriculture*
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. *fax:* *(833) 256-1665 or (202) 690-7442; or*
3. *email:* *program.intake@usda.gov*

This institution is an equal opportunity provider.

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member reguarly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income

How often? Weekly ○ | Bi-Weekly ○ | Monthly ○ | 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ | Reduced ○ | Denied ○

Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Check all that apply

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Adult Household Members (Including yourself)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - ____

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials **may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."**

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

CONSENT AND RELEASE

I hereby give Pathways it's affiliates, nominees, agents and assigns, my free unlimited consent and permission, waiving all claims for any compensation by reason thereof or damages by reason thereof, (1) to take photographs, moving pictures and videotapes of me and record my voice.(2) to use publish or republish the same, and/or photographs I may provide to them, in the furtherance of its work with or without identification of me by name, (3) to use my name and/or information referring to me in conjunction therewith if they so desire and (4) in furtherance of their work, to release such photographs, moving pictures, videotapes and recordings and to authorize any newspaper company or other organization to use. Publish or republish the same with or without identification of my by name and to use my name and/or information referring to me in conjunction therewith if they so desire.

Date: _____

Print Child Name: _____

Address: _____

_____

Parent signature: _____

I represent that I am the parent/guardian of the above minor, and hereby consent and agree_____, do not agree_____, individually and as a parent/guardian to all terms and provisions above.

Date: _____

Parent/ Guardian Name: _____

Signature: _____

relationship_____

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

Rainbow's End Health Policy

A child will be excluded from attending childcare in the following situations…

- If the child is unable to participate in the daily classroom activities, generally lethargic, needing constant one on one attention, or not able to participate in large motor or outdoor play.
- If the child has a fever of 100.4 degrees or higher.
- Diarrhea- excess liquid in stool, occurring two or more times in a two-hour time period or if the stool can't be contained within the diaper. Food intolerance will be taken into consideration.
- Vomiting- first occurrence (Reflux will require a note from a physician.)
- A rash present on a child's body.
- Has symptoms of a contagious illness. The child will be excluded from care if one of the following illnesses is suspected- including, but not limited to the following:

Roseola	Scarlet Fever	Croup	Pink Eye
Impetigo	Ringworm	Lice	Fifth Disease
Chicken Pox	Pneumonia	Flu (3-5 days)	Strep Throat
Hand Foot and Mouth	RSV (5-8 days)	Covid-19	

The symptoms will be assessed by the staff, on the basis of prior experience and the *Managing Infectious Diseases in Child Care and Schools* reference guide published by the American Academy of Pediatrics.

Parents must arrange to pick up their child within 1 hour of the time they are notified of the illness.

A child may return to care if they meet *all* the following requirements:

- 24 hours after the second dose of an antibiotic has been administered when prescribed by a physician.
- No fever has been present for 24 hours and **no fever reducers** (Tylenol, Ibuprofen, etc.) **have been administered within the last 12 hours.**
- The child has not vomited in the last 24 hours.
- The child can participate in all daily activities, including outdoor play. The child is considered able to participate when the illness does not require more care than the childcare staff are able to provide without compromising the needs of the other children in care.
- In the event of a rash or contagious illness, the child will be readmitted with a physician's written release.

Reviewed 8/23/24

I have read and understand the Rainbow's End Health Policy and agree to abide by it.

Parent Signature / Date **Director's Signature / Date**

Suspension and Expulsion Policy

At Rainbow's End Learning Center we understand it is essential for all children to have a positive educational experience from the start to build steps for lifelong learning. Suspending and/ or expelling a child from our Early Learning Program is not considered normal practice and prevention of suspension or expulsion from the program is essential to promote partnerships between our program and families. This supports healthy development, continuous quality improvement and supports children's social, emotional and behavioral health.

Policies and expectations within the center are discussed and agreed upon at enrollment to ensure all parties are working collaboratively together. Children are welcome with support staff into the program and behavioral plans are used as needed. Children will not be excluded from enrollment if a parent identifies the need for support staff and the center will follow any necessary plans to assist the family and support staff with the child. All families will be encouraged to participate in their child's care as much as they are able.

Rainbow's End supports developmentally appropriate practice in each classroom and provides children with a safe and interactive as well as stimulating learning environment. Staff are offered and must take professional development on age-appropriate behavior as well as partnering with parents. Classrooms are set up to avoid conflict as much as possible, and staff are encouraged to develop professional relationships with families and the children enrolled. Each child will be treated equally.

For all children, including anyone with an Individualized Education Program (IEP)/ Individualized Family Service Plan (IFSP), once a behavioral concern is identified - this refers to any behavior observed in a child that may fall outside typical developmental expectations, including but not limited to: hitting, kicking, spitting, harm to self or others, foul language, damaging property, eloping from classroom, etc.

1. If a child exhibits behavioral issues, staff will alert the director and document the behaviors as well as any relevant information such as, but not excluded to: time, date, antecedents, interactions, what redirection is used and amount of time from start to end of behavior.
2. Documentation will be shared with families, and we will collaborate with families to develop a behavioral support plan that best meets the child's needs.
3. Staff will share helpful resources with families and places they may go to for additional assistance.

4. Once a plan is established staff will document daily and share with families both positive and negative behaviors and how the plan of action is working.
5. Staff will provide the child with reasonable accommodations to assist the child. Some examples include, but are not limited to: need for a snack, fidget toy, extra time to prepare for transitions, signal cards, etc.
6. Staff will document daily and share documentation with parents as often as needed.
7. All children will be given positive reinforcement on a regular basis
8. All children will have lessons on social and emotional development with their classroom teachers.
9. If violent or unsafe behavior continues, a discussion with parent / guardian regarding the need for a suspension or expulsion will occur.

For the safety of the child, other children in the center and the staff, it may become necessary to suspend or expel a child from Rainbows End Learning Center. There may be instances based on the severity of an incident where the prior listed items may not all be followed prior to a suspension/expulsion.

Transition Process:

If an expulsion must occur, Rainbow's End will assist the family and child in transitioning to another program by identifying and engaging mental/behavioral health consultants and community resources to assist in determining the most appropriate placement for the child.

ACKNOWLEDGEMENT:

I, the parent/ guardian of _____

Acknowledge the Expulsion and Suspension Policy was explained to me, and I have read and received a copy of the Expulsion and Suspension Policy.

Parent / Guardian Signature: _____

Date: _____

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: Rainbow's End Learning Center		
FACILITY PHONE: 724-627-5421	COUNTY: GREENE	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.

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

Date: _____

Dear Family,

We both share a common interest in your child's well-being, growth and development. One of the ways we advance this is with development plans and assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. Would you kindly complete the lower part of this form and return.

Thank you,
Daralyn Jurkovich
Director

☐ I am enclosing a copy of my child's IEP or IFSP.

_____I give permission for Rainbow's End Learning Center to obtain information from Early Intervention and Intermediate Unit

_____I give permission for Rainbow's End learning Center to release my child for services within the building to Early Intervention and Intermediate Unit. These services are held within the Center only.

These services are held within Pathways building ONLY.

☐ I am not providing a copy of my child's IEP or IFSP or this is not applicable to my child.

Child's name:_____

Parent's Signature _____Date:_____

GETTING TO KNOW YOU?

In order to make your child more comfortable and well adjusted, we need to know a little about them.

1. Does he/she have a nickname?_____
2. Does he/she have a special blanket or item they like for nap?_____
3. Is there a special way he or she goes down for nap?_____
4. Is he/she allergic to any foods?_____
5. What is his/hers favorite food?_____
6. Is he/she allergic to any medications, environmental? If so what?_____
7. Any special needs that we need to be aware of?_____

   _____
8. Any information that will make them more comfortable in attending daycare?_____

   _____

Sign:_____ Date:_____

If under 1yr of age complete the back page.

Welcome to the infant room. In order to make you and your child comfortable please complete the following information.

Infant Feeding Schedule:

Infant Nap Schedule:

How do you soothe your baby from crying?

Child's Name:_____

Parent's Signature:_____

Date:_____

Rainbow's End Learning Center
Part of PathWays | Fulfilling Potential

RAINBOW'S END LEARNING CENTER
POLICY AGREEMENT

• Emergency Closings: In the event of extreme weather conditions, closings will be announced on ClassDojo. Parents will be responsible for the daily fee if their child was scheduled.

• Holidays: Rainbow's End Learning center is open Monday through Friday 6:30 AM-6:00 PM. We are closed most major Holidays. Tuition will be charged for closed holidays if your child is scheduled to attend on the day a holiday falls on.

• Tuition Fee: Tuition is based on the number of days you reserve in writing on your agreement.

•Tuition payments: Tuition is due Fridays by 6:00 pm prior to the week of service. If the payment is late there will be a penalty fee added. Failure to pay account in full (including penalty fee) will result in termination. Additionally after 4 delinquency notices within the year your child will be terminated and you will be considered a new enrollment.

• Absence Policy: Parents are responsible for payment of ALL scheduled days as per agreement.

• Enrollment fee: A $50 non-refundable enrollment is charged per child.

• Drop off and Pick Up Policy: Parents must accompany their child to and from the child's classroom and sign them in daily. Parents are required to adhere to times listed on the agreement. A late fee of $5 per every 15 minutes is charged if parent is late picking them up.

• After Closing Late Fee: A $25 fee + late charge of $10 per 5 minutes a parent is late picking up their child after 6:00 pm.

• Returned Check fee: A $40 fee will be assessed for any returned checks.

• Health Appraisals: Child Health exams must be updated according DHS. Past due child health reports can result in your child being excluded from care until the form is turned in.

• Sibling Discount: Parents are given $3.50 discount per day for multi children. There is a $2.50 discount per day for children enrolled 5 FT days a week.

Rainbow's End Learning Center admits students of any race, color, national and ethnic origin to all rights privileges, programs, and activities generally accorded or made available to students in the school. It does not discriminate on the basis of race, color, national or ethnic origin in administration of its admission policies and educational policies.

I have read the policies outlined here and in the Parent Handbook, I understand and agree to adhere to the policies set forth.

Parent Signature: _____ Date: _____

Director Signature: _____ Date: _____

RAINBOW'S END LEARNING CENTER

Permission signatures

Please initial next to each item and sign the bottom.

1. _____Yes I would like to be on REMIND so I can get notifications:

   Cell Phone number:_____

2. _____ Please provide email for newsletters and such:

   _____

3. _____ I give RELC permission to apply diaper cream/lotion/powder and /or chapstick as needed. Parent must provide.
4. _____ I give permission for RELC to apply sunscreen to my child from Spring to Fall months. Parent must provide.
5. _____ I give permission for my child to participate in Water Day during summer months.

Child's name:_____

Parents Signature:_____

Parents printed name:_____

Date signed:_____

WASHINGTON HEALTH SYSTEM

CONSENT FOR:
EMERGENCY TREATMENT, MEDICAL/SURGICAL CARE AND MINOR'S MEDICAL INFORMATION

I _____ hereby grant consent for _____
☐Mother ☐ Father ☐Legal Guardian ☐Son ☐Daughter

of _____years of age to the rendering of such care including diagnostic procedures, surgical and medical care and blood transfusions by the authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the child's conditiion.

I have read this form and certify that I understand its content.

We/I hereby give our/my consent to **RAINBOW'S END LEARNING CENTER**

Who will be caring for our/my child_____
(name of child)

for the period _____ to PRESENT to arrange for routine or emergency medical care and treatment necessary to preserve the health of our/my child.

We acknowledge that we/I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

NAME: _____

ADDRESS: _____

_____

PHONE: _____

Name of Health Ins. Carrier:

_____

_____

Group No.: _____

Social Security No. _____

Family Physician: _____

Pediatrician: _____

Surgeon: _____

Orthopedist: _____

Child's Allergies: _____

_____

Last Tetanus: _____

Current Medicines: _____

_____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

In case of emergency I/we can be reached at: _____

RAINBOW'S END LEARNING CENTER, INC.

APPLICATION FOR WAIVER OF ENROLLMENT AND REGISTRATION FEES

CHILD NAME: _____

PARENT/GUARDIAN: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

DAY CARE LOCATION: _____

HOUSEHOLD SIZE: _____

*ANNUAL HOUSEHOLD INCOME: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

_____

EMPLOYER TELEPHONE NUMBER: _____

*The income you report must be the total gross income for each household member. Total gross income is defined as all income earned before taxes and other deductions. Supporting documentation must be submitted in order to verify your annual income. For example, you can submit your paycheck stubs for the previous month. If the previous month's income does not accurately reflect your circumstances, you may provide a projection of your income along with an explanation and a contact person to verify this information.

Please use the following as a guide to assist you in annualizing your income:

			ANNUAL INCOME
WEEKLY INCOME:	_____	X 52 =	_____
BI-WEEKLY INCOME:	_____	X 26 =	_____
SEMI-MONTHLY INCOME:	_____	X 24 =	_____
MONTHLY INCOME	_____	X 12 =	_____

I certify the information listed above is current and correct and all income was reported. I understand the fiscal department may verify the above information. I grant Rainbow's End Learning Center, Inc. permission to request the enrollment and registration fees from the UCP Foundation.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Please initial below to indicate whether you received a copy of the parent handbook and whether you have had a parent-director interview/conversation regarding the enrollment packet for Rainbow's End Learning Center.

Thank you,

Rachel

I have received and reviewed a copy of the parent handbook _____

I have met with the director to discuss the enrollment packet _____

Signature _____

Child's Name _____

Date _____

Rainbow's End Learning Center

Please initial and sign below to indicate whether you received a copy of the parent handbook.

Thank you,

Rachel Raber

Director

Yes, I received a copy of the parent handbook _____

No, I did not receive a copy of the parent handbook _____

Signature _____

Child's Name _____

Date _____

pennsylvania
DEPARTMENT OF EDUCATION

Children and Adults with Disabilities and Special Dietary Needs

Operators of the Child and Adult Care Food Program (CACFP) and Summer Food Service Program (SFSP) are required to make reasonable modifications to Program meals or the meal service to accommodate children or adults (Program participants) with disabilities that restrict the diet.

1. Licensed Medical Authority's Statement for Participants with Disabilities
U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in Program meals for participants whose disabilities restrict their diets. Sponsors, centers, and day care homes must provide modifications for participants on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document ("Medical Plan of Care for Child Nutrition Programs") may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in Pennsylvania includes a:

- Physician,
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the participant's physical or mental impairment restricts the diet;
- An explanation of what must be done to accommodate the participant; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Special Dietary Needs
Program operators may make food substitutions for individual participants who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Program operators are encouraged, but not required, to have documentation on file when making menu modifications within the meal pattern.

Special dietary needs and requests such as those related to general health concerns and personal preferences are not disabilities and are optional for Program operators to accommodate. Meal modifications for non-disability reasons are reimbursable provided that these meals adhere to Program regulations.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act
Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008,* a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Children and Adults with Disabilities and Special Dietary Needs

4. Individuals with Disabilities Education Act
Preschool children, infants, and toddlers with disabilities have additional rights under the *Individuals with Disabilities Education Act* (IDEA). Questions regarding the IDEA's requirements should be directed to the U.S. Department of Education, which is the federal agency responsible for the administration and enforcement of the IDEA.

Child Nutrition Program (CACFP/SFSP) Contact
For more information about requesting accommodations to Program meals and the meal service for participants with disabilities, contact:
Click here to enter local contact name and information.

USDA Nondiscrimination Statement
In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail**:
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. **fax**:
   (833) 256-1665 or (202) 690-7442; or

3. **email**:
   program.intake@usda.gov.

This institution is an equal opportunity provider.

Medical Plan of Care for Child Nutrition Programs (CACFP and SFSP)

Please read pages 1 and 2 before completing this form.

Participant's Name	Date of Birth	Age/Classroom
Name of Center/Program/Site		
Name of Parent/Guardian or Participant's Representative	Phone Number of Parent/Guardian/Representative	
Signature of Parent/Guardian or Participant's Representative	Date	

1. Provide an explanation below of how the participant's physical or mental impairment restricts the participant's diet:

2. Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the participant's needs:

3. List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.
Foods to be omitted:

Suggested substitutions:

4. Indicate texture modifications, if applicable:

☐ Chopped/Cut into bite-sized pieces ☐ Diced/Finely Ground ☐ Pureed ☐ Other:

5. List any required special adaptive equipment:

Name of Physician/Medical Authority & Title (Please Print)	Provider Phone Number
Signature of Physician/Medical Authority	Date

Signing the following section is optional but may prevent delays by allowing the Program to speak with the physician/medical authority.

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ *(medical authority)* to release such protected health information of the participant as is necessary for the specific purpose of Special Diet information to _____ *(center/program/site)* and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning the participant with the childcare/adult care/ summer food program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for the participant. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ *(date)*. This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is **(*circle one*): Parent Guardian Adult participant** or **Representative of participant** listed on this document and has the legal authority to sign on behalf of that person.

Signature: _____ Date: _____

pennsylvania
DEPARTMENT OF EDUCATION

CACFP Infant Enrollment Form

Center/Provider Name:_____

Dear Parent/Guardian,
This childcare center/provider participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires childcare centers/providers to follow specific meal patterns according to the age of the infant.

Childcare centers/providers participating in the CACFP **are required** to offer at least one iron fortified infant formula for infants who are enrolled in care. You may decline the infant formula offered, and supply breast milk and/or your own CACFP approved iron-fortified formula.
(NOTE: A CACFP approved iron-fortified formula must have 1 mg of iron or more per 100 calories of formula when prepared using the label directions and must be regulated by the FDA.)

Additionally, when you determine, in consultation with your physician, that your infant is developmentally ready, the childcare center/provider will also be **required** to offer iron fortified infant cereal and other infant foods.

Infant's Name_____Infant's Date of Birth_____

Iron Fortified Formula offered by the Center/Provider_____

Breast milk and/or Formula preference

Record date to indicate your preference (choose all that apply) *I understand that I may change my decision at any time with advance notice	**Birth -5 months Date & Initial**	**6 – 11 months Date & Initial**
I will provide expressed breast milk for my infant.		
I will breast feed my infant on site at the center/provider.		
I want the childcare center/provider to provide the infant formula it offers for my infant.		
I will provide the infant formula for my infant. (must be iron fortified) **Name of infant formula I will provide:** _____		
My infant has a special dietary need that requires a formula that does not meet the criteria for an approved iron fortified formula. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, and the recommended substitution. **Name of infant formula:** _____ ☐ Center will provide the formula. ☐ I will provide the formula.		

Preference regarding infant cereal and other foods

Record date to indicate your preference *I understand that I may change my decision at any time with advance notice	**6 – 11 months Date & Initial**
I want the childcare center/provider to provide the iron fortified infant cereal and other foods for my infant.	
I want the childcare center/provider to provide all food items with one exception. (This option is only applicable if center/provider is providing the iron-fortified infant formula) **One food item that I will provide (must be a creditable CACFP food item): _____**	
My infant has a special dietary need that requires modifications to the infant meal pattern requirements. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, the foods to avoid and the recommended substitutions	
I am aware and understand the all information provided on this form and my ability to have my infant participate in the CACFP; however, **I decline** the infant formula and food offered by the center/provider and elect to furnish ALL infant formula and food for my infant. **(Center/Provider may not claim meals for this infant)**	

Parent/Guardian _____ **Date** _____ **Center/Provider signature** _____ **Date** _____

This supplemental infant form must be completed for all infants in care and must be maintained by center/provider and if applicable, a copy must be maintained by the Sponsoring organization.

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1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

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