



Bethany Academy

6537b Rising Sun Avenue Philadelphia, Pa. 19111 | Phone: (215) 742-1300 | Fax: (267) 731-6093

Email: gndcbethanyacademy@gmail.com

Director: _____

Checklist for Required Documents

- ☐ Emergency Contact/Consent Form
- ☐ Copy of State Issued ID of Parent/Guardian
- ☐ Health Assessment/Physical
- ☐ Immunization Records
- ☐ Copy of Medical Card
- ☐ Copy of Birth Certificate
- ☐ Request for Medication Administration
- ☐ Child Pick-Up Authorization
- ☐ Tuition Agreement & Website Picture Form (Signed and Dated)
- ☐ Payment Receipt# _____ Date _____
- ☐ Parent Handbook (Signed and Dated)
- ☐ "Getting to know You"
- ☐ C.B.S. Child Enrollment Form (CACFP)

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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 (As it APPEARS on Child's state / government issued "Birth Certificate")		DATE OF BIRTH	
ADDRESS			
PARENT'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER ()	
ADDRESS		E-MAIL ADDRESS	
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS			
PARENT'S NAME/LEGAL GUARDIAN		HOME 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 REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION, SPECIAL SITUATION	
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	
WALKS AND TRIPS		SWIMMING / WADING	
TRANSPORTATION BY THE FACILITY		I allow Photos/ Videos used for classroom ONLY	

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

Child's Name (Last):		Child's Name (First):		Child's Date of Birth:		
Parent/Guardian Name:		Address:		Contact Phone #:		
PA child care providers must document that enrolled children have received age-appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007. The schedule is available at www.aap.org or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.						
Health history and medical information pertinent to routine care and emergencies (describe, if any): <input type="checkbox"/> NONE				DATE OF MOST RECENT WELL-CHILD/PHYSICAL EXAM:		
Allergies to food or medicine (describe, if any): <input type="checkbox"/> NONE				Do not omit any information. This form may be updated by health professional (initial and date new data).		
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? <input type="checkbox"/> YES <input type="checkbox"/> NO - IF NO, PLEASE EXPLAIN YOUR ANSWER:						
LENGTH/HEIGHT		WEIGHT		BLOOD PRESSURE		
_____ IN/CM %ILE _____		_____ LB/KG %ILE _____		(BEGINNING AT AGE 3) /		
PHYSICAL EXAMINATION		<input checked="" type="checkbox"/> = NORMAL		IF ABNORMAL - COMMENTS		
HEAD/EYES/EARS/NOSE/THROAT						
TEETH						
CARDIORESPIRATORY						
ABDOMEN/GI						
GENITALIA/BREASTS						
EXTREMITIES/JOINTS/BACK/CHEST						
SKIN/LYMPH NODES						
NEUROLOGIC & DEVELOPMENTAL						
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTap/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						
SCREENING TESTS		DATE OF TEST		NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL		
LEAD						
ANEMIA (HGB/HCT)						
URINALYSIS (UA) at age 5						
HEARING (subjective until age 4)						
VISION (subjective until age 3)						
PROFESSIONAL DENTAL EXAM						
HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (attach additional sheets if necessary) <input type="checkbox"/> NONE						
MEDICAL CARE PROVIDER: ADDRESS:				SIGNATURE OF PHYSICIAN OR CRNP:		
ZIP CODE:		PHONE:		LICENSE NUMBER:		
				DATE FORM SIGNED:		



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EMERGENCY CHILD RELEASE

I, _____ AUTHORIZE Bethany Academy to release my child(ren) to the person(s) designated. This is consonance with the Bethany Academy Emergency Plan.

Child's Name

Designated Custodian(s) (Name & Relationship)

Your Signature

Relationship

Date

Print Name

Street Address

City

State

Zip Code

(Home Phone)

(Work)

(Cell)

Please Print Clearly

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Child's Name: _____ Child's Date of Birth: _____
Admissions Date: _____ Withdraw Date: _____

(Circle One): Young Toddler Older Toddler Preschool
Before School – ONLY After School – ONLY Before & After School Summer Camp: June – August ONLY

1. Services to be provided as part of tuition include SEE PARENT HANDBOOK.
2. Extra services to be provided at an additional fee, if applicable are: N/A
3. Agree to update the Emergency Contact/ Parental Consent Form information whenever changes occur or every six (6) months at a minimum.
4. I agree to pay- a Registration Fee of \$25.00 at the time of enrollment. I understand this is a non-Refundable fee and not applicable toward tuition.
5. I understand that a deposit of _____ must accompany the approved enrollment application and will be applied to the child's first week's co-pay/tuition payment, if applicable.
6. I agree to pay by the preceding Friday, the sum of _____. I will automatically include a late fee of \$10.00 to the tuition payment when made after Monday at Noon. Should tuition remain unpaid, I will be asked to withdraw my child until the outstanding balance is paid in full. All legal and collection fees incurred in the collection of tuition are the responsibility of the parent/guardian.
7. If additional time or a change in schedule days is required during any given week. I understand that after prior approval is given, I may be required to pay an additional rate. If an occasion arises where fewer days are needed during the week, my usual week's tuition is still required.
8. I agree to pay a \$25.00 processing fee for any check that is returned by my bank for any reason, If more than two checks are returned, money orders or cash will be required.
9. I understand that in order for accurate emergency and bookkeeping records to be maintained, it is crucial that I sign my child in and out daily.
10. I understand that my will only be released to the following individuals:

1. I understand that if my child remains at the Center past the designated closing time, I will be charged and agree to pay an additional fee of \$1.00 for each additional minute after 6:00pm, or my part thereof, he/she remains.
2. I understand there will be no reduction in tuition. for holiday's, vacations (NO more than 1 week), illness, inclement weather, or any other absences from school. In the event my child contracts a contagious and/or infectious illness, I must notify the school and make alternative arrangements for my child's care until the danger to others has passed, I agree to notify the Center whenever my child is absent.
3. I understand the Center is opened all year, except for holidays declared by the Center Director.
4. I do ____ I do not ____ give permission for my child to be *photographed/ videotaped and the photos/tape to be displayed in the school.*
5. I/We ____ Grant I/We ____ DO NOT Grant permission for use of picture, voice, video, name, work and participation of this child/ student to be published on the center's website. **(Center images are used on the internet to promote student activities and celebrate your child's work and participation. Rest assured, the center will safeguard all content and will not share/release any information without prior consent from you the parent/ guardian.)**
6. I agree to give two weeks written notice before withdrawing my child from the school or changing my guaranteed days. My account must be current.
7. I consent to all terms of this Agreement and have received a signed and dated copy of this contract. I have read, understand, and accept the conditions of this tuition agreement as school policy and realize that these fees and conditions may be revised as necessary without prior notice. The school further reserves the right to dismiss the named student if it is determined that the school's program does not benefit the child or in the event of non-payment of fees.

Parent / Guardian (Signature & Date)

Periodic Review (Parent/ Guardian Signature & Date)

**BETHANY ACADEMY
PARENT/GUARDIAN HANDBOOK**

PARENT / GUARDIAN AGREEMENT FORM

READ CAREFULLY (Write your Initial on each statement)

1. _____ I/We agree to comply with the rules and regulations of the Bethany Academy.
2. _____ I/We will immediately notify the Bethany Academy if my child/children will be absent or lateness.
3. _____ I/We agree to give two weeks written notice to Bethany Academy if my child / children will be withdrawing from the program.
4. _____ I/We agree to pick up my child at the agreed upon dismissal time designated on the enrollment form. Failure-to do so will result in late fee charges and possible termination from the program.
5. _____ I/We understand that tuition payments can be paid in advance, on Thursday and no later than Friday by 5:00 p.m. for the following week of care. Tuition payments are due no later than Monday morning for the current week.
6. _____ I/We agree to cooperate with Bethany Academy staff to ensure that my child/children will have a rewarding learning experience.
7. _____ I/We understand that my/our failure to comply with any of the above statements could jeopardize my/our child's / children's enrollment at Bethany Academy
8. _____ I/We agree to sign up to Class Dojo, and check the app daily for upcoming events, and any information or news provided by Bethany Academy.

ORIGINAL: of the Parent/ Guardian Agreement Form and the Acknowledgement of Handbook is given to the PARENT / GUARDIAN. **COPY** is kept in the CHILD'S FILE.

ACKNOWLEDGMENT OF HANDBOOK

I acknowledge by my signature that I have received a copy of the Bethany Academy Parent / Guardian Handbook I also acknowledge that it is my responsibility to read this handbook to ask questions if I do not understand, to observe and follow the policies and procedures as outlined herein. I understand further that from time to time the contents herein may change and that I will be responsible for keeping abreast of the changes as they occur after I have been informed of the changes.

Child's Name: _____

Date: _____

Parent/ Guardian Signature

Parent/ Guardian Signature

To better serve our community, Bethany Academy will like to know the following information:

where did you hear about us: _____ (Google, Social Media, Etc.)

Referred By: _____ (Print Name)

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CIVIL RIGHTS COMPLIANCE
Parents / Guardians

In Accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as a resident of this agency, have the right:

To be provided services at this agency and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, including Limited English Proficiency, 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, disability, ancestry, national origin, age or sex.

Complaints of discrimination may be filed with any of the following:

Bethany Academy
Director
6537 Rising Sun Avenue
Philadelphia, PA 19111

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite #5034
Philadelphia, PA 19107

DHS – BEO
Room #223, Health & Welfare Building
P.O BOX #2675
Harrisburg, PA 17105

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

PA Human Relations Commission
Philadelphia Regional Office
110 North 8th Street
Suite #501
Philadelphia, PA 19107

Child's Name: _____

Parent / Guardia Signature

Date

Director Signature

Date

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"GETTING TO KNOW YOU"

Child's Name: _____

Enrollment Date: _____

1. Tell me about your household. (Neighborhood, who lives there, names, and relationship to child)?
2. Does your child have any parents that do not live in the home?
3. Does your child visit this parent?
4. Are there any custody issues that we should discuss?
5. Does your child have any siblings (names and ages)?
6. Does your child have any special needs and do any of these special needs require special care by our teachers?
7. Does your child have an IEP (Individualized Education Plan) or ISFP (Individualized Family Service Plan)?
(Note: If yes, we would like a copy of the plan, so we can provide the best possible learning experience for your child.)
8. What program or individuals work with your child in regards to these special needs? Would you sign a release of information form with them, so they can speak with us about how to provide enhanced support to your child?
9. Does your child have any allergies?
10. How are your child's allergies treated?
11. Do you have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.)?
12. Any other medical or special needs?