REGISTRATION & APPLICATION PACKAGE

HAVERFORD PROGRAM
SCHOOL YEAR 2021-2022

KnowledgePoints Learning Academy
P.O. Box 1392 • Havertown, PA 19083

KnowledgePoints Learning Academy

KINDERGARTEN ENRICHMENT and BEFORE & AFTER SCHOOL PROGRAMS
2021-2022 SCHOOL YEAR
Registration Form - page1

PLEASE COMPLETE A FORM FOR ***EACH CHILD*** - PLEASE PRINT LEGIBLY AND ***KEEP A COPY FOR YOUR RECORDS***

Child's Name

Home School(Chatham Park,Chestnutwold,Coopertown, Lynnewood or Manoa) Grade in '21 - '22

Primary Parent/Guardian *(Last Name, First Name)*

Primary Phone (*circle one* - Cell/Work/Home) Secondary Phone (*circle one* - Cell/Work/Home)

Primary Mailing Address City State Zip Code

Primary Email Address

Second Parent/Guardian *(Last Name, First Name)*

Primary Phone (*circle one* - Cell/Work/Home) Secondary Phone (*circle one* - Cell/Work/Home)

Email Address *(include if this email address should also receive communications, including billing)*

Registration Fee: ***$50 per Family*** *(Registered by 5/31/21)* **, *$75 per Family*** *(Registered on or After 6/1/21)*

Before School Care (3 day minimum)
7:00am until 8:30pm
*2 day option available for Hybrid/Virtual only

M	T	W	TH	F

		Annual	9 Monthly Payment
☐	**5 DAYS -**	**$ 1,550**	**$ 175**
☐	**4 DAYS -**	**$ 1,300**	**$ 150**
☐	**3 DAYS -**	**$ 1,100**	**$ 125**
☐	***2 DAYS -**	**$ 875**	**$ 100**

After School Care (3 day minimum)
3:30pm - 6:00pm
*2 day option available for Hybrid/Virtual only

M	T	W	TH	F

		Annual	9 Monthly Payment
☐	**5 DAYS -**	**$ 3,350**	**$ 375**
☐	**4 DAYS -**	**$ 2,650**	**$ 300**
☐	**3 DAYS -**	**$ 2,000**	**$ 225**
☐	***2 DAYS -**	**$ 1,325**	**$ 150**

Kindergarten Enrichment (**3** day minimum)
AM: (8:30am - 11:30am) PM: (12:30pm - 3:30pm)

M	T	W	TH	F

		Annual	9 Monthly Payments
☐	**5 DAYS -**	**$ 5,200**	**$ 580**
☐	**4 DAYS -**	**$ 4,200**	**$ 470**
☐	**3 DAYS -**	**$ 3,100**	**$ 350**

Primary Parent's/Guardian's Signature **Date**

Signed registration forms **WITH** registration fee (check or money order only) should be mailed to:

KnowledgePoints Learning Academy
Attn: School Programs Billing - Haverford
P.O. Box 1392
Havertown, PA 19083

Office Use Only

KnowledgePoints Learning Academy is an Equal Opportunity Care Provider (EOCP) and an Equal Opportunity Employer (EOE)

KnowledgePoints Learning Academy

FULL DAY & PARTIAL DAY PROGRAMS

2021-2022 SCHOOL YEAR (Hybrid/Virtual Options)

Registration Form - page2

PLEASE COMPLETE A FORM FOR ***EACH CHILD*** - PLEASE PRINT LEGIBLY AND ***KEEP A COPY FOR YOUR RECORDS***

Child's Name

Primary Parent/Guardian *(Last Name, First Name)*

Full Day Program (2 day minimum)

7:00am until 6:00pm

M	T	W	TH	F

	Monthly Payments
5 DAYS -	**$ 900**
4 DAYS -	**$ 800**
3 DAYS -	**$ 690**
2 DAYS -	**$ 570**

Partial Day Program (2 day minimum)

AM: _____ (7am until 12Noon)

PM: _____ (1pm until 6pm)

M	T	W	TH	F

	Monthly Payments
5 DAYS -	**$ 570**
4 DAYS -	**$ 475**
3 DAYS -	**$ 370**
2 DAYS -	**$ 290**

Primary Parent's/Guardian's Signature **Date**

Signed registration forms should be emailed to: keith.bocian@knowledgePoints.com
or mailed to:

KnowledgePoints Learning Academy
Attn: School Programs Billing - Haverford
P.O. Box 1392
Havertown, PA 19083

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REGISTRATION CHECKLIST

Please initial on each line:

_____ In addition to the completion of the Registration Form, I understand that the forms listed below must be completed **BEFORE** my child can attend the program. Failure to do so will result in a delay of their start date.

___ Emergency Contact ***___ Child Health Assessment*** ***___ Enrollment Agreement***

___ Consent Form ***___ Health & Safety Plan Acknowledgement Form***

_____ I understand if my child has an IEP document, I must provide a copy upon registration.

_____ ***Family Handbook**- I have reviewed a copy of the KnowledgePoints Learning Academy Family Handbook, which includes behavioral and inclement weather policies & procedures. It is my responsibility to understand and familiarize myself with the Family Handbook and to ask Center management for clarification of any policies, procedures or information, if necessary.

_____ I understand that if there is a custody agreement in place, a copy must be provided to KnowledgePoints.

_____ I understand that there are no refunds or credits for days missed due to illness, vacations, snow days, school closings or township employee work stoppages.

_____ I understand that any change in my child's schedule must be reported to the Main Office @ 610-853-0115. There is a $25 change fee associated with any adjustment after the start of the school year.

_____ ***General Information-** I have reviewed the General Information packet which includes the **Billing Information and Fee Explanations** information sheet.

_____ I understand that KnowledgePoints Learning Academy runs programs on regular school days only. For Professional Development (Act 80) In-Service full and half days as well as Parent/Teacher Conferences, a School Closing Package is available at certain locations for an additional fee and on a limited basis. Check with Center Management for more details.

_____ ***Getting To Know You**- I have completed the "Getting To Know You – Meeting Guide".

_____ I understand that the failure to comply with KnowledgePoints policies may result in termination of services.

_____ _____

Child's Name (*please print*) Parent/Guardian Signature

_____

Date

*** Forms available online at** www.knowledgepointspa.com *navigate to Before and After Care Programs, choose your Location, and download the forms from the links provided.*

return completed forms to:

KnowledgePoints Learning Academy

P.O. Box 1392

Havertown, PA 19083

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	BIRTHDATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'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 CONDITIONS
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
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

Child Health Assessment Overview

The Department of Human Services (DHS), the licensing agency that oversees child care providers, requires that all children enrolled in a child care program receive a health screening and immunizations. We are required to obtain from the parent/guardian a child health report showing compliance within 60 days of enrollment. Parents of school-age children are required to provide updated health reports for children in accordance with the requirements for medical exams for school attendance in their district.

The health report must be signed by a physician, physician's assistant, or a CRNP. The signature MUST include the individual's professional title. The health report must also contain the following:

- A review of the child's health history
- A list of the child's allergies
- A list of the child's current medication and the reason for the medication
- An assessment of the acute or chronic health problem or special need and recommendations for treatment or services, including information regarding abnormal results of screening tests for vision, hearing or lead poisoning.
- A review of the child's immunized status according to recommendations of the AICP.
- A statement of the child's medical information pertinent to diagnosis and treatment in an emergency.
- A statement that the child is able to participate in child care and appears to be free from contagion or communicable diseases.
- A statement that age-appropriate screenings recommended by the American Academy of Pediatrics were conducted since the time of the previous health report provided for enrollment in child care.
- A list of the dates the child was administered immunizations in accordance with the recommendations of the ACIP.

Children without a health screening and the pertinent immunization records on file by the 60th day of enrollment will no longer be able to attend and KnowledgePoints is required by the DHS to implement dismissal procedures in accordance with the Dept. of Health regulation 28 Pa. Code 27.77 relating to immunization requirements for children in child care group settings.

A copy of the official Child Health Assessment form (form CD 51) is provided with the Parent Application Packet. Additional copies are available upon request.

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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: KnowledgePoints		
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						

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.

ENROLLMENT AGREEMENT

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

Name of Child

Annual Payment Amount

Monthly Payment Amount (9 payments only)

Day Payment to be Made:

* Annual - Due prior to the start of the program
* Monthly - 1st of each month - September 1st thru May 1st/ No June Payment
* $25.00 Late payment fee

Services to be provided as part of the child care

* Homework assistance
* Enrichment and recreational activities
* Afternoon snack
* Supervised walking escort may be available from some local schools

Please check:

- ☐ Before Care Program
- ☐ Kindergarten Enrichment
- ☐ After Care Program
- ☐ Full Day Program
- ☐ Partial Day Program

Extra services to be provided at an additional fee if applicable

* Late pickup fee is $15 per 15 minute interval after 6pm
* $30 Bank fee for returned checks
* $25 Program Change Fee

Person(s) Designated by Parents to Whom Child May be Released

1.)
2.)
3.)
4.)

I, the parent/guardian (please check):

☐ have received complete written program information at the time of enrollment (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum (§ 3270.124, 3280.124, 3290.124)

SIGNATURE - PARENT/GUARDIAN **DATE**

SIGNATURE - DIRECTOR/TEACHER **DATE**

DATE OF CHILD'S ADMISSION

DATE OF CHILD'S WITHDRAWL

PERIODIC REVIEW

I have reviewed and updated the above information

SIGNATURE - PARENT OR GUARDIAN **DATE**

CONSENT FORM

Child's Name: _____ Parent's/Guardian's Name: _____
Please Print *Please Print*

KnowledgePoints Learning Academy's Extended Day Programs or School Programs are licensed by the Commonwealth of Pennsylvania, Department of Human Resources. In order to comply with their regulations, we need your written permission for the following. Please check off and sign. If you have any concerns, please use the Comment Section below.

I give permission for the KnowledgePoints staff to:

____ 1. Post notes regarding allergies or other special medical or personal needs.

____ 2. Share my address and/or phone number with other class members or program participants.

____ 3. Allow the school nurse to have a copy of my child's health form.

____ 4. Take my child's picture or videotape during program activities, which might be used for publicity or in future KnowledgePoints brochures, newsletters or its website.

____ 5. Allow KnowledgePoints to share my child's test scores or academic information with his/her classroom teacher and other professionals involved in my child's academic progress.

_____ _____
Parent/Guardian Signature Date

Comments:

_____
_____
_____
_____
_____

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Health and Safety Plan Acknowledgement

Child's Name: _____ Parent's/Guardian's Name: _____
Please Print *Please Print*

KnowledgePoints Learning Academy's Extended Day Programs or School Programs are licensed by the Commonwealth of Pennsylvania, Department of Human Resources. In response to the COVID-19 pandemic, we have instituted an updated Health and Safety Plan that follows the guidelines provided by the Department of Heath (DOH) and the Child Care Certification. These guidelines were derived from the Centers for Disease Control (CDC) guidance documents for the reopening of schools and child care providers.

I affirm that I have been provided with a written copy of the Health and Safety Plan for the KnowledgePoints Learning Academy. I understand that the Health and Safety Plan may change in response to updated and revised guidelines from the DOH and the CDC.

_____ _____
Parent/Guardian Signature Date

If you believe your child is at higher risk for severe illness or has complex health needs, please describe in more detail below. A staff member will contact you to discuss your individual needs and any unique safety protocols that may be required.

_____
_____
_____
_____
_____