

**GREATER PHILADELPHIA COMMUNITY ALLIANCE
FY 24 Rising 1st -8th Summer Achievers Program
REGISTRATION INFORMATION AND APPLICATION**

PLEASE READ CAREFULLY!!!

1. Registration application must be filled out COMPLETELY. All highlighted fields must be filled out. DO NOT write “same as above” in any section. DO NOT leave anything blank. Please WRITE N/A if something does not apply. Incomplete packets will not be accepted, and a spot will not be reserved until the packet is fully completed.
2. Applications must be handed in directly to the Site Director of the program. Applications should NOT be dropped off to the school or to school personnel. Parents are responsible for making sure the Site Director receives the application and confirms your child’s enrollment.
3. If you have your child’s most recent health assessment, please submit it to the Site Director. Health assessments should be provided before the start of the program. If you cannot provide one by the start date, please speak to a program Site Director.
4. Any questions regarding the program should be addressed to the program’s Site Director listed below.

**PROGRAMA DE VERANO DE LA ALIANZA COMUNITARIA DEL GRAN FILADELFIA
INFORMACIÓN DE REGISTRO Y SOLICITUD**

¡¡¡POR FAVOR LEA CUIDADOSAMENTE!!!

1. La solicitud de registro debe llenarse COMPLETAMENTE. Todos los campos resaltados deben ser llenados. NO escriba “igual que arriba” en ninguna sección. NO deje nada en blanco. ESCRIBA N/A si algo no se aplica. No se aceptarán paquetes incompletos y no se reservará un lugar hasta que el paquete esté completamente completado.
2. Las solicitudes deben entregarse directamente al Director de Sitio del programa. Las solicitudes NO deben entregarse en la escuela ni al personal de la escuela. Los padres son responsables de asegurarse de que el Director del sitio reciba la solicitud y confirme la inscripción de su hijo.
3. Si tiene la evaluación de salud más reciente de su hijo, envíela al Director del sitio. Las evaluaciones de salud deben proporcionarse antes del inicio del programa. Si no puede proporcionar uno antes de la fecha de inicio, hable con un director de sitio del programa.



Office Use Only
 Enrollment Date:
 City Span Date:
 Staff Signature:

FY 24 Rising 1st -8th Summer Achievers Enrollment Packet

Office Use Only

DHS Referral: Yes _____ No _____

Program Site: ___ Childs ___ Fell ___ Sharswood/Fell ___ Steel ___ Vare Washington

Parent: Please take the time to complete this application in full. Empty fields will result in your application being returned and your child’s enrollment being delayed. Your child’s spot will not be confirmed with an incomplete application. If a particular field does not apply to your child, please write in “N/A.”

Student Profile

Student Information:

PLEASE PRINT ALL INFORMATION CLEARLY

Youth’s Full Name: _____

Gender: Male Female Agender Bi-Gender Gender Non-conforming Date of Birth: _____ Age: _____

Street Address: _____

City & State: Philadelphia, PA Zip: 191 _____ Home Telephone: _____

School Name: _____ Student ID #: _____

Grade level during 2023-2024 School year: _____

Race: (check all that apply)

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White or Caucasian

Two or more races

Other (write in) _____

Ethnicity: (check all that apply)

Hispanic/Latino of any Race

Non-Hispanic

Not Disclosed

***Primary language spoken at home:** English other (write in): _____

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	CITY & STATE	ZIP CODE	
		191	
MOTHER'S NAME/LEGAL GUARDIAN	EMAIL ADDRESS	D.O.B	HOME PHONE NUMBER
ADDRESS	CITY & STATE Philadelphia, PA	ZIP CODE 191	
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS	CITY & STATE Philadelphia, PA	ZIP CODE 191	
FATHERS NAME/LEGAL GUARDIAN	EMAIL ADDRESS	D.O.B	HOME PHONE NUMBER
ADDRESS	CITY & STATE Philadelphia, PA	ZIP CODE 191	
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS	CITY & STATE Philadelphia, PA	ZIP 191	
EMERGENCY CONTACT NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER WHEN CHILD IS IN CARE	
1.			
2.			
3.			
NAME OF PERSON CHILD MAY BE RELEASED TO	RELATIONSHIP TO CHILD	ADDRESS	TELEPHONE NUMBER
1.			
2.			
3.			
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER	
ADDRESS			
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORAMTION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORAMTION ON SPECAIL NEEDS OF CHILD			
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENIFITS		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 PROCEDDURES	
X		X	
WALKS AND TRIPS		SWIMMING	
X		NO SWIMMING – DO NOT SIGN	
TRANSPORTATION BY THE FACILTY		WADING	
X		NO WADING – DO NOT SIGN	

PERIODIC REVIEW (Every 6 months)

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

*******Family Size & Income: (Means Test)**

Is the Child a U.S Citizen or qualified alien? ____ Yes ____ No

Does your family receive any of the following benefits?

- Cash Assistance
- S.S.I
- Food Stamps
- Medical assistance
- Medicaid
- Free or Reduced lunch
- No Benefits

Total Size of Household: _____ **Total Yearly Household Income:** _____

****** Does youth receive Therapeutic Staff Services (TSS)?**

- Yes (If yes, a mandatory meeting must be held with the parent, child, TSS worker and the site director.)
- No

****** Does youth receive Individualized Education Program (IEP) assistance?**

- Yes
- No

****** Does youth receive any Prevention Services Support?**

- City of Philadelphia DHS
- Truancy Case Management
- Family Empowerment Services (FES)
- Community Umbrella Agencies (CUA)
- No

Please use this space to specify any special needs your child may have:

Closing Statement:

I hereby certify that the statements in this application are correct and true. I understand that my child's enrollment as a student is based, in part, on the information provided within this application and my agreeing to the terms as outlined in writing by Greater Philadelphia Community Alliance.

PRINT NAME

SIGNATURE

DATE

AUTHORIZATION FOR RELEASE OF SCHOOL STUDENT RECORDS

This consent is valid for the 2024-2025 fiscal years, unless otherwise revoked by me in writing.

I, _____, Authorize the Philadelphia School District to
Parent/Guardian

Release additional school record regarding, _____,
_____ Student Name Date of Birth

to Greater Philadelphia Community Alliance employees of the following summer program sites: Sharswood, G.W. Childs and Arthur.

RECORDS TO BE RELEASED (CHECK ALL THAT APPLY)

Attendance records Health Records Students School ID Report Cards Student Profile

Do Not Authorize

Emergency Medical Care

Authorization

I hereby authorize the Greater Philadelphia Community Alliance employees to:

- Transport my child to a medical facility in case of an emergency.
- To render medical treatment and assistance to the student if such treatment should be necessary or desirable during the course of the program.

Authorize ← (CHECK ONE ONLY) → Do Not Authorize

UNITED COMMUNITIES MEDIA REALEASE CONSENT

I hereby give permission for my child, _____, to participate in academic enrichment activities sponsored by Greater Philadelphia Community Alliance. I agree that Greater Philadelphia Community Alliance is allowed to have photographs of my child(ren) taken as related to any academic and/or enrichment activity sponsored by the organization including, but not limited to, summer programs, after-school activities, and field trips. Such photographs may be used in promotional brochures, annual reports, and other reasonable circumstances that serve to enhance awareness of the program.

Agree ← (CHECK ONE ONLY) → Do Not Agree

Parent/ Guardian Signature

Date

CITY OF PHILADELPHIA AFTER SCHOOL PROGRAM DATA SHARING CONSENT FORM

Agency Name: Greater Philadelphia Community Alliance

Program Location: _____

Purpose:

The City of Philadelphia (the City) funds after school programs, also called “Out of School Time” (OST) through various city agencies and departments; other OST programs are funded and run by independent providers (collectively “OST programs”). When you enroll your child in an afterschool program, the City will collect information from you and your child and from OST programs and the School District of Philadelphia and store it in a secure centralized system, where it may be shared with other OST programs in order to help to manage the programs, provide academic assistance, publicize the programs, identify unused participant public benefits, as well as improve programming, services, and participant safety.

Process:

- When you sign up for an afterschool program, you will be asked to provide information about your child, including but not limited to his or her name, age, address, and other demographic information.
- OST program staff may also visit the program and talk to your child about being at that program and may also ask your child to complete short surveys about the program to learn more about the experience; these visits are a part of afterschool programs for every child and every afterschool site.
- Additional information may be added to your child’s file, including from the School District (if you agree) and other OST programs your child has attended including but not limited to: date of birth, gender, race, ethnicity, phone, ID, school name, grade, and attendance.

Information Privacy and Sharing of Information:

- The information that is collected about your child will be shared with staff at the afterschool program.
- In addition, the information about your child will be shared with approved City and OST program and administrative staff.
- If the City ever allows the information to be used for research or evaluation purposes, no identifying information about your child or your family will be shared.
- All of the information will be stored in a database that complies with requirements for managing student education records as set forth in the Family Educational Rights and Privacy Act (FERPA).
- Furthermore, the system is guarded by layered security protocols that prevents unauthorized persons from accessing the system. You also have the right to inspect and review documents collected and maintained in that system.

Consent to Collection and Use of Child’s Information:

- I give permission to the City Out of School Time program to collect, store, and share the information I provide on my child for use in the OST program as outlined above and for my child to complete programmatic surveys that may be shared with other OST programs.
- I give permission for the OST program to provide the School District of Philadelphia with information about my child’s attendance in the OST program for the purposes of programming for my child and overall program evaluation.
- I give permission for the OST program to check my child’s name against any public benefit databases run administered by or for the City for the purposes of locating additional benefits to which my child or family may be entitled.
- I give permission for the School District of Philadelphia to release my child’s educational reports to the OST programs that have need for it. The information to be released under this consent is: all records; grades, test scores; AIMS scores; attendance; and any other measurements of academic performance tracking programmatic progress. The information will be released for the following purposes: programming for my child and overall program evaluation.

If you do not give permission for the School District to release your child’s educational records, please initial here

- I give permission for the OST program to photograph, digitally record, videotape, or audio tape my child while s/he is participating in the OST program. I further agree that any material may be used in publications, promotional literature, or in other similar ways, and that such use shall be without payment of fees. I understand that any photographs, videotapes, or audio tapes shall remain the property of the City and that I do not have the right to prior approval of their use. I release and hold harmless the City of Philadelphia, the City OST program, OST providers and their officers, employees, and agents from all claims and causes of action that I or my child may have as a result of the use of my child’s photograph, videotape, or audio tape in connection with the program.

If you do not give permission for the OST program to use your child’s image, please initial here

- I understand that I may revoke this consent upon providing written notice to the OST program that my child attends. I further understand that until this revocation is made, this consent shall remain in effect and my educational records will continue to be provided to the OST program for the reasons described above.

ACKNOWLEDGEMENT AND SIGNATURE:

By signing below, I acknowledge that I have read and understand this OST Data Sharing Consent Form and agreement to have my child’s information shared as described above.

Child Name: _____
Child Address: _____
Parent Name: _____
Parent Signature: _____
Date: _____



Witness Name: _____
Witness Signature: _____
Agency: Greater Philadelphia Community Alliance

**The City of Philadelphia
Out-of-School Time Project
CONSENT TO RELEASE EDUCATION RECORDS UNDER FERPA**

Student Name: _____
Student ID #: _____

The Out-of-School Time Project (“OST”) is a Philadelphia effort to improve the well-being of children and youth through effective academic support, enrichment and youth development activities during non-school hours. OST programming provides safe, constructive activities to children when they are not in school, and has been demonstrated to improve in-school performance.

In order to assess and improve the quality of OST programs, The City of Philadelphia Department of Human Services (the “City”) asks for permission to collect personally identifiable information from education records regarding children’s school performance. The City will collect standardized test scores, report cards and school attendance, disciplinary and other relevant school records (“education records”). The City will use these education records to measure the impact of OST programming on children’s school performance and to improve the quality of those programs.

I am the parent or guardian of the student named above (“Student”). As authorized by applicable law, including but not limited to the Family Education Rights and Privacy Act, 20 U.S.C. 1232g, and 34 C.F.R. Part 99 (“FERPA”), I consent and authorize The School District of Philadelphia (the “School District”) to release education records concerning the Student, including confidential records of the School District, to the City’s Department of Human Services, the Public Health Management Corporation, and my Student’s OST program (“Recipients”).

The School District releases these education records in connection with the Student’s participation in an OST program. The School District may disclose these education records only to the Recipients, and the Recipients may share this information only with other named Recipients, and with the Recipients’ officers, staff, administrators and independent contractors under the Recipients’ control. The Recipients may use these education records to research, study or evaluate OST programs.

If I ask, the School District will provide me with a copy of the records disclosed.

FERPA and other applicable laws protect the confidentiality of and your right to privacy concerning the Student’s education records. The Recipients shall keep all information concerning the Student confidential and private to the fullest extent provided by applicable laws, including FERPA. Neither The School District nor the Recipients require me to waive any rights under these laws, and I give my consent voluntarily.

Parent/Guardian Signature (or Student’s signature, if Student is 18 years old or an emancipated minor)

Date: _____

Name of school in which Student is currently enrolled

Student’s Grade: _____

Greater Philadelphia Community Alliance

Name of Student’s OST Provider Agency

Student’s Date of Birth: _____

Name of Student’s OST Provider Location (School Name)

Client Rights & Responsibilities

The following is a summary of the policies of Greater Philadelphia Community Alliance in regards to client rights and responsibilities. This document, and/or a summary of key points, will be displayed publically at all Greater Philadelphia Community Alliance sites and provided to any clients accessing services through the agency. A client is assumed to be any individual at least 18 years of age; Greater Philadelphia Community Alliance will not provide services to minors without the expressed consent of a parent/guardian.

Normal business hours for Greater Philadelphia Community Alliance are 9am-5pm Monday through Friday. All federal and state holidays are observed. Certain programs operate alternate hours as determined by program schedule. For client convenience, appointments may be scheduled outside of normal business hours on an as-need basis and according to staff availability. All agency closings due to weather will be posted on www.myfoxphilly.com and announced via the local Fox TV station.

<u>Client Rights</u>	<u>Client Responsibilities</u>
<ol style="list-style-type: none"> 1. You have the right to fair treatment and not be discriminated against by reason of race, color, religion, national origin, sex, age, sexual orientation, physical ability, or primary language. 2. You have a right to have information communicated to you in your primary language in either oral or written format, whichever is most appropriate. 3. You are an active partner in developing service plans as appropriate to the programs in which you participate. You have a right, along with other family members, to make decisions regarding your service plan. You have the right to refuse services offered and discontinued at any time, and to be notified in advance of any potential consequences. 4. You have a right to protection of confidential information in accordance with Greater Philadelphia Community Alliance policies on confidentiality and privacy, which can be provided upon request. You are guaranteed confidential service according to the following principals: You are the primary source of information. Information about you or your family will only be shared within the organization on a need-to-know basis. Other organizations will only be given information with your expressed consent. Exceptions include professionals conducting audit reviews and authorities where a legal report is mandated by law as in cases of suspected child abuse, domestic violence, elder abuse or threats of violence to self or others. The agency may refer clients to external research studies but will not directly provide confidential client information or data to outside agencies or universities. 5. You have a right to revoke any authorization to obtain or release information about you or your family, with the exception as noted above. 6. You have a right to access your records unless deemed harmful or prohibited by law, and to add additional information and statements. Requests for records should be made directly to the program supervisor. 7. You have a right to be informed in advance of Greater Philadelphia Community Alliance discontinuance of services and the reasons for any discontinuation. Generally, Greater Philadelphia Community Alliance will discontinue services if you consistently fail to keep appointments, fail to comply with individual program requirements, if services are deemed inappropriate, or if you violate any general policies of Greater Philadelphia Community Alliance in regards to safety, etc. You have a right to request information about alternate services if Greater Philadelphia Community Alliance cannot or will not service you. 8. You have a right to work with a trained service provider who is supervised by qualified staff according to the requirements of the program you are engaged with. 9. You have a right to be fully informed of all charges and payment procedures for services rendered. All services at Greater Philadelphia Community Alliance are provided free of charge except certain services within the Housing and Out-of-School-Time programs, which will inform all potential clients in advance of any fees associated with the service. 10. You have a right to register complaints about any aspect of the services provided by Greater Philadelphia Community Alliance. Any complaints should first be discussed with the staff member you are working with, and if necessary, the program supervisor. If you are dissatisfied with the response, you may file a formal grievance with the Executive Director. The process for filing a formal grievance is available upon request from the program manager. Should you make a complaint, you have a right to a copy of the grievance procedure and a written response. A civil rights grievance process is also available; information will be provided upon program intake or upon request. 	<ol style="list-style-type: none"> 1. You are asked to collaborate in any service planning and provide a signature indicating agreement with plans made. Services cannot be provided without such an agreement. 2. You are asked to cooperate in and follow through as needed according to any service plan. 3. You have a responsibility to attend all appointments as scheduled. If cancellation is necessary, it is your responsibility to do so at least 24 hours in advance of the appointment. 4. You are required to conduct yourself in a safe manner, which includes not bringing weapons or being under the influence of illegal substances on the premises. It is a policy of Greater Philadelphia Community Alliance to treat all individuals with dignity and positive approaches. Physical restraint interventions are not used with any clients over the age of 14 and only brief holdings may be used in emergency situations with any Out of School Time youth under 14. However, the police may be notified immediately of any individual who is perceived through their behavior to be a safety threat to others and/or refuses to vacate the premises. 5. You are asked to participate in Greater Philadelphia Community Alliance evaluation of services, which may include a follow up contact with you regarding the effectiveness of services provided. Your identity will be protected as much as possible during any evaluation of services. Your refusal to participate in any evaluation will not affect the quality of services offered to you. Should you decline, please notify program staff. 6. You may be asked to adhere to additional program standards as outlined during the intake process of that particular program. <p style="margin-top: 10px;"><i>Any Greater Philadelphia Community Alliance staff member or volunteer is a Mandated Reporter. If a Greater Philadelphia Community Alliance staff member or volunteer has reason to believe that any individual may harm themselves or another person, s/he will contact the appropriate authorities to ensure safety for all. If a Greater Philadelphia Community Alliance employee or volunteer has reason to believe that a child may be a victim of child abuse (including neglect), s/he will report to the Dept. of Human Services in order to protect the safety of the child.</i></p> <p>Consent: I give permission to receive services provided by Greater Philadelphia Community Alliance and acknowledge that I have read and understand Client Rights and Responsibilities.</p> <p>Client's Name (Print): _____ D.O.B.: _____</p> <p>Signature: _____ Date: _____</p> <p>Staff/Witness Signature: _____ Date: _____</p> <p><i>(If Applicable) I give permission for my child/ren to receive services from Greater Philadelphia Community Alliance</i></p> <p>_____ Parent/Guardian Signature _____ Date: _____</p> <p><i>(Optional) I consent for the following individual to receive information about my case from Greater Philadelphia Community Alliance:</i></p> <p>_____ Name _____ Relationship _____</p>

AGREEMENT

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

NAME OF CHILD			
FEE AMOUNT \$	FREE	PER-DAY-WEEK N/A	DAY PAYMENT TO BE MADE N/A
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)			
Activities include but are not limited to academic enrichment (STEAM, PBL, SEL, Literacy), sports & fitness, healthy living, special events and trips.			
CHILD'S ARRIVAL TIME 3pm	CHILD'S DEPARTURE TIME 6pm	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED	
LATE FEE \$	\$10 first 15 mins Plus \$1/min after 15 mins	1. 2. 3.	
Extra services to be provided at an additional fee if applicable			
N/A			

I, the parent/guardian;

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-OPERATOR

DATE

SIGNATURE-PARENT OR GUARDIAN

DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN

DATE

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:
<input type="checkbox"/> 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/ID						
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.

This form must be filled out and returned or the child's most recent health assessment must be submitted. Please note shot records cannot be used as a health assessment. You must have a complete health assessment.