AVE MARIA ACADEMY

Bethel Park Campus
134 Fort Couch Road
Pittsburgh, PA 15241
412-833-1412

Mt. Lebanon Campus
401 Washington Road
Pittsburgh, PA 15216
412-341-5444

EXTENDED DAY PROGRAM
REGISTRATION FORM
20____ - 20____ SCHOOL YEAR

(1) Student's Name: _____ Grade: _____

Health Problems/Medications: _____

_____

(2) Student's Name: _____ Grade: _____

Health Problems/Medications: _____

_____

(3) Student's Name: _____ Grade: _____

Health Problems/Medications: _____

_____

Parent(s)/Guardian(s) _____ _____

Home Phone _____ _____

Work Phone: _____ _____

Cell Phone: _____ _____

Email: _____ _____

Please provide your email address as invoices are sent electronically on a monthly basis.

Tell us who will regularly pick up your child(ren) if someone other then the 2 people listed above:

NAME	RELATIONSHIP	PHONE NUMBER

Anyone picking up your children will be asked to show a valid ID.

In the event of apparent serious illness or accident, when the parent/guardian cannot be reached, YOU authorize one of the following people to be notified by phone. These people listed below are authorized to act in your absence and have your authorization to release your child from the Extended Day Program into their care.

NAME	RELATIONSHIP	PHONE NUMBER

Please note: In the event of an emergency, EMS will be contacted immediately for assistance. Parent/emergency authorized person will then be notified. **The child will be transported to St. Clair Hospital if necessary. Should you NOT want your child transported to St. Clair Hospital, please indicate your hospital of choice below**:

_____

Please initial on the left that you have read and understand the following:

_____ I have read and understand the Ave Maria Academy Extended Day Program Agreement and Guidelines, and have discussed these with my child(ren).

_____ I have completed all necessary emergency information and will advise the Extended Day Program staff should any changes be necessary throughout the school year.

_____ I will complete a monthly reservation calendar and submit it on time for the months that my child will be using the Extended Day Program.

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

FOR OFFICE USE ONLY:

Date Received: _____ Amount: $_____ Cash/Check #: _____ Received By: _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

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.