CORA Early Years SUMMER CAMP Checklist

Child's Name:_____ **Date of Birth:** _____

Date: _____ **Center:** _____ **Room #:** _____

Enrollment Documents:
(Required prior to first day of camp)

- ☐ Application (Signed by parent and reviewed by Staff)
- ☐ Birth Certificate/ Passport (Proof of Age)
- ☐ A State Issued ID for parent/guardian (valid)

Child Record Documents:

- ☐ Enrollee Information Form
- ☐ Parent Fee Agreement
- ☐ ealth Assessment/ Physical w/ Immunization Record* ***(less than a year old)***
- ☐ ealth insurance Card
- ☐ mergency Contact/ Parental Consent Form* ***(Email Address Required)***
- ☐ hotograph Consent Form
- ☐ Consent to Exchange Information
- ☐ Getting to Know You Form (Keystone Stars)
- ☐ amily Handbook Receipt
- ☐ Updated Policies and Procedures Receipt
- ☐ ndividualized Evaluation Plan (I.E.P.)* ***(Most Recent)***

Summer Camp Program Information

- CORA Early Years Summer Camp will run from **June 21st 2021 to August 20th 2021**
- Due to **decreased capacity,** in order to comply with appropriate safety guidelines, there are limited spots available. Enrollment priority will be given to *current Early Years families* and *families of essential workers* with children needing full time care. Additional families who have expressed interest will be kept on a waiting list and notified as slots become available.
- You cannot sign your child up for camp until any previous balances accrued from the school year are paid in full. No exceptions.
- The weekly camp tuition fee is **$175/wk for Preschoolers.** This tuition fee covers camp *T-shirt, and all in house activities, materials, meals and experiences.*
- The camp day/week is Monday to Friday 8:00 am-3:00pm.
- There is a ZERO TOLERANCE policy for early drop offs/late pick ups.
- In addition to the weekly tuition there is a one-time, deposit fee which will hold your child's spot, and will be applied to the final week of camp in the amount of **$50.00**. This camp registration fee is due at time of registration.
- A full, complete registration packet including your child's health assessment and immunization record, and all signed forms is due before their first day of camp.
- Without this paperwork, and the deposit they cannot start camp. If you have any questions, please call or email the Center Director.

Parent Name Parent Signature

Child Name Date

Camp Themes and Weekly Registration Form

Please check the boxes to indicate the weeks you are interested in having your child attend camp. Camp is 9 weeks beginning June 20, 2021. Each week of camp is $175 per child plus a one-time deposit of $50 that will be deducted from the last week (Aug 16) of camp.

☐	Week 1	June 21- June 25	All About Me
☐	Week 2	June 28-July 2	The Animal Kingdom
☐	Week 3	July 6- July 9	The Animal Kingdom
☐	Week 4	July 12-16	Fairy Tales, Fables and Folktales
☐	Week 5	July 19-23	Fairy Tales, Fables and Folktales
☐	Week 6	July 26- 30	Messy Mad Science
☐	Week 7	August 2-6	Messy Mad Science
☐	Week 8	August 9-13	The Beach
☐	Week 9	August 16-20	Luau Week

Childs Name_____ **Date**_____

Parents Name_____ **Parent Signature**_____

****

Administrative Use Only

Total Number of Weeks ___ Total Deposit Amount ____Weekly Amount _____

- ☐ Pay in Full Discount Applied
- ☐ ELRC
- ☐ Shanahan

AGREEMENT

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

NAME OF CHILO

FEE AMOUNT	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
$		

Services to be provided as part of the day care ee examp es; ranspor a 10n, care, mea s, etc.

CHILD'S ARRIVAL TIME	C LD'S DEPARTURE TIME	PERSONS ESIGNATED BY PARE T TO WHOM CHILD AV BE RELEASED
LATE FEE $	PER MIN-HR	

Extra services to **be provided at an additional ee** 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 co.osent form information whenever changes occur or every 6 months **at a** minumum. (9 3270.124, 3280.124, 3290.124)

SIGNATURE·OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN 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:

☐ 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						

Parents may write immunization dates; health professional should verify and complete all data.

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

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: ***(Required)***
MOTHER'S NAME/LEGAL GUARDIAN: ***(Required: Unless Court Order, Incarcerated or Deceased, please specify):***	Home Phone: ***(Required)***
ADDRESS:	
CITY, STATE, and 5- DIGIT ZIP CODE:	E-mail:
Business Name:	Cell Phone:
Address, City, State, and 5-Digit Zip Code:	Business Phone:
FATHER'S NAME/LEGAL GUARDIAN: ***(Required: Unless Court Order, Incarcerated or Deceased, please specify):***	Home Phone:
ADDRESS:	
CITY, STATE, and 5-DIGIT ZIP CODE:	E-mail:
Business Name:	Cell Phone:
Address, City, State, and 5-Digit Zip Code:	Business Phone:
EMERGENCY CONTACT PERSON (s) (list below) ***(Minimum of (3) Individuals Over 18 yrs. Old)***	**Telephone Number (when in care)**
1	
2	
3	
Person (s) Whom Child May Be Released and Address (list below)***(Min. (3) Over 18 yrs. Old)***	**Telephone Number (when in care)** ***(Required)***
1	
2	
3	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER: ***(Required)***	**Phone Number + Area Code:** ***(Required)***
ADDRESS, CITY, STATE, and 5-DIGIT ZIP CODE: ***(Required)***	
Special Disabilities: ***(Copy of IFSP or IEP Required, if applicable)***	**All Allergies (*Listed on Health Assessment)***
Medical or Dietary Information necessary in an emergency situation ***(Dietary Form Required)***	***Medications (List Medications Taken Daily)***
Additional Information on Special Needs of Child ***(Copy of IFSP or IEP Report Required, if applicable)***	
Health Insurance Coverage or Medical Assistance Benefits	**Policy Number** ***(Required)***

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

OBTAINING EMERGENCY MEDICAL CARE **X**	ADMIN. OF MINOR FIRST - AID PROCEDURES **X**
TRANSPORTATION BY THE FACILITY IN CASE OF EMERGENCY **X**	WALKS **X**
I allow child in ***Swimming Pool***/Sprinkler **X**	I allow Photos/video **X**

Signature of Parent or Guardian ***(at least one signature required)*** **X**	**Date**
Signature of Parent or Guardian **X**	**Date**

Permission Form for Use of Student Picture, Voice, Video and/or Full Name On CORA Services, and/or School District of Philadelphia Materials

This letter is to both inform you and request permission for your child's picture, voice, video and/or full name to be published on the CORA Early Years website/Facebook Pages.

Student images are used on the Internet to promote student activities and celebrate student work. However, there are potential dangers associated with posting personal identifiable information on a website because global access to the Internet means that CORA Early Years cannot control who may view the website.

Accordingly, CORA Early Years will not release any information without prior written consent from you as the parent or legal guardian. Please complete this form to indicate if your child's image, voice, video and/or full name may be used on the Internet. This permission will be applicable to any use of full name, picture, voice or video taken in the school year in which permission is given and will remain in effect until the full name, picture, video or voice is removed from the website or until consent is withdrawn. As parent or legal guardian, you may withdraw your consent at any time by sending a written letter along with a new form, to the Director of the Center. Thank you for your cooperation.

Check on of the following options:

☐ I/We **GRANT** permission for any photo/image, voice, video, work and/or full name of this student to be published on CORA Early Years and/or CORA's Internet site.

☐ I/We **DO NOT GRANT** permission for any photo/image, voice, video, work and/or full name of this student to be published on the school and/or CORA's Internet site.

In addition, I agree to release and hold harmless CORA Services, Board Members, staff members, the School District of Philadelphia, its School Reform Commission members and Board of Education, agents, officers, contractors, volunteers, and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's picture, voice, video and/or full name on the Internet.

Student's Name:_____ **Center Name: CORA Early Years**

Print Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____

Consent to Exchange Information with Partners

Center:_____

Child's Name:_____**Date of Birth:** _____

CORA Early Years programs partner throughout the year with The Department of Human Services, the School District of Philadelphia (SDP), the PA Office of Child Development and Early Learning (OCDEL,) Elwyn/ Early Intervention Services, and PA Child Care Works (ELRC). I understand that information contained in my child's registration/enrollment folder may be shared within these partnerships.

The following information may be shared:

- **Enrollment Application**
- **Proof of Birth/Age**
- **Observations and Assessments**
- **Referral Information/ Family Resources**
- **Family Size**
- **Attendance**
- **Immunization/ Health Assessment**
- **Emergency Contact/ Parental Consent**
- **Photos/Videos**

Parent Signature:_____**Date:** _____

Getting To Know You!

Enrollment Date: _____

MEETING REQUEST: Parents can request a meeting the center director within 45 days from your child's enrollment date	
Child's Name:	Birthdate:
Parent's Name:	Center Location: ☐ Huntingdon Mills or ☐ Fox Chase
□ I would like to request a Getting to Know You meeting with my child's center director at the center location. I understand that this meeting will take place 45 days from the date of my child's enrollment date. Choice #1: Date_____ Time_____ Choice #2: Date_____ Time_____ □ I decline the option of having a Getting to Know You meeting with the center director at my child's center location. I will completed the below sections and return this form to the center director within 45 days of my child's enrollment date.	
PARENT/GUARDIAN INFORMATION This section provides CEY with vital information on your expectations, desires and information you feel we need to know about your child.	
Name:	Home Number:
Mobile Number:	Work Number:
Email Address	
Tell us the best way to contact you: □ Home Number □ Mobile Number □ Work Number □ Email	
1. What are your expectations of the program?	
2. Is there a particular aspect of our education program especially important to your family?	
3. Is there information about your family's culture, ethnicity, language or religion that is important for us to know (celebrations, dietary restrictions)?	
4. Would you and/or your family like to be a resource for any cultural awareness activities? □ Yes □ No	
5. Are you interested in volunteer opportunities in our classrooms? □ Yes □ No	
CHILD INFORMATION The section provides CEY with information on your child's likes, dislikes and special needs. Complete this section to the best of your knowledge.	
Describe your child's likes and dislikes.	
List the activities your child enjoys (reading, tummy time, music, playing outdoors, etc.)	
List your child's favorite toys.	
Does your child respond to a nickname? □ Yes □ No If yes, what is it? _____	
Does your child have allergies? □ No □ Yes If yes please list: □ Food_____ □ Environmental_____ □ Medicine_____	

How is the allergy treated? _____
Is your child completely toilet trained? □ Yes □ No
Provide additional information you feel is important for us to know to provide the best possible care for your child.
CHILD WITH SPECIAL NEEDS INFORMATION The section provides CEY with information on your child's likes, dislikes and special needs. Complete this section to the best of your knowledge.
Does your child have special needs (medical, developmental, social, mental health, etc.)? □ Yes □ No If yes, please complete this section.
List your child's special needs.
Does your child have an Individual Education Plan (IEP) or an Individual Family Service (IEFS)? □ Yes □ No If yes, provide us with a copy of the plan so we can provide the best possible learning experience for your child.
List all programs and/or individuals who work with your child in regard to the above needs. Will you sign a release of information with the program/individual so we may communicate with them about how to provide enhanced support for your child? □ Yes □ No
Provide additional information you feel is important for CEY to know to provide the best possible care for your child.

CEY offers a Getting to Know You meeting to all new families within 45 days of enrollment. To request a meeting, return the attached meeting request form to your center director. If you decline the meeting, you will be required to completed the child information section below and return it to your center director within 45 days of enrollment.

By signing I acknowledge I have read, understand and agree to follow the Getting to Know You program.

Parent's/Guardian's Signature:_____ Center Director's Signature: _____

Date: _____

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Student's Name:_____ **Center Name: CORA Early Years**

Print Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____

Consent to Exchange Information with Partners

Center:_____

Child's Name:_____**Date of Birth:** _____

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- **Emergency Contact/ Parental Consent**
- **Photos/Videos**

Parent Signature:_____**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:

☐ 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

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☐ 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
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ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
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INFLUENZA						
MMR						
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HEP-A						
MENINGOCOCCAL						
OTHER						

Parents may write immunization dates; health professional should verify and complete all data.

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

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: ***(Required)***
MOTHER'S NAME/LEGAL GUARDIAN: ***(Required: Unless Court Order, Incarcerated or Deceased, please specify):***	Home Phone: ***(Required)***
ADDRESS:	
CITY, STATE, and 5- DIGIT ZIP CODE:	E-mail:
Business Name:	Cell Phone:
Address, City, State, and 5-Digit Zip Code:	Business Phone:
FATHER'S NAME/LEGAL GUARDIAN: ***(Required: Unless Court Order, Incarcerated or Deceased, please specify):***	Home Phone:
ADDRESS:	
CITY, STATE, and 5-DIGIT ZIP CODE:	E-mail:
Business Name:	Cell Phone:
Address, City, State, and 5-Digit Zip Code:	Business Phone:
EMERGENCY CONTACT PERSON (s) (list below) ***(Minimum of (3) Individuals Over 18 yrs. Old)***	**Telephone Number (when in care)**
1	
2	
3	
Person (s) Whom Child May Be Released and Address (list below)***(Min. (3) Over 18 yrs. Old)***	**Telephone Number (when in care)** ***(Required)***
1	
2	
3	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER: ***(Required)***	**Phone Number + Area Code:** ***(Required)***
ADDRESS, CITY, STATE, and 5-DIGIT ZIP CODE: ***(Required)***	
Special Disabilities: ***(Copy of IFSP or IEP Required, if applicable)***	**All Allergies (*Listed on Health Assessment)***
Medical or Dietary Information necessary in an emergency situation ***(Dietary Form Required)***	***Medications (List Medications Taken Daily)***
Additional Information on Special Needs of Child ***(Copy of IFSP or IEP Report Required, if applicable)***	
Health Insurance Coverage or Medical Assistance Benefits	**Policy Number** ***(Required)***

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

OBTAINING EMERGENCY MEDICAL CARE **X**	ADMIN. OF MINOR FIRST - AID PROCEDURES **X**
TRANSPORTATION BY THE FACILITY IN CASE OF EMERGENCY **X**	WALKS **X**
I allow child in ***Swimming Pool***/Sprinkler **X**	I allow Photos/video **X**

Signature of Parent or Guardian ***(at least one signature required)*** **X**	**Date**
Signature of Parent or Guardian **X**	**Date**