

# Anointed Hands Too Child Development Center

3134 Willits Road Philadelphia, PA 19136

APPLICATION FEE: \$35

## BEFORE & AFTER SCHOOL APPLICATION FORM 2020-2021 Calendar School Year

Requested Start Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name of Child \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

### Parent/Guardian 1

### Parent/Guardian 2

Name \_\_\_\_\_

\_\_\_\_\_

Relationship \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

\_\_\_\_\_

Name of Workplace \_\_\_\_\_

\_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

### Enrollment Options:

What elementary school will/does your child attend? \_\_\_\_\_

Grade this Fall \_\_\_\_\_ Room # \_\_\_\_\_ Teacher \_\_\_\_\_

Please check all the days below that you wish your child to attend the Before/After School Program. Also indicate if your child will be attending BEFORE and/or AFTER care. We require each child to sign up for at least 3 days.

	Monday	Tuesday	Wednesday	Thursday	Friday
Before Care	_____	_____	_____	_____	_____
After Care	_____	_____	_____	_____	_____

### Emergency Contact Information:

#### Emergency Contact #1

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relation to child \_\_\_\_\_

#### Emergency Contact #2

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relation to child \_\_\_\_\_

### Medical Information:

FAMILY PHYSICIAN \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

ALLERGIES \_\_\_\_\_ MEDICATIONS \_\_\_\_\_

MEDICAL CONCERNS/ ACCOMODATIONS \_\_\_\_\_

**Child Release Information:**

\_\_\_\_ I will pick up my child(ren) from Anointed Hands Child Development center.

**PLEASE ALSO LIST AN ADDITIONAL PERSON AUTHORIZED TO PICK UP YOUR CHILD(REN)**  
I, hereby give permission for my child to be released to the following person below:

**Person #1**  
First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**CHILD TERMS OF AGREEMENT/ ENROLLMENT AGREEMENT**

**PLEASE READ THE FOLLOWING AGREEMENTS CAREFULLY. PLEASE INITIAL AFTER EACH AGREEMENT AND SIGN AT THE BOTTOM.**

**TRANSPORTATION RELEASE**

I, HEREBY GIVE ANOINTED HANDS CHILD DEVELOPMENT CENTER PERMISSION TO PICK MY CHILD UP FROM THE SCHOOL STATED ABOVE AND GIVE ANOINTED HANDS PERMISSION TO TRANSPORT MY CHILD, VIA ANOINTED HANDS VANS, BACK TO THE CENTER.

**PARENT/GUARDIAN INITIALS \_\_\_\_\_**

**RELEASE AGREEMENT**

I UNDERSTAND THAT ANOINTED HANDS AFTER SCHOOL PROGRAM CLOSSES PROMPTLY AT 5PM EACH WEEK DAY. I ALSO UNDERSTAND THAT I MUST PICK UP MY CHILD(REN) ON TIME EACH DAY. IF I AM LATE PICKING MY CHILD(REN) UP MORE THAN THREE TIMES, I UNDERSTAND THAT THE PROGRAM DIRECTOR HAS THE RIGHT TO REMOVE MY CHILD(REN) FROM THE PROGRAM.

**PARENT/GUARDIAN INITIALS \_\_\_\_\_**

**EMERGENCY CARE RELEASE**

IN THE EVENT OF AN EMERGENCY IN WHICH I CANNOT BE REACHED, I AUTHORIZE EMERGENCY MEDICAL PERSONNEL TO PROVIDE THE NECESSARY FIRST AID AND/OR HOSPITALIZATION.

**PARENT/GUARDIAN INITIALS \_\_\_\_\_**

**ENROLLMENT AGREEMENT**

I UNDERSTAND THAT THIS ENROLLMENT FORM MUST BE FILLED OUT COMPLETELY. MISSING SECTIONS MAY PREVENT MY CHILD(REN) FROM ATTENDING THE PROGRAM.

**PARENT/GUARDIAN INITIALS \_\_\_\_\_**

**CODE OF CONDUCT**

I UNDERSTAND MY CHILD IS REQUIRED TO FOLLOW THE ANOINTED HANDS BEFORE & AFTER SCHOOL PROGRAM CODE OF CONDUCT. I UNDERSTAND THAT ALL PARENTS AND CHILDREN ARE EXPECTED TO RESPECT THE PROGRAM AND CENTER STAFF. IF MY CHILD EXHIBITS INAPPROPRIATED BEHAVIORS, DURING THE PROGRAM, A BEHAVIOR REPORT WILL BE ISSUED. AFTER THREE BEHAVIOR REPORTS ARE ISSUED, MY CHILD MAY BE SUSPENDED OR REMOVED FROM THE PROGRAM.

**PARENT/GUARDIAN INITIALS \_\_\_\_\_**

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

Date \_\_\_\_\_

**ANOINTED HANDS TOO CHILD DEVELOPMENT CENTER  
3134 WILLITS ROAD  
PHILADELPHIA, PA 19136  
(P) 215.464.1164  
(F) 215.673.3591**

# 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



ANointed HANDS CHILD DEVELOPMENT CENTER



CHILD PICK-UP AUTHORIZATION FORM

Child's name: \_\_\_\_\_

**Main pick-up person:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Additional persons who may pick up child/children on a less frequent basis:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Any person(s) NOT authorized to pick up my child/children:**

\_\_\_\_\_

**Note: Any person unfamiliar to staff will be required to show proof of identification. Under NO circumstances will the child be released to anyone other than those listed above without WRITTEN or VERBAL permission from the parent.**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Anointed Hands Too Child Development Center

3134 Willits Road, Philadelphia, PA 19136 Tel: 215.464.1164 Fax: 215-673-3591

## Parental Agreement

Starting Date: \_\_\_\_\_ Arrival \_\_\_\_\_ Departure \_\_\_\_\_

Category: Before/After Care \_\_\_\_\_ Summer Camp: \_\_\_\_\_

Anointed Hands Child Development Center, is a child facility offering full day and part day programs for infants, toddlers, preschool and school age children. Children are accepted for enrollment without regard to race, color or religious creed, handicap, ancestry, national origin, limited English proficiency or sex. The center is open year round Monday through Friday from 7:00a.m. to 5:00p.m. (Holiday closing schedule is attached)

The center shall provide care for:

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME OF PARENT/GUARDIAN \_\_\_\_\_

### SERVICES:

1. Child care services between the hours of 7:00 a.m. and 5:00 p.m. for \_\_\_\_\_ days per week. **PLEASE BE ADVISED!!** Parents who exceed their departure/pickup time will be assessed a late fee and could possibly lose their child care services. (see late pickup fee below ↓)
2. The child shall be furnished breakfast, lunch (no school), and snack. (Parents have the option of providing children with meals).
3. The child will be given assistance with personal care as needed.
4. The child shall be provided with an opportunity to receive down time between the hours of 1:00 pm- 3:00 pm when children are at the center for a full day.
5. The child shall be placed in a group of peers based on a age and/or special needs as determined by the staff.
6. The child shall be involved in a program of play and learning experiences that are age appropriate for the child. A balance of active and

quiet play is provided with individual and group activities that are geared toward the emotional, social, physical and individual growth of young children.

7. As per State Regulations, your child will play outside every day, in the yard or playground, if weather permitting per State Regulations.
8. Anointed Hands Too CDC will assume responsibility for the child after the child arrives at the center and will remain responsible until the child is picked up by the parent/guardian.
  
9. **Medications** – The child shall be administered **ONLY** if medication is current, prescribed by a physician AND parent has filled out a Medication Log Form, located at the front desk. The center shall have no responsibility of any kind whatsoever for failure to provide the medication nor for any adverse reactions caused by the medication.
10. **First Aid** – The center shall provide first aid to any hurt child. A parent/guardian shall be called if immediate attention is needed. If the injury is of an emergency nature, paramedics shall be called and the Director shall accompany the child. The parents/guardians shall be Notified immediately.
11. **ILL Child** – a sick child shall be isolated and given appropriate care until picked up by the parent/guardian.
12. **Communicable Diseases** – The center shall notify parent/guardian of a suspected exposure to communicable disease.
13. **Personal Belongings** – The center shall make every effort to safeguard personal belongings brought by the child, but shall not be held responsible for lost or broken items. *Please mark your child's name on everything sent in to us including their lunch.*
14. Should the management of Anointed Hands Too CDC determine in its sole discretion, that a child has not adjusted to the daily program, the child dismissed and this agreement will be terminated at the option of Anointed Hands Too CDC. Parents will be given one week's notice of their child's termination.
15. **The center will issue a report** describing your child's growth and development in the context of the services provided by our facility. The areas of observation in each area align with Pennsylvania's Early Childhood Standards and will be issued in January and June.

#### **Obligation of Parent/Guardian**

1. Parent/guardian are encouraged to visit the center at any time.
2. Parent/guardian shall furnish requested medical and immunization material within 30 days of enrollment. **Yearly appraisal is needed thereafter**

3. *The Emergency Contact/Parental Consent Form must be updated every 6 months OR when any information has changed.*
4. *The parent/guardian shall notify the center when someone else is picking up the child if the person is not listed on the Child-Authorization Form. This person must have a **photo identification**. A Verbal Consent Form will be filled out by Administration. If the designated persons does not present photo identification, the child will not be released.*
5. **Communicable Diseases** – The parent/guardian must notify us of the child's possible exposure to a communicable disease.
6. **Absences** – Please call the center when the child is absent.
7. **Termination of Services** – Please give the center two weeks notice.
8. **Late pick up** – The parent/ guardian shall notify the center. If you pick up the child after closing time, you must pay the late fee of, \$10.00 for the 1st minute and \$1.00 per minute thereafter.
9. **Late Payment** – Payments are due on Friday no later than the following Monday 12pm for daycare services for the following week. If payment is not received by the due date a \$10/per day late payment penalty will be applied.

**Payment Provisions:**

1. A non-refundable registration fee of **\$35.00** is due upon enrollment.
2. Tuition/Co-payments for your child will be \$\_\_\_\_\_ to be paid every Friday, no later than Monday by 12 noon, with **NO DEDUCTION FOR ABSENCES, HOILDAYS OR EMERGENCY WEATHER CLOSINGS.** (see attached Holiday closing schedule)
3. I agree to pay one half of the week's tuition if child is absent for an entire week. (5 days in a row)... This refers to full time children ONLY.

This agreement may be modified whenever any of the circumstances covered by this agreement changes.

\_\_\_ I have read the above information completely and understand the terms and conditions of Anointed Hands Too Child Development Center tuition policies. (please initial)

\_\_\_ I also agree to cooperate with the general policies of the center to perform the obligations of Parent/guardian set forth in this agreement and to abide by the rules and regulations. (please initial)

X

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

X

\_\_\_\_\_  
Signature of Administration

## Anointed Hands Too Child Care Agreement

Name of Child(ren):		
Tuition/Co-pay Amount:	# Days per week	<b>Payment Due Date:</b> Every Friday the week prior to service, no later than Monday the week of service.
Child's Start Date:	Child's Arrival Time:	
<p><b>Late Fee:</b> Services are only rendered during the times mentioned above. If you fail to adhere to the <u>departure time</u> mentioned above, a late fee will apply. There will be a <b>\$10.00 charge for the 1<sup>st</sup> minute late, in addition to a \$1.00 charge thereafter.</b> Please be on time to avoid these charges.</p>		
Person(s) authorized by parent to whom child can be released (please list below & to the right).		

Services to be rendered as part of the child care fee: **(please check all that apply)**

- Child Care
- Transportation (additional fee)
- Meals
- Extended Care (additional fee)

**I, the parent/ guardian: (please check box, sign and date)**

- have received a complete written program enrollment packet at the time of enrollment.
- have agreed to update the emergency contact/parental consent/child care agreement forms whenever changes occur and/or every 6 months, minimum.

X

Administration

Date

X

Parent/Guardian

Date

Child's Start Date	Withdrawal Date

**Periodic Review Signature : (Please sign and 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:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> 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](http://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/ID						
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.

# **ANOINTED HANDS TOO CHILD DEVELOPMENT CENTER**

To: Parents

Subject: Nondiscrimination in Services

From: Christina Humphrey, Owner

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, age, sex, national origins or Limited English Proficiency (LEP).

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

Anointed Hands Child Development Center  
3134 Willits Road Philadelphia, Pa 19136

Depart Of Public Welfare  
Bureau Of Equal Opportunity  
Room 223, Health & Welfare Building  
PO Box 2675  
Harrisburg, PA 17105

PA Human Relations Commission  
Philadelphia Regional Office  
110 N. 8th Street, Suite 501  
Philadelphia, Pa 19107

U.S Department of Health and Human Services  
Office for Civil Rights  
Suite 372, Public Ledger Bldg.  
150 South Independence Mall West  
Philadelphia, PA 19106-9111

Commonwealth Of Pennsylvania  
DPW Bureau of Equal Opportunity  
Southeast Regional Of Equal Opportunity  
801 Market Street, Suite 5034  
Philadelphia, PA 19107

---

Parent Signature and Date

# ANOINTED HANDS TOO CHILD DEVELOPMENT CENTER



3134 WILLITS ROAD  
PHILADELPHIA, PA 19136  
PHONE: 215.464.1164  
FAX: 215.673.3591  
EMAIL: [ANOINTEDHANDSCDC@GMAIL.COM](mailto:ANOINTEDHANDSCDC@GMAIL.COM)

## CIVIL RIGHTS COMPLIANCE PARENT AWARENESS

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your children, as a client of the facility have the right:

To be provided services at this facility and to be referred for services at to other facilities without regard to your race, color, religious creed, handicap, ancestry, national origin, age or sex.

To file a complaint of discrimination, if you feel you have been discriminated against on the basis of your race, color, religious creed, handicap, ancestry, national origin, age or sex. Complaints of discrimination may be filed with any of the following agencies:

**Department of Public Welfare  
Bureau of Equal Opportunity  
Room 223, Health & Welfare Building  
P.O. BOX 2675 Harrisburg, PA 17105-2675**

**Pennsylvania Human Relations Commission  
110 North 8th Street  
Suite 501  
Philadelphia, PA 19107**

**U.S. Department of Health & Human Services  
Office of Civil Rights  
Suite 372, Public Ledger Building  
150 South Independence Mall West  
Philadelphia, PA 19106-9111**

**Commonwealth of Pennsylvania  
DPW / Bureau of Equal Opportunity  
Southeast Regional Office  
Suite 5034, 801 Market Street  
Philadelphia, PA 19107**

By signing this form below I indicate I have received a copy for my records.

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

Director's Signature \_\_\_\_\_

# ANOINTED HANDS CHILD DEVELOPMENT CENTER



## Hand Sanitizer Parent Permission Form

Dear Parents,

ANOINTED HANDS is required by law to have in our files your permission to administer hand sanitizer. Hand sanitizer would be used after blowing one's nose, before and after handling toys etc. Regular hand washing will continue before and/or after meals/snack and after toileting etc.

---

I / We give permission for \_\_\_\_\_ to receive hand sanitizer in the event there is no water to use for hand sanitizing.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## **Anointed Hands Child Development Center**

Parents please note that in order for us to comply with State Regulations and Guidelines we have to provide our Staff with Training and Professional Development and in order for us to do so, we close our Center the 3<sup>rd</sup> Friday of every month and if there are any changes to the 3<sup>rd</sup> Friday, we will notify you in advance. Also, late fees will apply when your child is not picked up by the 3pm closing time.

**We Thank You For Your Understanding!**

Please sign below showing that you understand this policy.

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

**Admin Signature** \_\_\_\_\_