Handbook Signature Page

I/We, _____ the parents of _____, have received, read and had the opportunity to ask questions about, understand and agree to abide by the policies set forth in The Torre Academy's parent handbook.

Furthermore, I/We agree to abide by the policies set forth in the manual. I/We understand that the policies described in the Parent Handbook and not conditions of enrollment and the language does not create a contract between The Torre Academy and the parents. The Torre Academy reserves the right to alter, amend or otherwise modify these guidelines, in its sole discretion, without prior notice.

I/We also understand that future question regarding policies in the parent handbook may be directed to the center Director.

I/We also understand that future questions regarding policies in the parent handbook may be directed to the center Director or corporate office.

By typing your name below, You agree that this is valid as your signature.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date Date

_____Parent /Guardian Agreement

The Torre Academy

Child's Name:	Date of Birth:

Enrollment Date: _____ ☐ Full Time ☐ Part Time M T W Th F

Child's Arrival Time: _____ Child's Departure Time: _____

Tuition Fees:

☐ Weekly Tuition – weekly tuition is due each Monday before services are provided for the current week.

☐ Monthly Tuition – monthly tuition is due on the 1st day of each month before services are provided.

☐ CCIS copay (please check only if enrolled in CCIS)

Tuition does not fluxgate based on child's attendance or center closures (please read below).

Tuition / Copay	Discount Type	Discount Amount	Total Tuition
$	$	$	$

Person(s) Designated by Parent To Whom Child May Be Released:

Services provided for Full Time & Part Time (when applicable):

* Care up to 10hrs per day
* Breakfast, Lunch and Afternoon Snack
* Enrichment Programs (Language)
* Individualized Curriculum with Attention to Early Literacy
* Individual Portfolios & Assessments

I the parent/guardian:

□ have received the Parent Handbook at the time of enrollment of my child. I have read the contents and agree to abide by the policies contained therein.

□ agree to update forms necessary to meet government and facility requirements when notified and to update Emergency Contact/Consent Child Health Assessments and Tuition Agreement forms whenever changes occur every 6 months.

Parent/Guardian Signature: _____Date: _____

Center Director Signature: _____Date: _____

Parent/Guardian Information

Registration Date:_____

Mother/Guardian First Name: _____ M.I.___ Last Name: _____

Address: _____

Occupation: _____ Home Phone: ( ) _____

Employed By: _____ Office Phone: ( ) _____

Work Address: _____ Work Hours: _____ Cell Phone: ( ) _____

[ ] Custodial Parent (If married, mark both parents) Mother's SS#: _____

Email: _____ Driver's License #: _____

Preferred PIN number for checking in/out (4 digits, numbers only) 1st choice _ _ _ _ 2nd Choice _ _ _ _

Marital Status:[ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other_____

Father/Guardian First Name: _____ M.I.___ Last Name: _____

Address: _____

Occupation: _____ Home Phone: ( ) _____

Employed By: _____ Office Phone: ( ) _____

Work Address: _____ Work Hours: _____ Cell Phone: ( ) _____

[ ] Custodial Parent (If married, mark both parents) Father's SS#: _____

Email: _____ Driver's License #:_____

Preferred PIN number for checking in/out (4 digits, numbers only) 1st choice _ _ _ _ 2nd Choice _ _ _ _

Marital Status:[ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other_____

Child Information

1st Child First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

Child's Address: _____

Gender: [ ] Male [ ] Female Date of Birth:_____ Child's S.S. #: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone: ( ) _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? [ ] Yes [ ] No

Child Information - Continued

2nd Child First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

Child's Address: _____

Gender: [ ] Male [ ] Female Date of Birth:_____ Child's S.S. #: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone: ( ) _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? [ ] Yes [ ] No

3rd Child First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

Child's Address: _____

Gender: [ ] Male [ ] Female Date of Birth:_____ Child's S.S. #: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone: ( ) _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? [ ] Yes [ ] No

4th Child First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

Child's Address: _____

Gender: [ ] Male [ ] Female Date of Birth:_____ Child's S.S. #: _____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Allergies: _____

Pediatrician's Name: _____ Phone: ( ) _____

Address: _____

Photographs: May we take and maintain a photo of your child for security purposes? [ ] Yes [ ] No

Emergency Contacts & Authorized Pickup Persons:

1st Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _ _ _ _

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

2nd Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _ _ _ _

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

3rd Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _ _ _ _

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

4th Contact/Pick Up Name: _____ Phone: _____

Relationship to the Child: _____ PIN for check in/out (4 digits, numbers only) _ _ _ _

[ ] Able to pick up all children in the family

[ ] Not able to pick up the following children: _____

Tuition / Payment Information:

Current Tuition Amount: _____ [ ] Weekly [ ] Bi-Weekly [ ] Monthly [ ] Other_____

Please outline below whom is responsible for payment of tuition and fees. Please fill out if parents are divorced and split tuition payment or if tuition payment is the responsibility of an adult other than the parents listed above.

_____

_____

_____

Additional Comments & Information:

Is there is any other information that that would be helpful to our management and teaching staff?

_____

_____

Signature:

Parent's Signature: _____ Date: _____

Thank You!

The Torre Academy
7504 Haverford Ave
Philadelphia, Pa 19151
(215) 877-ABC9
torreacademy@gmail.com

Subject: Nondiscrimination in Services

To: Parents

From: Jowanna Gordon, CEO

Signature Date

Admissions, the provisions of services and referrals of clients shall be made without regard to race, color, religious creed, ancestry, disability, age, national origin (including limited English proficiency) and 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 only be considered as a last resort among available methods.

Any student (and/or their parent or guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

The Torre Academy
7504 Haverford Ave
Philadelphia, Pa 19151

PA Human Relations Commission
110 North 8th St
Suite 501
Philadelphia, Pa 19107

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

Commonwealth of Pennsylvania
DPW/Bureau of Equal Opportunity
Southeast Regional Office
801 Market St, Suite 5034
Philadelphia, Pa 19107

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

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	BIRTH DATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE 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 REACTIONS)
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)

PARENTS 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
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

Child Health Assessment

Parents & Child Care Providers 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:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

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 child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM % ILE _____	_____LB/KG % ILE _____	(Birth to Age 2) _____IN/CM % ILE _____	(Beginning at age 3) _____ / _____

PHYSICAL EXAMINATION	☑ = NORMAL	If ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTa/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	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)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

Medical care Provider:		Signature of Physician or CPNP:	
Address:			
	Phone:	License Number:	Date Form Signed:

Parents may write immunization dates, health professionals should verify and complete all data.

Individual Education Plans (IEP) & Individual Family Service Plans (IFSP) Information Sheet

Because of the diverse set of needs of the children it is important to gather as much information as possible about each child. If your child has an IEP or an IFSP in place we all benefit from sharing this information so that we may care for your child in the best possible way.

Parent Sign Off Sheet

Child's Name: _____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP or an IFSP, it would be beneficial to share a copy of this plan with us so that we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

_____ I am providing a copy of my child's IEP or IFSP.
_____ My child does not have/I am not providing an IEP or IFSP.

By typing your name below, You agree that this is valid as your signature.

_____ _____

Parent/Guardian Signature Date

Video / Photo Release

I hereby give permission for images of my child, captured by The Torre Academy, through video, photo and digital camera, to be used solely for the purposes of The Academy's promotional material and publications. I also waive any right to compensation or ownership thereto.

Child's Name: _____

By typing your name below, You agree that this is valid as your signature.

_____ _____

Parent/Guardian Signature Date

Go Paperless

Parents,
In an effort to go paperless, we will be using email to communicate on a regular basis throughout the school year. This communication will include monthly newsletters and any non-urgent issues that may arise during the course of the school year. Please provide at least one email address per family. We will add as many email addresses as you like to our database. Thank you for your cooperation.

Child's Name: _____

School Name: _____

Parents Name and assigned email address

1. _____

2. _____

3. _____

Remember to update our records if you email changes over the course of your child's enrollment.

By typing your name below, You agree that this is valid as your signature.

_____ _____

Parent/Guardian Signature Date

GETTING TO KNOW YOU FORM

Child's Name: _____

Names of Meeting Attendees: _____

Enrollment: _____ Meeting Date: _____

Attached list of information shared in written form.

FAMILY INFORMATION

Tell me about the people in your household? _____

_____

Does your child have any parents that do not live in the home? _____

If yes, does your child visit this parent? _____

Are there any custody issues that we should know? _____
Does your child have any siblings? _____

CHILD INFORMATION

What type of pregnancy did you experience? ◯ Full-Term ◯ Premature

If premature, how many weeks? _____

Were developmental milestones met? _____

If yes, are you receiving any early intervention services,such as PT or OT? _____

If no, would you be interested in receiving information if services are needed? _____

Has your child been in child care before? _____ If yes, would you share information with us? (Where? When? For how long?) _____

What kind of care (family day care home, relative/neighbor care, group, center)? _____

Is there a reason for leaving that program? _____

Are there any special problems or fears that we should know about? _____

_____

continued...

Getting to Know You Form
Page 2

Does your child have any imaginary friends? _____

Any special needs (medical, developmental, social, mental health)? _____

_____

Does your child have an IEP (Individual Service Plan) or IFSP (Individual Family Service Plan)?

_____

If so, we would like a copy of the plan so we can provide the best possible learning experience for your child.

What program or individuals work with your children in regards to these special needs? _____

_____

Would you sign a release of information with them so they can speak with us about how to provide support to your child? _____

Does your child have any allergies? _____

• Food Allergies (doctor's documentation should be provided by parent) _____

• Environmental Allergies _____

• Allergies to medicine _____

How are your child's allergies treated? _____

Do you have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.)? _____

Any other medical or special needs? _____

Describe your child's schedule:
• Normal bedtime, waking time, nap time and duration _____

_____

• Does your child have a different schedule at any other child care setting (babysitter, relative/ Neighbor care, school)? _____

Is your child toilet trained? _____

Getting to Know You Form

Is there information that will help us make the first few days in our program easier for your child?

_____

Is there any other information you would like to share that was not addressed?

_____

PARENT INFORMATION

What are your expectations of our program? (explain structural play)

_____

Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know? Would you and /or your family like to be a resource for any cultural awareness activities? _____

_____

Are you willing to be a volunteer in our classroom? _____

Are there any other ways you would like to be involved? _____

What times are best for us to reach you and for you to come in for parent conferences? _____

Tell me about your child's:

- Favorite Toys _____
- Other _____

Has your child talked to you about bis or her experiences in our program so far? _____

_____

Is he/she positive about the program, other children, and the teaching staff? _____

_____

By typing your name below, You agree that this is valid as your signature.

_____ _____

Signature Of Parent Or Guardian Date

_____ _____

Signature Of Director Date

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®–a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

John Sample
Mary Sample
123 Nice Street
Anytown, USA

BANK OF THE WEST
555-555-5555

00226

Pay to the order of: Attach Voided Check Here $

Deposit slips not accepted _____ Dollars

⑆123456789⑆ 1800338⑈ 0226

Routing Number Account Number Check Number

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