Muncy First UM Church Preschool
602 S. Market St.
Muncy, Pa 17756
Telephone: 570-546-8030

Dear Parent/Guardian:

Thank you for choosing First United Methodist Church Preschool for your child. Attached is the registration form for the 4-year-old program. Listed below is some information for you to know.

Children must be 4 years of age by October 1, 2019 and toilet trained.

There is a $30.00 non-refundable registration fee. This will secure your child's spot in class. Checks should be made payable to FUMC and are due with your child's application.

Tuition is $175.00 per month. This is payable the first class day of each month. Again, checks should be made payable to FUMC.

Preschool days/hours are as follows: Class days: Monday-Friday; class hours: 12:30pm-3:30pm.

Our school year will begin the week of Labor Day. You will receive a letter in mid to late August with the exact date.

The completed physical form is due the first week of school. This form must be completed by your child's physician.

If you have any questions, or would like to visit the preschool, please call 570-546-8030.

Again, thank you for choosing First UM Church Preschool.

Sincerely,

Kelly Hoover
Preschool Director/Teacher

First United Methodist Church Preschool
602 So. Market St., Muncy, PA 17756
Phone: 570-546-8030

4 year Old Class 2019-2020

Parental Consent Form / Emergency Contact

Child's Name:_____ Nickname:_____

Birthdate:_____ Sex:_____ Right or Left or both Handed (circle one)

Child's Address:_____

Mother's Name:_____

Mother's Address:_____

Home Phone:_____ Cell Phone:_____ Texting: yes or no

Employment:_____

Employment Address:_____

Employment Phone:_____

Email Address:_____

Father's Name:_____

Father's Address:_____

Home Phone:_____ Cell Phone:_____ Texting: yes or no

Employment:_____

Employment Address:_____

Employment Phone:_____

Email Address:_____

Marital Status of Parents:_____

List Siblings and their age:_____

Any Special or Medical conditions from birth to present:_____

_____

Any medical or dietary information necessary in an emergency situation:_____

_____

Any allergies including medication reactions:_____

_____

Additional information on special needs of the child:_____

_____

Name of Child's Physician/Medical Provider:_____

Address of Provider:_____

Phone Number of Provider:_____

Health Insurance Provider:_____

Health Insurance Policy Number:_____

Persons to be notified in case of emergency (Parents will be called first unless otherwise noted)
Name:_____Phone Number:_____

Name:_____Phone Number:_____

Name:_____Phone Number:_____

Persons to whom child may be released to: (besides parents, unless there is a court order, then we need a copy)

Name:_____Phone Number:_____
Address:_____

Name:_____Phone Number:_____
Address:_____

Name: _____Phone Number:_____
Address:_____

Parents Signature is required below to indicate Parental Consent:

Obtaining emergency medical care:_____

Admin.of minor first aid:_____

Walks:_____

Photographs:_____

Videos:_____

Sharing of address and phone number with other parents:_____

Use of hand sanitizer:_____

Sharing of information with the entering kindergarten:_____

Permission to conduct screenings and assements:_____

Periodic Review:

AGREEMENT

55 PA CODE CHAPTERS3270. 123 & 181©; 3290.12 & 181 ©

Name of Child

Fee Amount:	Per: Day/ Week /Month	Day payment to be made:
$175.00	Month	1st class day of every month

Services to be provided as part of the preschool fee (examples transportation meals etc.)

Child's arrival time	Child's departure time	Person(s) designated by parent to whom Child may be released
12:30 pm	3:30 pm	

Extra services to be provided at an additional fee if applicable

I the parent or guardian:

- received complete written program information at the time of enrollment (3270.121, 3280.121 3290.121)
- agree to update the emergency contract/parental consent form information whenever changes occur or every 6 months at a minimum (3270.124, 3280.124, 3290.124)

Signature – Operator Date

Signature-Parent or Guardian Date

Date of Child's Admission

Date of Withdrawal

Signature-Parent or Guardian

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: FIRST U.M. CHURCH PRESCHOOL		
FACILITY PHONE: 570-546-8030	COUNTY: LYCOMING	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.