THE KID'S STOP
SUMMER 2021

$75 summer registration fee *plus* final week payment due at time of registration

Return completed forms along with
Non-refundable registration fee to
THE KID'S STOP
20 Media Line Road, Newtown Square, Pa 19073

REGISTRATION FORM
PLEASE PRINT CLEARLY

Name of Child	Sex	Birth Date
Complete Home Address		

Parent 1 / Guardian Name		Home Phone
Home Address		Cell Phone
Town / Zip	Email	
Employer		Work Phone
Employer Address		Occupation

Parent 2 / Guardian Name		Home Phone
Home Address		Cell Phone
Town / Zip	Email	
Employer		Work Phone
Employer Address		Occupation

Name child goes by	Current School	Grade child is in NOW

I am the legal, custodial parent/guardian of this child	Parent / Guardian Signature
PRINT NAME:	

A PARENT'S COMPLETE *SIGNATURE* IS REQUIRED FOR EACH ITEM BELOW	
EMERGENCY MEDICAL CARE	BASIC FIRST AID
SUPERVISED NEIGHBORHOOD WALKS	USE OF HAND SANITIZER
MAY WATCH G OR PG MOVIES	STAFF TO APPLY SUNSCREEN, IF NEEDED
SCHOOL BUS TRANSPORTATION	

General Attendance Information

Daily Arrival Time	Daily Departure Time

I am aware that there are risks inherent in all recreational outlets and agree not to hold the *Marple Newtown Joint Recreation Commission*, Marple *Newtown School District*, or any of their agents or staff liable for personal injuries or property damage sustained by my child / myself in connection with such participation.

Parent / Guardian Signature ______________________________ Date ______________

SUMMER EMERGENCY CONTACT and PARENTAL CONSENT FORM

CHILD'S NAME		BIRTHDATE	M F
HOME ADDRESS			
MOTHER'S NAME / LEGAL GUARDIAN		HOME PHONE	
ADDRESS		CELL PHONE	
BUSINESS NAME		WORK PHONE	
BUSINESS ADDRESS	EMAIL @		
FATHER'S NAME / LEGAL GUARDIAN		HOME PHONE	
ADDRESS		CELL PHONE	
BUSINESS NAME		WORK PHONE	
BUSINESS ADDRESS	EMAIL @		

EMERGENCY CONTACT PERSON(S)		
NAME	RELATIONSHIP	DAYTIME PHONE
NAME	RELATIONSHIP	DAYTIME PHONE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	*If necessary, indicate additional names on reverse*	
NAME	Relationship to Child	DAYTIME PHONE
NAME	Relationship to Child	DAYTIME PHONE
NAME	Relationship to Child	DAYTIME PHONE
☐ Check here if additional names are listed on back		

CHILD'S DOCTOR / MEDICAL PROVIDER	PHONE
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES INCLUDING ALLERGIC REACTION
MEDICAL OR DIETARY INFORMATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HAS CHILD BEEN IDENTIFIED BY SCHOOL DISTRICT FOR SPECIAL PROGRAMMING? ☐ YES ☐ NO ***If "YES", please submit a copy of child's IEP/504 Plan***	
HEALTH INSURANCE CARRIER FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

SIGNATURE of PARENT or GUARDIAN	*DATE SUBMITTED*

Be sure to sign here!

Camp Director: Tracey Dudek
Ph: 610.353.2326| Fax: 610.353.2330
Email: thekidstop@gmail.com

Camp Kid's Stop

Fees Camp Hours are 9:00 am – 3:30 pm	**Payment Schedule** Additional fee charged for extended care – see below
$150 per week / regular 5 day program *Please call for toddler/preschool rates	Payment due MONDAY of scheduled week
$100 per week / regular 3 day program *Please call for toddler/preschool rates	Payment due first day of attendance EACH week

Minimum 6 week enrollment

Please check the boxes for which you would like to register:	**Week 1** **6/28 – 7/2**	**Week 2** **7/6 – 7/9** **Tues.-Fri. only**	**Week 3** **7/12 – 7/16**	**Week 4** **7/19 – 7/23**	**Week 5** **7/26 – 7/30**	**Week 6** **8/2 – 8/6**	**Week 7** **8/9 - 8/13**	**Week 8** **8/16 - 8/20**
5 day week		(No camp 7/5)						
3 day week								
Extended AM (7:30-9) - $5/day								
Extended PM (3:30-5) - $5/day								

If you are registering for 3 days a week please specify days attending: ________________________________

Camper's Name ______________________________Parent/Guardian Signature________________________________ Date ___________

THE KID'S STOP

CIVIL RIGHTS COMPLIANCE
PARENT AWARENESS

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your children, as a client of this facility, have the right:

- ✓ To be provided services at this facility and to be referred for services at other facilities without regard to your race, color, religious creed, disability, ancestry, national origin, 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:

MN Joint Recreation Commission
Administrator of Child Care
20 Media Line Road
Newtown Square, PA 19073

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105

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

Pennsylvania Human Relations Commission
Philadelphia Regional Office
110 N. 8th Street, Suite 501
Philadelphia, PA 19107

Commonwealth of Pennsylvania
DPW Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

____
Signature of Parent / Guardian Date

____
Staff Signature Date

THE KID'S STOP Medication Policy

This facility will administer medication to children for whom a plan has been made, reviewed and approved by Program Administration. ***Because administration of medication in the facility is a safety hazard, families should check with the child's physician to see if a dose schedule can be arranged that does not involve the hours the child is at THE KID'S STOP***. Whenever possible, the first dose of medication should be given at home to see if the child has any reaction. Parents or legal guardians may administer medication to their own child during the child care day.

THE KID'S STOP will administer medication only if the parent or legal guardian has provided written consent, the medication is available in an appropriate labeled and stored container, and the Program has on file the written or telephone instructions of a licensed physician to administer the specific medication.

1. For prescription medications, parents or legal guardians will provide caregivers with the medication in the original, child-resistant container that is labeled by a pharmacist with the child's name, the name of the medication; the date the prescription was filled; the name of the health care provider who wrote the prescription; the medication's expiration date; and administration, storage and disposal instructions.
2. For over-the-counter medications, parents or legal guardians will provide the medication in the original, child-resistant container. The medication will be clearly labeled with the child's first and last names; specific legible instructions for administration and storage supplied by the manufacturer; and the name of the health care provider who recommended the medication for the child.
3. Instructions for the dose, frequency, method to be used, and duration of administration will be provided to Program Staff in writing (by a signed note or prescription label) or dictated over the phone by a physician or other person legally authorized to prescribe medication. This requirement applies to both prescription and over-the-counter medications.
4. A physician may state that a certain medication may be given for a recurring problem, emergency situation or chronic condition. The instructions should include the child's name; the name of the medication; the dose of the medication; how often the medication may be given; the conditions for use; and the precautions to follow. ***Example:*** *children may use sunscreen to prevent sunburn; children who wheeze with vigorous exercise may take one dose of asthma medication before vigorous active play; children who weigh between 25-35 pounds may be given 1 teaspoon acetaminophen for up to two doses every hour for fever.*
5. A child with a known serious allergic reaction to a specific substance who develops symptoms after exposure to that substance may receive epinephrine supplied by the parent from a staff member who has received training in how to use an auto-injection device (e.g., Epipen®). In the case of severe allergies which require monitoring, special accommodation and/or emergency medication/response, an ANAPHYLAXIS and ALLERGY TREATMENT PLAN must be provided by child's physician
6. Medication will be kept at the temperature recommended for that type of medication, in a sturdy child-resistant, closed container that is inaccessible to children and prevents spillage.
7. Medication will not be used beyond the date of expiration on the container or beyond the expiration of the instructions provided by the physician or other person legally permitted to prescribe medication. Instructions which state that the medication may be used whenever needed will be renewed by the physician at least annually.
8. A medication log will be maintained by Program Staff to record instructions for giving medication; consent obtained from the parent or legal guardian, amount; time of administration; and the person who administered each dose of medication. Spills, reactions, and refusals to take medication will be noted on this log.
9. Parent or legal guardian will supply all devices or equipment necessary such as medicine spoon or measurement cup
10. **NOTE:** the Program does NOT keep a supply of pain/fever reducers on hand (ex: Tylenol/Motrin, etc.). ***All medications must be provided by Parent.***

Signature of Parent or Legal Guardian indicating knowledge and understanding of **THE KID'S STOP** Medication Policy

_______________________	_______________________	__________
Print Name of Parent or Legal Guardian	Signature of Parent or Legal Guardian	Date

BEHAVIOR CONTRACT

Child's Name: ______________________________ D.O.B. ___________

THE KID'S STOP makes every effort to help children understand clear definitions of acceptable and unacceptable behavior. It is important that staff maintain good order and discipline in all program areas with the top objectives being safety and a positive atmosphere for learning and developing social skills.

A child's behavior is expected to be consistent with the following:

- ✓ Use appropriate language at all times
- ✓ Cooperate with staff and follow directions
- ✓ Follow all safety guidelines
- ✓ Respect other children and staff, equipment and facilities, and yourself
- ✓ Maintain a positive attitude
- ✓ Stay in program areas – running away or leaving program area is not acceptable

The following behaviors which may result in immediate dismissal include *but are not limited to*:

- ➢ pushing, kicking, shoving, tugging, tackling, pinching, choking, spitting or fighting
- ➢ name calling, talking about another's parents or family or making fun of someone's race or appearance
- ➢ throwing stones, rocks, sticks, toys or other objects
- ➢ tackle football, wrestling or rough play
- ➢ playing with toys that are considered look-alike or make-believe weapons
- ➢ harassment or bullying of any kind between students
- ➢ vandalism

Special Circumstances

Parents or guardians are required to inform **THE KID'S STOP** *in writing*, prior to a child's acceptance in to the Program, of any special circumstances which may affect the child's ability to participate fully and within the guidelines of acceptable behavior, including but not limited to any serious behavioral problems or special circumstances regarding psychological, medical or physical conditions.

Upon being informed of such circumstances, the Program Administrator (or an official designee, i.e., Site Director, Group Supervisor or Coordinator) may require a conference with the parent(s)/guardian(s) to discuss issues created by these circumstances.

I understand and acknowledge that:

1. It is the responsibility of the parent(s)/guardian(s) to make full disclosure to **THE KID'S STOP** of any special circumstances which may affect the ability of the child to participate, as described above.
2. It is the responsibility of the parent(s)/guardian(s) to inform **THE KID'S STOP** of any requested accommodation believed by the parent(s)/guardian(s) to be necessary and readily achievable for such participation; and
3. Full disclosure of any special circumstances is material to **KID'S STOP** evaluation of the child's ability to participate and the Program's consideration of any requested accommodation.

Please initial, indicating you have read and understand the above:

Parent/Guardian Initials: ______________ Date _______________

I have read, understand and agree with the policies as stated in this document and have or will discuss the expectations of behavior with my child/ward.

______________________________ ______________________________ _______________
Signature of Parent/Guardian Please Print Name 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: Kid's Stop		
FACILITY PHONE: 610-353-2326	COUNTY: Delaware	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.