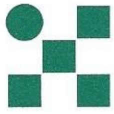

Greene Towne Montessori School

GENERAL STUDENT INFORMATION for 2018-2019

Please fill in the information below and complete in full. This information is imperative when we need to contact you due to illness or emergency and is updated annually. GTMS may contact you by phone, mail, or e-mail.

CHILD'S NAME: ________________________________ DATE OF BIRTH: ___________________________

STREET ADDRESS: ______________________________ STATE and ZIP: _____________________________

HOME PHONE: __________________________________

PARENT/GUARDIAN 1

NAME: ____________________________________

WORK PHONE: ______________________________

CELL: _____________________________________

EMPLOYER: _________________________________

TITLE: ____________________________________

PARENT/GUARDIAN 2

NAME: ____________________________________

WORK PHONE: ______________________________

CELL: _____________________________________

EMPLOYER: _________________________________

TITLE: ____________________________________

Please confirm the email address we should use to send you weekly updates and time sensitive/emergency information.

E-MAIL: __________________________________ E-MAIL: ____________________________________

Please write in street address with state and zip if different from child's street address above

ADDRESS:_________________________________ ADDRESS:__________________________________

____ ____

PARENT HOBBIES/INTERESTS:

____ ____

CHILD'S CAREGIVER(s)______________________________________ CELL(s)_____________________________

My child can be released to this caregiver. Yes_____ No_____ WILL YOUR CHILD NAP AT SCHOOL THIS YEAR?________

DOES YOUR CHILD HAVE ANY **ALLERGIES or FOOD RESTRICTIONS** THAT WE NEED TO KNOW ABOUT?

____

DOES YOUR CHILD TAKE ANY **MEDICATIONS** THAT WE NEED TO KNOW ABOUT?

____

SIBLING: _________________________DOB:______________ SIBLING: _________________________DOB:______________

PETS AT HOME____________________________________

If you would like to opt in for grandparents/family to be kept up on GTMS news please list their names, addresses and email address:

____ ____

____ ____

____ ____

____ ____

☐ Please check here if there are no changes to the contact information.

Please email **info@gtms.org** if any information should be different for the Family Directory.

Administrative Use Only

Date received:_____ Date processed in database:_____

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

03891A

CY 867 - 1/93

ORIGINAL

Child's Name____

Please read, initial, and sign the following:

RELEASE for PHOTOGRAPHS, VIDEO RECORDINGS, WRITING SAMPLES, ART WORK

I agree to the use by Greene Towne Montessori School of photographs, videos, writing samples, and art work of the student named above in print and electronic publications or advertising. I give permission for my child's photograph to appear on the Greene Towne website. I understand that ***no children on this site will be identified by name.***

*This will sign off on **all** or **none** of the above.* **______Please Initial**

PERMISSION TO LEAVE SCHOOL PREMISES

FOR ALL CHILDREN:

I agree to allow my Toddler/Primary child to leave Greene Towne Montessori School as part of a staff-supervised group of students for walks in Greene Towne's Logan Square Neighborhood. Parents are requested to sign the Permission to Leave School Premises at the beginning of the year. This permission allows your child to participate in walking field trips to destinations within Greene Towne's neighborhood, i.e.: the city blocks bounded by Pennsylvania Avenue, 19th Street, 23rd Street, and Market Street. This includes but is not limited to Coxe Park, The Franklin Institute, The Academy of Natural Sciences, The Free Library, Logan Circle, Von Colln Park, and Trader Joe's. **______Please Initial**

FOR KINDERGARTEN CHILDREN ONLY:

I agree to allow my Kindergarten child to take part in any field trip organized by the school, provided that I have been informed in advance of the specific plans which have been made concerning the destination of the trip and the transportation arrangements. **______Please Initial**

EMERGENCY MEDICAL TREATMENT

I/we, the parent(s) and/or guardian(s) do hereby authorize Greene Towne Montessori School (GTMS), through its Head of School, Assistant Head of School, teachers, staff, and other agents and employees, to obtain medical care and treatment, including hospitalization, in the event of a medical emergency involving my/our child.

In the event of such a medical emergency, GTMS shall make its best efforts to first notify the parent(s) or guardian(s) of the medical emergency. If, however, the student's parent(s) or guardian(s) is not available, or, the emergency necessitates immediate action by GTMS I/we expressively authorize GTMS to obtain such emergency medical care and treatment in my/our absence for my/our child with the same legal right, power and authority as I/we ourselves possess.

I/we fully understand and acknowledge the terms of this consent for the student's emergency medical treatment.

______Please Initial

I have read and understood the Photo Release, Permission to Leave School Premises, and Emergency Medical Treatment portions.

PLEASE SIGN____ **Date**_____________

For the Purpose of the National Association of Independent Schools Statistical reports, please check one of the following that best reflects your child's background:

_____African American _____Asian _____International _____Caucasian _____Other

_____Latino/Hispanic _____Native American _____Multiracial _____Middle Eastern

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:

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

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.

Screening	Result
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:

Greene Towne Montessori School
Civil Rights Compliance for Parents/Students

In accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as a parent/ student of this school, have the right:

> To be provided services at this agency and to be referred for services of other agencies 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, or sex

Complaints of discrimination may be filed with any of the following:

Greene Towne Montessori School
2121 Arch Street
Philadelphia, PA 19103

Department of Public Welfare
Bureau of Equal Opportunity
Room 521 Health and Welfare Building
PO Box 2675
Harrisburg, PA 17105-2675

Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office-Rm 1105B
1400 Spring Garden Street
Philadelphia, PA 19130

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

PA Human Relations Commission
711 State Office Building
1400 Spring Garden Street
Philadelphia, PA 19130

Parent Name:____

Parent Signature:____Date:____________________

Parent Name:____

Parent Signature:____Date:____________________