Perry County Generations
Childcare & Preschool

ENROLLMENT PACKET

A New Student is Coming!

My Name_____

My Mom and or Dad's names are_____

My first day will be_____

My schedule_____

My Developmental Assessment MUST be completed by

_____

Emergency Information Form

Child's Full Name _____D.O.B._____

*4 Digit Door Code*_____

Parent Guardian Information

Mother's Name_____Email: _____

Address_____

Place of Employment_____

Phone Home (_____)_____ Cell(_____)_____

Father's Name_____Email: _____

Address_____

Place of Employment_____

Phone Home (_____)_____ Cell(_____)_____

Physician Information

Name of Child's Physician_____

Physician Address_____

Physician Phone Number (_____)_____ Ext. _____

Health Ins. Prov._____ Ins Group #_____

Please list any health concerns your child may have:

*Allergies_____

_____

Allergy Medication/s _____

Name of Dr. who Prescribed medication_____ Dose Given_____

Asthma Action Care Plan Yes No

Does your child have an IEP (Individual Education Plan) Yes No

***If your child does have an IEP/IFSP, PCG respectfully requests that our teaching staff and or administrative staff be included in any IEP based meetings (goal setting, up-dates, transition to Kindergarten etc.)**

Does your child use sign language, picture cards or a communication device? Yes No

What language is primarily spoken at home?

If a language other than English is spoken primarily at home, PCG staff will make every effort to incorporate your child's home language into their daily life at PCG.

*Other special concerns you feel would impact your child's well being at PCG?

Developmental, Social, Emotional or other Medical concerns:

_____

_____

_____

***If a child does have a diagnosed, chronic medical condition or educationally based delay, a Care Plan or IEP, signed by a physician and or psychologist, MUST be in place before they will be allowed to start attending Perry County Generations Child Care.**

Emergency Contact People

Please list three people ***other than parents/legal guardians*** that could be contacted if parents or guardians cannot be reached.

Name_____Cell (_____)_____

Work Phone (_____)_____Ext._____Hours at this #_____

Relationship to Child_____

Name_____Phone(_____)_____

Relationship to Child_____

Work Phone (_____)_____Ext._____Hours at this #_____

Name_____Phone(_____)_____

Relationship to Child_____

Work Phone (_____)_____Ext._____Hours at this #_____

Enrollment Authorizations

Perry County Generations, Inc.

Child's Name: _____

Program/Classroom: _____

Enrollment Date: _____

Please initial next to each authorization below.

Assessments & Observations

_____ I give permission for PCG staff to complete developmental assessments for my child.

_____ I give permission for my child to participate in daily classroom observations by PCG staff, consultants, or college interns.

Media Authorization

I give permission for my child's **name and/or photograph** to be used in the following ways:

_____ Taken during PCG activities

_____ PCG public Facebook page

_____ PCG private Facebook group

_____ PCG public website

_____ Newspapers or magazines

_____ Promotional materials

_____ Yearbooks

_____ Classroom materials

Sharing Information Authorization

_____ I authorize PCG to share information about my child **within the program** as necessary to support care and education.

I understand separate written authorization is required for information shared **outside of PCG**.

Sunscreen Authorization

(Please initial **one** option)

_____ Program-provided sunscreen (SPF 30+, lotion only)

_____ Parent-provided sunscreen (labeled with child's name)

_____ I will apply sunscreen to my child as needed

Diaper Cream Authorization

I give permission for Perry County Generations child care staff to apply the following **parent-provided creams, lotions, or ointments** to my child's skin **during diaper changes as needed**.

I understand that **powders are not permitted** at PCG due to inhalation safety hazards.

I acknowledge that PCG staff will apply products according to program procedures, and I agree **not to hold Perry County Generations or its staff responsible for any adverse reactions** my child may have to the approved products.

Approved creams/lotions/ointments (please list):

☐ No diaper creams or lotions are to be applied to my child.

Hand Sanitizer Authorization

When a child turns **2 years old**, PCG begins supervised use of hand sanitizer throughout the day when appropriate (e.g., after outdoor play or nose blowing). Children will **continue to wash hands**:

- Upon entering the classroom
- Before meals and snacks
- After using the restroom

Please initial one option below:

☐ **I give permission** for staff to apply hand sanitizer to my child's hands or for my child (ages 2+) to use hand sanitizer when needed.

☐ **I do not give permission** for hand sanitizer to be used on my child.

Medical/Allergy Information Authorization

_____ I authorize PCG to post and share information about my child **within the program** as necessary to medical and allergy conditions. Please attach any further needed information.

Medical Condition/Allergy:

Parent / Guardian Acknowledgment

I have read and understand the authorizations above.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

First Aid/ Medical Treatment Release

****

I hereby give my permission to the staff of Perry County Generations Child Care Inc. to administer first aid to my child_____ and to seek further medical treatment if necessary.

Parent/Guardian Signature _____Date_____

Parent/Guardian Signature _____Date_____

****

In order to post medical information about children, staff must obtain written permission from the parent. Please sign this form standing that Perry County Generations has permission to post your child's name on our medical/allergy posting.

Child's Name_____

Allergy/Medical Condition_____

Parent/Guardian Signature_____

Date _____

Military Family Discount

PCG offers a 5% military discount to verified parents and/or guardians that are active duty, reserve, retired, and veteran members of the Army, Navy, Air Force, Marines, Coast Guard, and National Guard. This discount may be applied with the multiple child discount.

To obtain the discount, military members need to show a valid military ID card.
Other Acceptable documents:

Service Members
• Military pay stubs - Leave & Earnings Statement (LES)
• Record briefs - ARB/ERB/ORB (US Army)
• Reserve Activation Orders
• Enlistment contracts

Veterans
• DD-214 form
• Driver's License or DMV-Issued State ID with VETERAN endorsement
• Honorable Discharge Certificate
• NGB form 22
• Reserve Separation Orders
• Veterans' Health Identification Card (VHIC), or Veteran Identification Card (VIC)

Retirees
• DD-214 form (must show 20 years of service or the reason for discharge was retirement)
• NGB form 22 (must show 20 years of service or the reason for discharge was retirement)
• Retiree Account Statement (eRAS)
• VA disability letter

Teacher Discount

PCG offers a 5% discount to verified teachers that are currently working in an education field. This discount may be applied with the multiple child discount.
To obtain the discount, parents need to show BOTH a current pay stub and a valid teacher/school ID card.

Perry County Generations
Child Day Care Agreement

55 PA Code Chapters 3270.123 & 181(c); 3280.123 & 18l(c):3290.123 & 181. ©

Name of Child_____

Date of Admission_____ Date of Withdraw_____

Tuition Amount_____ Per-Day-Week_____ Day Payment is Due_____

Services to be provided as part of the day care fee.
- Constant supervision/ care of child
- Breakfast, two snacks, and lunch
- Developmentally appropriate/ appropriate activities
- Additional items such as administering approved medications listed below:

_____

_____

Child's Arrival time_____Child's Departure Time_____

Persons Designated By Parent To Whom Child May Be Released:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

I, the Parent/Guardian:

___Have received complete written program information at the time of enrollment (3207.121, 320.121, 3290.121)

___Agree to update the emergency contact/parental consent form information
Changes occur every 6 months at a minimum (3270.124. 3280.124. 3290.124)

_____ _____

Signature Operator Date Signature Parent/Guardian Date

Perry County Generations Child Care

Payment Policy

Effective August 2026

TUITION DEPOSIT & WITHDRAWAL

- A **deposit equal to one week's tuition** is required to reserve enrollment and must be paid **one week prior to the start date**.
- Deposits may be paid by **cash or check**.
- A **written two-week notice** is required to terminate care.
- The deposit will be applied to the **final week of care**.
- Failure to provide notice results in **forfeiture of the deposit** and may affect **future enrollment eligibility**.

TUITION PAYMENTS

- Tuition may be paid **weekly, bi-weekly, or monthly**.
- **Weekly payments:** Due **every Friday by 9:00 a.m.**
- **Bi-weekly payments:** Must be **one week current and one week in advance**.
- **Monthly payments:** Due on the **first Friday of each month**.

PAYMENT METHODS

Playground Automated Payments

- Payments process **Thursday morning or on the last day of the week PCG is open** to be settled by **Friday morning**.
- ACH and recurring credit card payments are processed **no later than 9:00 a.m. Thursday**.

LATE PAYMENTS

- Payments not received by **Monday at 9:00 a.m.** incur a **$25 late fee**.

- Payments not received by **Tuesday at 9:00 a.m.** incur an **additional $20 fee**, and the child(ren) will **not be admitted** until the balance is paid in full.
- Repeated late payments may result in **mandatory enrollment into Playground automatic payment platform** or **termination of services**.

NON-SUFFICIENT FUNDS (NSF)

- NSF payments will incur a **$25 fee**.
- After **two NSF Notifications**, families must pay **cash only**.
- If a family has two or more NSF notifications, and refuses to pay cash, or the cash payments are late, they will withdraw from care with **two weeks' notice**.
- The tuition deposit will apply to the **final week of care**.

CREDIT DAYS

- Credit days must be requested using a **PCG Credit Day Form**.
- Please allow **two business days** for processing.
- Accounts must be **current** to use credit days.
- Credit days **cannot be applied to late payments**.

ACKNOWLEDGMENT

I have read and understand the Perry County Generations Child Care Payment Policy.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Perry County Generations, Inc.
Tuition Agreement Payment Schedule

Automated payments will be processed on Thursdays for them to be settled by Fridays.

I, _____, agree to pay the following tuition for my child enrolled at Perry County Generations, Inc.

Child's Name: _____
Weekly Tuition Amount: $_____ per week

I, _____, agree to pay the following tuition for my child enrolled at Perry County Generations, Inc.

Child's Name: _____
Weekly Tuition Amount: $_____ per week

I, _____, agree to pay the following tuition for my child enrolled at Perry County Generations, Inc.

Child's Name: _____
Weekly Tuition Amount: $_____ per week

Monthly Payments
For families enrolled in a **monthly payment plan**, tuition is due on the **first Friday of each month**.

Total Tuition Amount Due: $_____

Agreement Acknowledgment

I have read, understand, and agree to the terms outlined in this Tuition Agreement.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Staff Representative Signature: _____ **Date:** _____

Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

○ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/ monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

○ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

_____

Parent or guardian's signature

_____

Date

Child's Name:_____

Child's date of birth:_____

If child was born 3 or more weeks prematurely, # of weeks premature:_____

Child's primary physician:_____

Consent Form

The first 5 years of life are very important. Social-emotional development within the first few years of life prepares your child to be confident, trusting, curious, and able to develop positive relationships with others. Your child's positive social-emotional development forms a foundation for learning throughout life.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

○ I have read the information provided about the Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ:SE-2™), and I wish to have my child participate in the screening/monitoring program. I will fill out questionnaires about my child's social-emotional development and will promptly return the completed questionnaires.

○ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ:SE-2™), and understand the purpose of this program.

_____

Parent or guardian's signature

_____

Date

Child's Name:_____

Child's date of birth:_____

If child was born 3 or more weeks prematurely, # of weeks premature:_____

Child's primary physician:_____

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education

PLACE PICTURE HERE

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

☐ **Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s) _____.**

Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.

For **ANY** of the following **SEVERE** SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE BODY SYSTEM**, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM A **SINGLE BODY SYSTEM** (E.G. SKIN, GI, ETC.), FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE DATE

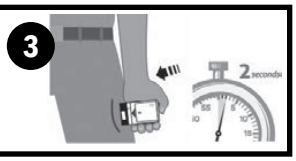
Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

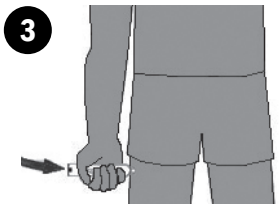
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q® from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q® against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



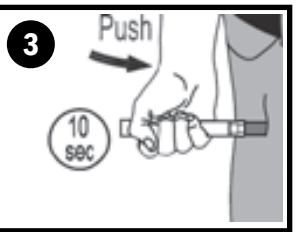
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



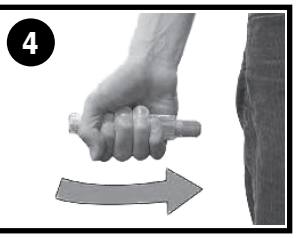
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Epinephrine first, then **call 911**. Monitor the patient and call their emergency contacts right away.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

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.

INFANT FEEDING PLAN

Child's full name_____ Date_____

Date of birth_____

Does child take bottle? Yes [ ] No [ ]
Is the bottle warmed? Yes [ ] No [ ]
Does the child hold own bottle? Yes [ ] No [ ]
Can the child feed self? Yes [ ] No [ ]

Does the child eat: (Check all that apply)
Strained foods [ ] Whole milk [ ]
Baby foods [ ] Table foods [ ]
Formula [ ] Other [ ]
Breast Milk [ ]

What type of formula used? _____

Amount of formula/breast milk to be given? _____

Updated amounts of formula/breast milk: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____
Amount: _____ Date: _____

Does the child take a pacifier? Yes [ ] No [ ] If yes, when? _____

_____

Food likes _____

Dislikes _____

Allergies? (Include any premixed formula) _____

FORMULA/ BREAST MILK			FOOD		
TIME	AMOUNT	TYPE	TIME	AMOUNT	TYPE

Instructions for the introduction of solid foods _____

_____

Any updated instructions regarding adding new foods or other dietary changes, please list as needed. _____

_____

_____

PARENTS' SIGNATURE: _____ **Date:** _____

INFANT/TODDLER (BIRTH TO 36 MONTHS) DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name _____ Date of Birth _____

Facility _____ Room _____

DAILY ROUTINES

SLEEPING

Please describe your child's usual bedtime routine (including what *time* and *where* he/she usually sleeps). _____

_____

How do you know that your child is sleepy/tired? _____

Does your child have any difficulties falling asleep? _____ If yes, what is helpful? _____

_____

About how many hours of uninterrupted sleep does your child get each night? _____

How many times per day does your child nap? _____ How many hours on average? _____

Does your child sleep with a special blanket, toy, pacifier, song? _____

Do you have any concerns about your child's sleep habits? _____ If yes, please explain: _____

EATING

Does your child generally enjoy eating? _____ Do *you* consider your child a good eater? _____

What are some of your child's favorite foods (temperatures, textures, etc.)? _____

_____

Is your child on any special diet? _____

If your child has any food allergies, please list here: _____

ⓘ If child has food allergies, ensure a **Feeding and Nutrition Care Plan** is established and on file.

Are there any other foods you do not want us to offer your child? _____

Are there foods from your home/culture that you would like us to offer? _____

Do you breastfeed your child? ❑ Yes ❑ No If yes, how often? _____

What does your child eat with? ❑ hands ❑ spoon ❑ fork Does your child eat independently? ❑ Yes ❑ No

What does your child use to drink? ❑ bottle (type of nipple: _____) ❑ tippy cup ❑ regular cup

Do you have any concerns or questions about your child's eating habits? _____ If yes, please explain: _____

_____

TOILETING

Does your child wear diapers? _____ If yes, what kind? ❑ disposable ❑ cloth ❑ Pull-ups For naps? _____

If no, does your child use the toilet regularly? _____ Please explain: _____

Families use a variety of words to describe bathroom activities. Indicate the words your family uses for:

urine _____ bowel movement _____ genital area _____

Do you have any questions or concerns about your child's toileting habits? _____ If yes, please explain: _____

_____

PLAY

Does your child have a favorite toy/object or song? _____

Does your child enjoy playing with others? _____ Does you child enjoy playing alone? _____

What activities and/or toys does your child enjoy? _____

HEALTH

Does your child have any health problems? _____ If yes, please explain: _____

_____

Is your child taking any medication(s) regularly? _____ If yes, please list: _____

_____

ⓘ If medications are to be given while in care, ensure a **Medication Administration Form** is utilized and on file for your child.

Does your child have a chronic health condition or specific health needs? (please be specific) _____

_____

ⓘ If yes, ensure a **Special Health Care Plan** is established and on file for your child.

Does your child have frequent ear infections? _____ diarrhea? _____

Do you have any concerns about your child's health? _____ If yes, please explain: _____

_____

Children in group care may become ill with colds, viruses, etc. several times per year. At times, we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please see our *Exclusion* policy.

GENERAL DEVELOPMENT

Do you have any concerns about your child's:

- hearing and/or vision? _____
- speech and language development? _____
- ability to move? _____
- overall development? _____

What languages are spoken at home? _____

What is your family's cultural identification (values, traditions)? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever been in group care? ❑ Yes ❑ No If yes, how many different settings? _____

How does your child respond in group situations? _____

What can we do to help your child adjust to child care? _____

How would you describe your child's temperament? _____

How does your child communicate his/her needs? _____

How do you comfort your child? _____

Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? _____

Does your child fear certain things? _____

How is your child disciplined? _____

What works best when you discipline your child? _____

Do you have any concerns about your child's social-emotional development or behavior? _____ If yes, please explain:

_____

What educational/developmental experiences would you like us to emphasize with your child (for example, language development, social relationships, kindergarten readiness skills, physical or self-help skills, etc.)? _____

Parent's Signature: _____ **Date:** _____

PRESCHOOL (3-5 YEARS OLD) DEVELOPMENT & ROUTINE

We want to provide your child with the best care possible. Please help us to get to know your child by filling out this questionnaire. Thank you!

Child's Name _____ Date of Birth _____

Facility _____ Room _____

DAILY ROUTINES

SLEEPING

- Please describe your child's usual bedtime routine (including what *time* and *where* he/she usually sleeps). _____

_____

- How do you know that your child is sleepy/tired? _____
- Does your child have any difficulties falling asleep? _____ If yes, what is helpful? _____

_____

- About how many hours of uninterrupted sleep does your child get each night? _____
- Does your child nap? _____ How many hours on average? _____
- Does your child sleep with a special blanket, toy, pacifier, song? _____
- Do you have any concerns about your child's sleep habits? _____ If yes, please explain: _____

EATING

- Does your child generally enjoy eating? _____ Do you consider your child a good eater? _____
- What are some of your child's favorite foods (temperatures, textures, etc.)? _____
- Is your child on any special diet? _____
- If your child has any food allergies, please list here: _____

  ⓘ If child has food allergies, ensure a **Feeding and Nutrition Care Plan** is established and on file.
- Are there any other foods you do <u>not</u> want us to offer your child? _____
- Are there foods from your home/culture that you would like us to offer? _____
- What does your child eat with? ❑ hands ❑ spoon ❑ fork
- What does your child use to drink? ❑ bottle ❑ tippy cup ❑ regular cup
- Do you have any concerns or questions about your child's eating habits? _____ If yes, please explain: _____

_____

TOILETING

- What does your child usually wear during the day? ❑ underwear ❑ diaper ❑ Pull-ups For naps? _____
- Families use a variety of words to describe bathroom activities. Indicate the words your family uses for:

  urine _____ bowel movement _____ genital area _____
- Do you have any questions or concerns about your child's toileting habits? _____ If yes, please explain: _____

_____

PLAY

- What is your child's favorite toy/object or song? _____
- Does your child enjoy playing with others? _____ Does your child do well playing alone? _____
- What activities and toys does your child enjoy? _____

HEALTH

- Does your child have any health problems? _____ If yes, please explain: _____

_____

- Is your child taking any medication(s) regularly? _____ If yes, please list: _____

_____

ⓘ If medications are to be given while in care, ensure a **Medication Administration Form** is utilized and on file for your child.

- Does your child have a chronic health condition or specific health needs? (please be specific) _____

_____

ⓘ If yes, ensure a **Special Health Care Plan** is established and on file for your child.

- Does your child have frequent ear infections? _____ diarrhea? _____
- Do you have any concerns about your child's health? _____ If yes, please explain: _____

_____

Children in group care may become ill with colds, viruses, etc. several times per year. At times, we are required to ask parents to keep their children out of child care until treatment begins or there are no symptoms. Please see our *Exclusion* policy.

GENERAL DEVELOPMENT

- Do you have any concerns about your child's:
  - hearing and/or vision? _____
  - speech and language development? _____
  - ability to move? _____
  - overall development? _____
- What languages are spoken at home? _____
- What is your family's cultural identification (values, traditions)? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

- Has your child ever been in group child care? ❑ Yes ❑ No If yes, how many different settings? _____
- How does your child respond in group situations? _____
- What can we do to help your child adjust to child care? _____
- How would you describe your child's temperament and personality? _____
- How do you comfort your child? _____
- Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? _____
- Does your child fear certain things? _____
- How is your child disciplined? _____
- What works best when you discipline your child? _____
- Do you have any questions or concerns about your child's social/emotional development or behavior? _____ If yes, please explain:

_____

- What educational/developmental experiences would you like us to emphasize with your child (for example, language development, social relationships, kindergarten readiness skills, physical or self-help skills, etc.)? _____

_____

Parent's Signature: _____ **Date:** _____

PREPARING YOUR CHILD TO STAY HOME ALONE

A parent guide for the transition from child care to greater independence

A child aging out of child care is reaching an exciting milestone—but staying home alone is a major responsibility. Readiness depends on maturity, judgment, confidence, the length of time alone, and the child's ability to respond safely when something unexpected happens.

IS YOUR CHILD READY?

- ☐ Feels comfortable—not pressured—about being alone
- ☐ Follows household rules without constant reminders
- ☐ Knows their full name, address, and parent phone numbers
- ☐ Can call 911 and explain what is happening
- ☐ Can stay calm and make a safe choice
- ☐ Can contact a trusted adult if worried or unsafe
- ☐ Understands fire, weather, and power-outage plans
- ☐ Can prepare an approved snack safely
- ☐ Will not tell anyone they are home alone
- ☐ Understands rules for phones, internet, appliances, and leaving the house

START SLOWLY AND PRACTICE

1
Begin nearby
Try 10–15 minutes while you are outside or close to home.

2
Practice in daylight
Use familiar routines before trying evenings or longer periods.

3
Check in
Agree on calls or texts and what to do if a parent is delayed.

4
Review together
Talk about what went well and what needs more practice.

CLEAR HOME-ALONE RULES

DOORS & VISITORS

- Keep doors and windows locked; do not open the door or invite friends inside.
- Never say you are home alone. Say: "My parent is unavailable. May I take a message?"

PHONE & INTERNET

- Communicate only with approved people.
- Never share your location, passwords, address, or home-alone status; report suspicious contact.

FOOD & APPLIANCES

- Use only appliances approved by a parent.
- Avoid the stove, oven, flames, and sharp knives unless specifically permitted.

MEDICINE & HAZARDS

- Take medicine only with clear parent instructions.
- Parents should secure medications, weapons, alcohol, vaping products, and hazardous materials.

Pennsylvania note: Pennsylvania does not set one specific minimum age for staying home alone. Parents are responsible for supervision appropriate to the child and circumstances. Consider maturity, duration, time of day, neighborhood safety, access to help, and younger siblings. Contact your county Children & Youth agency or local law enforcement for local guidance.

HOME-ALONE SAFETY PLAN

PCG CHILDCARE

Complete together • Review regularly • Detach and post near the phone or family command center

CALL 911	LEAVE SAFELY	CONTACT AN ADULT
Fire or smoke • serious injury • trouble breathing • someone trying to enter • immediate danger	Get outside for fire or smoke • never hide • do not return for belongings or pets • go to the family meeting place	Feeling sick or afraid • power outage • severe weather • broken rule or accident • parent is late

EMERGENCY INFORMATION

Child's full name: _____

Home address: _____

Child's phone number: _____

Parent/Guardian 1 + phone: _____

Parent/Guardian 2 + phone: _____

Trusted adult nearby + phone: _____

Second trusted adult + phone: _____

Family doctor + phone: _____

Family meeting place: _____

Alarm/security instructions: _____

OUR FAMILY RULES

Maximum time home alone _____	**Required check-in times** _____
Approved foods and appliances _____	**People my child may contact** _____
Internet/electronics rules _____	**What to do if a parent is delayed** _____

PRACTICE BEFORE THE FIRST DAY

- ☐ Someone knocks at the door.
- ☐ The smoke alarm sounds.
- ☐ A caller asks where your parent is.
- ☐ The power goes out.
- ☐ A severe-weather alert is issued.
- ☐ A friend asks to come inside.
- ☐ You feel sick, frightened, or unsure.
- ☐ A parent is late returning home.

✂ ---------- FAMILY AGREEMENT ---------- ✂

Child signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Playground Parent Engagement App

Dear Families,

We are thrilled to introduce our parent engagement and childcare management mobile application! Staying connected to your child's daily growth, learning, and milestones is essential. This mobile platform is designed to provide you with a seamless, secure, and real-time window into your child's day.

Whether you want to check in on daily activities, view photos, send a quick message to your child's teacher, or manage your tuition payments, everything you need is now available right at your fingertips.

Key Features of the App:

- Real-time activity feed
- Photos & Video sharing
- Direct Messaging
- Contactless Sign-In/Out
- Billing and Payments

Step-by-Step Setup Guide
Getting started takes less than 5 minutes. Please complete the following steps to activate your account:

1. **Check Your Email for an Invitation Link**
   You will receive an automated email invitation containing a unique registration link to create an account. If you do not see the email in your main inbox, please check your spam or junk folder.
2. **Download the Mobile Application**
   Visit the Apple App Store (iOS) or Google Play Store (Android) on your mobile device and search for the Playground app. Download and launch the app.

3. **Create & Verify Your Profile**
   Follow the on-screen prompts to register using the email address currently on file with our center. Set up a secure password.
4. **Review & Update Important Details**
   Once logged in, please review your child's profile details:
   - **Guardian/ Authorized Pickups:** Add photo identification and contact numbers for individuals authorized to pick up your child and more.
   - **Paperwork Information:** Verify all enrollment information is filled out and up to date.
   - **Payment Information:** Enter your preferred payment method (ACH transfer or Credit/Debit card) to ensure timely billing. Cash and Check are not accepted.

Thank you for your ongoing partnership and dedication to creating a strong, supportive learning community for our children. We look forward to sharing wonderful classroom moments with you!

Warm regards,

Perry County Generations Admin Staff

Perry County Generations

Parent Manual & Policies Acknowledgment Form

Parent/Guardian(s) Name: _____

Child Name: _____

Start Date: _____

I acknowledge that I have received access to and reviewed the **Perry County Generations Parent Manual**, including all policies, procedures, and guidelines contained within it. I understand that these policies apply to all families and are a condition of my enrollment.

I understand and acknowledge that the manual includes, but is not limited to, the following policies:

☐ Payment & Non-Discrimination Policies
☐ Food, Electronic, and Religion Policies
☐ Behavior, Zero-tolerance, Camera, and Late Pick-Up Policies
☐ Health & Wellness, Medication, Outdoor Polices

☐ Grievance, Arrival & Scheduling, Health, Safety, and Emergency Procedures
☐ Extended Leave, Fraternizing, Child Care Rules Policies
☐ Custody, Credit Day, Extended Leave and Confidentiality Policies
☐ Curriculum, Assessments, and Observations Documents

I understand that:

- I am responsible for **knowing and following all policies** outlined in the manual.
- Policies may be **revised, updated, or added** at the discretion of Perry County Generations.
- Continued enrollment indicates my agreement to comply with all current and future policies.
- Failure to comply with manual policies may result in **disciplinary action**, up to and including disenrollment.
- If I have questions or require clarification regarding any policy, it is my responsibility to seek guidance from Administrative Staff.

I further understand that the Parent Manual is **not a contract of enrollment** and does not guarantee enrollment for any specific length of time.

By signing below, I confirm that I have read, understand, and agree to comply with all Perry County Generations policies and procedures.

Parent/Guardian(s) Signature: _____

Date: _____

Administrative Representative Name: _____

Signature: _____

Date: _____

Optional Child File Checklist (Office Use Only)

☐ Manual Provided
☐ Policies Reviewed with Parent/Guardian(s)
☐ Signed Acknowledgment on File
