Queen Lane Montessori School

Where A Lifetime of Learning Begins!

Mary M. Calzadilla, M.Ed, Director
433 West Queen Lane
Philadelphia, PA 19144

215/843-0780

FAX: 215-843-5231

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270 124(a)(b), 3270 181 & 182, 3280 124 (a)(b), 3280 181 & 182 3290 124 (a)(b), 3290 181 & 182

CHILD'S NAME | BIRTHDATE

ADDRESS

EMAIL

MOTHER'S NAME/LEGAL GUARDIAN | HOME TELEPHONE NUMBER

ADDRESS

CELL #

BUSINESS NAME | BUSINESS TELEPHONE NUMBER

ADDRESS

CELL #

FATHER'S NAME/LEGAL GUARDIAN | HOME TELEPHONE NUMBER

ADDRESS

BUSINESS NAME | BUSINESS TELEPHONE NUMBER

ADDRESS

EMERGENCY CONTACT PERSON(S) | ADDRESS | TELEPHONE NUMBER

PERSON(S) TO WHOM CHILD MAY BE RELEASED | ADDRESS | TELEPHONE NUMBER

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER | TELEPHONE NUMBER

ADDRESS

SPECIAL DISABILITIES (IF ANY) | ALLERGIES (INCLUDING MEDICATION REACTION)

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)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES · HAND SANITIZER
WALKS AND TRIPS	PHOTOGRAPHS
TRANSPORTATION BY THE FACILITY	WADING/SPRINKLERS

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

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AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

Montessori instruction, transportation and meals.

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $ $5.00	PER (MIN-HR) K	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

☐ agree to pay all fees.

SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

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

CHILD HEALTH REPORT

QLMS fax 215-843-5231

(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: Queen Lane Montessori School		
FACILITY PHONE: 215-843-0780	COUNTY: PA	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.

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APPLICATION

@ EMAIL	DATE OF APPLICATION
NAME OF CHILD	BIRTHDATE
ADDRESS Cell #	
MOTHER'S NAME - OR LEGAL GUARDIAN	FATHER'S NAME - OR LEGAL GUARDIAN
MOTHER'S HOME ADDRESS	TELEPHONE NO.-HOME
FATHER'S HOME ADDRESS	TELEPHONE NO.-HOME
MOTHER'S BUSINESS ADDRESS	TELEPHONE NO.-BUSINESS
FATHER'S BUSINESS ADDRESS	TELEPHONE NO.-BUSINESS
NAME AND ADDRESS OF PERSON TO BE CONTACTED IN EMERGENCY IF PARENTS ARE NOT AVAILABLE	TELEPHONE NO.
NAME AND ADDRESS OF CHILD'S PHYSICIAN OR SOURCE OF MEDICAL CARE	TELEPHONE NO.

SPECIAL DISABILITY - IF ANY

ANY SPECIAL MEDICAL OR DIETARY INFORMATION NECESSARY FOR MANAGEMENT IN AN EMERGENCY SITUATION - ALLERGIES, MEDICATIONS, SPECIAL CONDITIONS

ANY ADDITIONAL INFORMATION ON SPECIAL NEEDS OF THE CHILD

HEALTH INSURANCE COVERAGE FOR CHILD UNDER FAMILY INSURANCE POLICY OR MEDICAL ASSISTANCE BENEFITS, IF APPLICABLE

SIGNATURE OF PARENT OR GUARDIAN:

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SUBJECT: Nondiscrimination In Services

TO: Parents

FROM: Mary M. Calzadilla, Director



Mary Calzadilla M. Ed. 9-27-21

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

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:

Queen Lane Montessori School
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Philadelphia, PA 19144
215/843-0780

Department 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 Office
801 Market Street, Suite 5034
Philadelphia, PA 19107



_____

Parent/Guardian Signature and Date

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"Getting to Know You"

Child's Name _____ Nickname: _____

Date of Birth: _____ Age: _____

Health History

Current Health _____

Previous illnesses/injuries: _____

Hospitalizations/surgeries: _____

Illnesses your child has had (chicken pox, measles, etc.):

Does your child... wear glasses? _____ wear a hearing aid? _____

use other physical assistance devices? (please specify) _____

Medications your child takes on a regular basis: _____

Chronic illnesses/disabilities:

Allergies (include statement of type of reaction and necessary treatment):

Food: _____ Epipen Required: ☐ Yes ☐ No

Medications:
(Please list meds your child is allergic to here) _____

Environmental:

Social Development

Describe your child's temperament: _____

Does your child have special fears? _____

How does your child respond to a stressful situation? _____

What seems to help your child feel better? _____

What method of discipline do you use at home? _____

Has your child been in previous child care? _____

"Getting to Know You"

Family Data

Who lives with your child?

Mother/Guardian: _____

Father/Guardian: _____

Child's Grandparents (name child calls them or if they are deceased):

_____

Other members of the household:

Brothers/Sisters (names & ages):

INFANTS

Nap Schedule: _____ Morning? _____ Afternoon? _____

Is your child breast fed? _____ and/or type of formula? _____

What is your child's feeding schedule?

PRESCHOOLERS

Is your child toilet trained? _____

How does your child communicate that he/she needs to use the toilet? _____

How would you describe your child's appetite? _____

Is there anything else we should know about your child's eating habits?

SCHOOL AGE

What school does your child attend? _____ Grade: _____

Favorite school subject(s)? _____

Homework Habits/Study Style: _____

Hobbies / Sports / Special Interests? _____

Anything we should know about your child's eating habits? If so, please explain:

What are some favorite "quiet time"/relaxing activities that your child enjoys?

ALL CHILDREN

Please add anything else about your child that would help us in providing care:

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IEP/ISFP PARENT SIGN-OFF SHEET

Your child's growth and development is measured with developmental 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. Because of the importance of the IEP/ IFSP to a child's learning, our program should have a copy before your child begins to attend, if possible.

Please remember, the information you share with us on an IEP/ IFSP is protected by privacy laws including the Health Insurance Portability and Accountability Act (HIPAA). Without your permission, we do not have access to this information

Child's Name: _____

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

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

☐ This is not applicable to my child.

Parent Signature: _____

Parent Printed Name: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

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MEDIA PERMISSION FORM

Child's Name _____

Children love to see photos of themselves and their friends. We sometimes use photos to record our projects, as parts of games, and as labels around the classroom. We also send many photographs home with parents when we are done with them. Please indicate if you give permission for your child's photo to be taken for classroom use.

_____ **NO**, I do not give permission for my child to be photographed.

_____ **YES**, I do give permission for my child to be photographed.

We are on Facebook and have a website. Our Facebook/website will be used to share news, reminders and information about your child's program. Please let QLMS know if you give permission to include your child's photo on these sites.

_____ **NO**, I do not give permission for photos of my child to be posted on Facebook/website.

_____ **YES**, I do give permission for photos of my child to be posted on Facebook/website.

Parent Signature _____ Date _____

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Transportation Agreement

_____ will participate in the transportation services provided at QLMS.
(child's name)

The policies and procedures listed below must be complied with in full to take advantage of these benefits.

- Seat belts must be worn at all times. After 3 violations, services will be probationary and further non-compliance will result in discontinuation.
- Children must be ready for pick up within 5 minutes of scheduled arrival. QLMS cannot wait and will not be able to return at a later time. This will ensure that all subsequent trips will not be impacted.
- Any deviations from current schedule, time or location, must be requested 24 hours in advance and approved by Rafael Calzadilla. There can be no exceptions unless it is a true emergency.
- All communication – phone, text or email will be answered during normal business hours, 6AM-8PM Monday to Friday. (i.e., if you need to request a change for Monday morning, this request must be approved by 8PM Friday.)
- Any location change must be listed on the current Emergency Contact as a person to whom child can be released.
- All fees must remain current and paid up-to-date for uninterrupted transportation services.

_____
(parent's signature) (date)

COVID 19 POLICY

Given the COVID-19 (Coronavirus) crisis that is spreading through our country, this new policy is to assure you that QLMS is monitoring the situation closely. Based on information we have at this time, we will re-open Queen Lane Montessori School when the Governor says it is safe to provide child care. If the situation should change, we will notify you immediately. Effective June 8, 2020 and for the foreseeable future, we will be taking extra precautions to ward off Coronavirus. These extra steps are to support the health and safety of your children, your family and our staff.

Please take note of the following changes to our policies and procedures:

Check-In and Pick-Up

All adults and staff will be required to wear a mask until further notice.

- Families will be greeted at the [DOOR/CURB] where a staff member will greet the child(ren).
- Parents and other family members will not be allowed inside the child care program. No items from home will be permitted with the exception of coats, etc. Prior to parents leaving the site, a trained staff member will take the temperature of their child(ren) and ask parents the following questions:

    - Do you live with anyone or have you had close contact with anyone who has been diagnosed with COVID-19 within the past 14 days?
    - Do you or anyone in your household have a fever, cough and/or shortness of breath?
    - Do you or your child(ren) have any other signs of communicable illness such as a cold or flu?

    If your child has a temperature **>100.4** they will not be permitted to attend child care that day.

- Children and staff will be required to wash their hands immediately upon entering the building and hourly throughout the day.
- When children are received for drop-off, they will be escorted into the nearest bathroom where their hands will be washed prior to being brought to their classroom/child care area.
- Upon your arrival to pick up your child, a staff member will bring your child out to you. Doing so will limit direct contact and help us to maintain social distancing.

Healthy Environment

- We will separate children into smaller sustainable groups that fall within state or local guidelines (max 10). ***Children are not required to wear mask*** but are encouraged to participate if feasible.
- We will not share equipment and will clean equipment between uses.
- All classrooms will remain separated to reduce the number of children in one area and to reduce the possibility of viral transmission.
- Staff will disinfect high-touch surfaces, such as door handles, light switches, faucets, toys and games that children play with at least once daily.
- We will perform an enhanced deep cleaning every night in all areas, on all touched surfaces.
- Staff will have access to anti-bacterial hand sanitizers and disposable gloves and use them as needed.
- Staff will wash/scrub their hands and children's hands a minimum of hourly (noted by the CDC as the most effective preventive measure).
- No program tours will be given until further notice to reduce the number of visitors in the building.

Meal Preparation & Service

- All surfaces will be disinfected before meal preparation and feedings using CDC or EPA approved products.
- All staff will wash hands before and after meal preparation and feeding.
- Each child's meal will be plated and served by staff, instead of served family-style.

Child Health

- Staff will receive education on COVID-19 symptoms as well as preventive measures.
- Children who start to experience symptoms of respiratory illness, including a fever of >100.4 while at child care, will be isolated from other children until they can be picked up no later than 30 minutes from notification that child is ill.
- Until further notice, all program field trips will be suspended.

Staff Health & Wellness

All staff will be required to wear a mask.

- Staff will receive additional training on infection control and workplace disinfection.
- Staff will not share their phone, devices or meal or utensils with one another or children.
- Staff will check their temperature at the beginning of each shift and notify their supervisor if >100.4 as well as self-monitor for signs and symptoms of COVID-19 and notify their supervisor if any develop (fever or respiratory symptoms).
- Staff will wash their hands immediately upon entering the program and immediately prior to leaving.
- Staff will not be allowed to work if they are feeling ill or experiencing respiratory symptoms.

Tuition

- No unpaid vacation weeks will be allowed to be used by families during this time period.
- As long as we are open and your child is in attendance, tuition will be due in full. This includes If we are only open for a portion of a week and need to close for the remainder of the week.
- If you are able to work from home and choose to keep your children at home, you will be required to pay [PART/ALL] of your normal weekly tuition to retain your spot.
- If you are laid off or are part of a reduction in staffing and choose to keep your child at home, you will be required to pay [PART/ALL] of your normal weekly tuition. We [WILL/WILL NOT] require proof of reduction from your employer.
- If you choose to pull your child out and not pay, there is no guaranteed spot upon a request to return.

Communication

- If the current situation changes and it becomes necessary to update our procedures or close QLMS temporarily, we will notify key family contact by email.

You may follow our social media page https://www.facebook.com/queenlanemontessori/ for late-breaking program updates.

Thank you for your understanding and patience as we implement these new procedures. Our goal is to minimize disruption while at the same time keeping you, your family and our staff healthy and well.

_____ _____

Parent Signature Date

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Parent/Guardian Agreement

To protect our children and staff, I agree to keep my child at home if he/she has:

- Fever (a temperature of 100.4 or more)
- Cough
- Sore throat
- Chills
- Muscle pain
- Headache
- New loss of taste or smell

If my child has any of these signs of COVID-19, I will not send him/her back to school until:

- My child tested negative for COVID and is otherwise well enough to go back to school
  OR
- A healthcare provider has seen my child and documented a reason for the symptoms other than COVID
  OR
- All are true: 1) at least 10 days since the start of symptoms AND 2) fever free off anti-fever medicines for 3 days AND 3) symptoms are getting better.

If my child is diagnosed with COVID-19, I will not send him/her back to school until the following:

- It has been at least 10 days since my child first had symptoms **AND**
- My child has had no fever off anti-fever medicines (ex: Tylenol, Ibuprofen) for 3 days **AND**
- My child's symptoms are getting better

If someone in my household is diagnosed with COVID-19 or my child is exposed to COVID-19, I will keep him/her home for 14 days.

If someone in my household develops new cough, shortness of breath or two of the following: sore throat, chills, muscle pain, headache, new loss of taste or smell, I will get that person tested for COVID-19. If that person tests positive, I will keep my child home for 14 days.

Child's name: _____

Parent/guardian name: _____

Parent/guardian signature: _____

Date: _____

Queen Lane Montessori School

Health Risk Disclosure Form

Child: _____ Start Date: _____

Parent: _____ Director: _____

I, _____, understand that whenever a child/ren participates in care at **Queen Lane Montessori School** there is a possibility of exposure to diseases including but not limited to cytomegalovirus, fifth disease, rubella, flu and other viruses. I understand that if higher risk factors exist it is my responsibility to inform **QLMS** as soon as possible.

My signature below indicates that I understand the inherent risk of exposure in a childcare setting. My signature further acknowledges I will hold **Queen Lane Montessori School**, and all of its agents harmless and assume sole responsibility to manage these risks with my personal primary care provider.

_____	_____	_____
Print Parent's Full Legal Name	Parent's Full Legal Signature	Date
_____	_____	_____
Print Director's Full Legal Name	Director's Full Legal Signature	Date

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I _____, hereby acknowledge that _____
(parent name) (parent name)
am aware of the conditions stated in the QLMS Parent/Policy Handbook, and agree to abide by the above policies and requirements in conjunction with the Agreement for childcare services.

Parent Name_____ Parent Signature_____Date_____

Parent Name_____ Parent Signature_____Date_____

Provider Signature_____Date_____