CHILD INTAKE FORM
2023-2024

Please select program location:

Philadelphia

☐ **Yaffe Center**
3975 Conshohocken Ave.
Philadelphia, PA 19131
Phone: 215-879-1000
Fax: 215-879-5051

☐ **Allegheny Center**
3111 W. Allegheny Ave
Philadelphia, PA 19132
Phone: 215-879-5010
Fax: 215-879-2196

Delaware County

☐ **Media**
468 North Middletown Rd.
Media, PA 19063
Phone: 610-565-2353
Fax: 610-565-5256

☐ **Marple**
85 N. Malin Road
Broomall, PA 19008
Phone: 610-565-2353
Fax: 610-565-5256

Bucks County

☐ **Brooks Center**
2901 Edgely Road
Levittown, PA 19057
Phone: 215-945-7200
Fax: 215-945-4073

Montgomery County

☐ **Gresh Center**
1161 Forty Foot Road, P.O. Box 333
Kulpsville, PA 19443
Phone: 215-368-7000
Fax: 215-368-1199

Child's Name: _____ **Date of Birth:** _____

Child's Address: _____

Ethnicity *(Please check):* We are required to ask for statistical purposes.

☐ Asian ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐ Unknow

Mother/Father/Guardian (please circle one)	Mother/Father/Guardian (please circle one)
Name: Relationship to child:	Name: Relationship to child:
Address:	Address:
Cell Phone: ☐ Emergencies only ☐ For other communications	Cell Phone: ☐ Emergencies only ☐ For other communications
Home Phone:	Home Phone:
Daytime Telephone:	Daytime Telephone:
Email Address:	Email Address:
Place of Employment/Occupation/Area(s) of Expertise:	Place of Employment/Occupation/Area(s) of Expertise:

Date form was returned to school office: _____

If your child is registered with your County MHIDD Office, please provide the BSU#: _____

Please identify any custody and/or visitation issues (Please Provide a copy of the agreement):
_____
_____

_____

What is your total household income? We are required to ask for statistical purposes and will be kept confidential.

_____ $0 to $29,999
_____ $30,000 to $59,999
_____ $60,000 to $89,999
_____ $90,000 to $129,999
_____ $130,000 to $150,000
_____ $150,001+
_____ Prefer not to answer.

How many household members? We are required to ask for statistical purposes and will be kept confidential.

_____ 1 – 3
_____ 4 – 6
_____ 7 – 9
_____ 10+

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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	DATE OF BIRTH
ADDRESS	
PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
PARENT'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 SITUATION
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 _____

WHITE COPY (Original) YELLOW COPY (Child Care Space) PINK COPY (Excursion) CY 867 10/22

AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT

In the event of an emergency requiring medical aid treatment, I authorize Easterseals to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the emergency treatment.

_____ _____

Signature of Parent/Legal Guardian Date

HEALTH INFORMATION

Please indicate any health concerns that might impact your child's day.

Vision: _____

Hearing: _____

Speech: _____

Other: _____

MEDICATIONS (include vitamins, laxatives, etc.)**:**

_____ _____ _____

_____ _____ _____

ALLERGIES AND REACTIONS (medications, foods, environmental)**:**

Allergy: Reaction:

_____ _____

_____ _____

EPI PEN: ☐ Yes ☐ No

SEIZURE DISORDER: ☐ Yes (Diastat ☐ Y ☐ N) ☐ No

PRIMARY PHYSICIAN/PEDIATRICIAN:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

PREFERRED HOSPITAL:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

SPECIALISTS:

Name: _____

Specialty: _____

Telephone: _____ Fax: _____

Name: _____

Specialty: _____

Telephone: _____ Fax: _____

Name: _____

Specialty: _____

Telephone: _____ Fax: _____

Please report any change of physician information to the school office.

GETTING TO KNOW YOU

Please write a brief description of your child's typical day: _____

_____

_____

What are his/her favorite toys, interests, and activities? _____

_____

_____

Who are the important people in his/her life? _____

_____

_____

Please describe his/her prior experience with children in a group setting: _____

_____

_____

What are your child's strengths? _____

_____

Please tell us a little about his/her progress with toileting: _____

_____

Does your child use any special words or signs to indicate s/he needs to use the bathroom? _____

_____

Does your child use any signs or gestures to communicate his/her basic needs and wants?

_____

What goals do you have for your child in preschool? _____

_____

_____

What family traditions, aspect of your culture and/or favorite customs would you like to share?

_____

Is there anything else you would like us to know about your child? _____

_____

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Public Relations/Photo/Video Release

Easterseals' mission is to change the way the world defines and views disability by making profound, positive differences in people's lives every day. Throughout the year, we will be sharing images of what we do and the amazing children we serve for marketing purposes.

Please respond to each of the questions regarding photos/videos:

Child's Name:
_____

I. I authorize Easterseals to photograph/take videos of my child for Easterseals publicity purposes (ie. Press releases, social media and marketing materials)

I authorize _____ I do not authorize _____

2. I authorize Easterseals to photograph/take videos of my child for internal purposes only (ie. Cubbies, schedules, and end of year celebrations).

I authorize _____ I do not authorize _____

Parent/Guardian Signature:_____

Date:_____

If you would like to receive email about Easterseals programs and news, please provide an email address.

_____

(email)

POLICY ON CHILD ABUSE REPORTING

Easterseals of Southeastern Pennsylvania supports and encourages all families in providing a healthy and safe environment for their children.

Easterseals of Southeastern Pennsylvania staff members are required by law to report if there is reasonable cause to suspect child abuse.

It is important to know that an Easterseals staff member does not need proof that abuse has occurred to take action. It is only required that the individual have reasonable cause to suspect abuse. Reasons for suspicion may include such things as:

- ✓ Observation of a child's physical appearance
- ✓ A child's verbal or non-verbal communications
- ✓ A change in a child's behavior (evidence of anxiety, withdrawal, fear, or agitation)

I understand Easterseals of Southeastern Pennsylvania is obligated by law to report the suspicions to the proper authorities.

_____ _____

Signature of Parent/Legal Guardian Date

NOTICE OF CONFIDENTIALITY

Files of all children are kept in a secured location, which is locked at the end of the day. Information kept in files is accessible to the child's parents/legal guardians and to Easterseals staff on a "need to know" basis. In other words, only the staff members who need to know this information to carry out their jobs responsibly will have access to the child's file. Each staff person who reviews a file, will document that access on a log sheet maintained with the files.

A "Release of Information" form must be signed by a parent or legal guardian in order for Easterseals staff to discuss the child's development with any person outside of the IFSP/IEP team members.

_____ _____

Signature of Parent/Legal Guardian Date

BICYCLE HELMET AUTHORIZATION

As many of our children are riding assorted vehicles, each child must wear a bicycle helmet as a safety precaution. This is in accordance with the Pennsylvania Bicycle Helmet Law, stating that all children under the age of 12 must wear a safety helmet when riding a bicycle or tricycle.

If possible, please send a bicycle helmet for your child to use at school. There are helmets for students to use if you are unable to provide one.

☐ I will provide a helmet for my child to wear at school

☐ My child will use the helmet provided at school.

_____
Child's Name

_____ _____
Signature of Parent/Legal Guardian Date

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, understand and agree that Easterseals of Southeastern Pennsylvania may use and disclose protected health information (including but not limited to name, address, health history, symptoms, examination and test results and treatment reports) for treatment, payment or other health care operations. I understand that I must consent to this use and disclosure to enroll in or receive services through Easterseals.

I understand and have been provided with a copy of the *"Your Information. Your Rights. Our Responsibilities."* document that provides a complete description of potential uses and disclosures of my protected health information. I understand that I have the right to review this document prior to signing this consent.

I understand that Easterseals reserves the right to change its privacy practices and will mail a copy of any revised notice to the address that I've provided.

I understand that I have the right to request that Easterseals restrict how protected health information is used or disclosed to carry out treatment, payment, or other health care operation. I further understand that Easterseals is not required to grant any request to restrict the use or disclosure of information. If, however, Easterseals agrees to a requested restriction, the restriction is binding on Easterseals.

I agree that I have the right to revoke this consent in writing, except to the extent Easterseals has already relied upon it.

_____ _____

Client, Parent or Personal Representative Signature Date

_____ _____

Witness Date

_____

Name of Individual to Receive Services

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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:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ 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	1 1 / 7 /	1 1 / 7 /	1 1 / 7 /	1 1 / 7 /	1 1 / 7 /	
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.

CD 51 09/08

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REFERRAL FOR PHYSICAL, OCCUPATIONAL, SPEECH, FEEDING THERAPY, NURSING and SOCIAL WORK SERVICES

Child's Name: _____

DOB: _____

TO BE COMPLETED BY PHYSICIAN:

I am requesting that _____ receive Occupational, Physical, Speech, Feeding, Nursing, and/or Social Work Services. I give permission for treatment if services are indicated as a result of an evaluation.

Physician's Signature: _____ Date: _____

Physician's License Number: _____

Authorization for services from _____ for one year unless otherwise designated.
(Date)

Special Precautions/Instructions:

_____

_____

_____

Physician's Mailing Address, Phone Number, Fax Number:

_____

_____

_____

_____

FOR YOUR INFORMATION

Easterseals of Southeastern Pennsylvania

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical and other confidential information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

SUMMARY --

Your Rights…..

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- File a complaint if you believe your privacy rights have been violated

Your Choices…..

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Include you in a school directory
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures…..

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address law enforcement and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical and/or student record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 10 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Include your information in a school directory

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Run our organization

We can use and share your health information to run our organization, improve your care, and contact you when necessary.

Bill for your services

We can use and share your health information to bill and get payment from governmental agencies, health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including governmental agencies if they want to see that we're complying with federal privacy law.

Address law enforcement and other government requests

We can use or share health information about you:

- For law enforcement purposes or with a law enforcement official
- With health and/or education oversight agencies for activities authorized by law

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective on January 1, 2013.

Questions and/or concerns regarding Easterseals privacy policies and procedures can be directed to:

Kimberley Brown-Flint
Director of Programs
Easterseals of Southeastern Pennsylvania
3975 Conshohocken Avenue
Philadelphia, PA 19131
215-879-1000
215-879-8424 – Fax
kflint@easterseals-sepa.org