St. Thomas Kids Daycare Preschool Inc.

Date of Application _____ Desired Enrollment Date _____
Child's Name _____ Date of Birth/ Due Date _____
Parent/ Guardian Name(s) _____
Address _____
Phone Contact(s): Home _____ Work _____ Cell _____
Email _____ **Emergency Contact** _____

Are you CCW eligible? (200% poverty level?) ☐ **Yes** ☐ **No**

Monthly Tuition Rates Effective the Start of September 2026.			
Classroom	**Classroom**	**Classroom**	**Classroom**
Nursery (6 weeks old)	**Younger Toddlers** (1 year old by Sept. 1st)	**Older Toddlers** (2 years old by Sept. 1st)	**Pre- K** (3-4 years old by Sept. 1st)
Schedule	**Schedule**	**Schedule**	**Schedule**
☐ **5 Days/Week** Full Day - **$1,450**	☐ **5 Days/Week** Half Day - **$950** Full Day - **$1,400**	☐ **5 Days/Week** Half Day - **$900** Full Day - **$1,300**	☐ **5 Days/Week** Half Day - **$870** Full Day - **$1,135**
☐ **4 Days/ Week** Full Day - **$1,210**	☐ **4 Days/ Week** Half Day - **$805** Full Day - **$1,150**	☐ **4 Days/ Week** Half Day - **$765** Full Day - **$1,090**	☐ **4 Days/ Week** Half Day - **$680** Full Day - **$955**
☐ **3 Days/ Week** Full Day - **$965**	☐ **3 Days/ Week** Half Day - **$660** Full Day - **$920**	☐ **3 Days/ Week** Half Day - **$630** Full Day - **$875**	☐ **3 Days/ Week** Half Day - **$570** Full Day - **$830**

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival					
Departure					

Hours of Operation: 8:00 am -5:00 pm

Priority full-week (5 day/week) enrollment:

- initial registration fee $100 single/family
- re-enrollment fee $100 (i.e. summer withdrawal and fall re-enrollment)
- no annual registration for year-round enrollment
- sibling discount 5% each child.
- morning & afternoon snack provided
- breakfast provided by parent(s)/guardian(s) BEFORE arrival. Daily packed lunch provided by parent(s)/guardian(s).
- tuition rates are subject to change.

Admission, the provision of services and the referrals of clients to St.Thomas Kids Daycare and PreSchool shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency, age or sex.

St. Thomas Kids Daycare Preschool Inc.

Parent / Center Contract

Child(ren) Name(s): _____

- I have read the St. Thomas Kids Family Handbook and agree to comply with all policies and procedures.
- I agree to follow the agreed scheduled drop-off and pick-up times listed below. Late fees may be applied. Any corrections and/or adjustments need to be made by the director.
- I agree to pay the initial registration fee of 100 single/family.
- I agree to the monthly tuition rates effective September 2026. Tuition must be paid in full on the 1st of each month or can be split into two payments (First half of payment made on the 1st of the month and the second payment on the 15th of each month).

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival					
Departure					
Hours of Operation: 8:00am-5:00pm					

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Director Signature: _____ Date: _____

AGREEMENT

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

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE Monthly

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

care

snacks

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $	PER MIN-HR	

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 minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE

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 _____

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:

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.

St. Thomas Kids Daycare Preschool Inc.

Shaken Baby, Abusive Head Trauma, and Child Maltreatment Policy

This policy is designed to prevent, recognize, respond to, and report instances of Shaken Baby Syndrome or Abusive Head Trauma, and Child Maltreatment. We at St. Thomas Kids Daycare Preschool Inc., believe that preventing, recognizing, responding to, and reporting shaken baby syndrome and abusive head trauma (SBS/AHT) is an important function of keeping children safe, protecting their healthy development, providing quality child care, and educating families.

Procedures and Practices

Recognizing Symptoms Children are observed for the following signs and symptoms of SBS/AHT:

- Irritability and/or high-pitched crying
- Vomiting
- Lack of appetite
- Seizures
- Bruises on upper arms, rib cage, or head
- Poor feeding or sucking
- Lack of smiling or vocalizations
- Difficulty staying awake
- Difficulty breathing and/or blue color due to lack of oxygen
- Inability to lift the head
- Unequal pupil size

Response if SBS/AHT is suspected, employees will:

- Call 911 immediately upon suspecting SBS/AHT and inform the director.
- Call the parents/guardians.
- If the child has stopped breathing, trained staff will begin pediatric CPR[4].

Prevention strategies to assist staff in coping with a crying, fussing, or distraught child:

Staff first determines if the child has any physical needs such as being hungry, tired, sick, or in need of a diaper change. If no physical need is identified, staff will attempt one or more of the following strategies[5]:

- Rock the child, hold the child close, or walk with the child.
- Stand up, hold the child close, and repeatedly bend knees.
- Sing or talk to the child in a soothing voice.
- Gently rub or stroke the child's back, chest, or tummy.
- Offer a pacifier or try to distract the child with a rattle or toy.
- Take the child for a ride in a stroller.
- Turn on music or white noise.
- Other _____

Recognizing Child Maltreatment:

- Obvious malnourishment or fatigue
- Stealing or begging of food
- Lack of personal care, hygiene, torn or dirty clothing
- Untreated medical, dental, eye care needs
- Frequent absence or tardiness to school
- Child inappropriately left unattended or without supervision

Prevention of Child Maltreatment

- Knowing the signs and reporting abuse
- Supporting families
- Creating a safe environment for the child
- Educating and supporting parents
- Educating youself
- Being a nurturing parent/guardian
- Changing social norms
- Supporting prevention programs

In addition, the facility:

- Allows for staff who feel they may lose control to have a short, but relatively immediate break away from the children[6].
- Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.
- Other _____

Prohibited Behaviors:

Behaviors that are prohibited include (but are not limited to):

- shaking or jerking a child
- tossing a child into the air or into a crib, chair, or car seat
- pushing a child into walls, doors, or furniture

Strategies to assist staff members understand how to care for infants:

Staff reviews and discusses:

- The five goals and developmental indicators in the 2013 North Carolina Foundations for Early Learning and Development, ncchildcare.nc.gov/PDF_forms/NC_Foundations.pdf
- How to Care for Infants and Toddlers in Groups, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/77-how-to-care-for-infants-and-toddlers-in-groups
- Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy, the Network of Infant/Toddler Researchers, pages 7-9, www.acf.hhs.gov/sites/default/files/opre/nitr_inquire_may_2016_070616_b508compliant.pdf

Parent Web Resources:

- The American Academy of Pediatrics: www.healthychildren.org/English/safety-prevention/at-home/Pages/Abusive-Head-Trauma-Shaken-Baby-Syndrome.aspx
- The National Center on Shaken Baby Syndrome: http://dontshake.org/family-resources
- The Period of Purple Crying: http://purplecrying.info/

Parent or Guardian Acknowledgement:

I acknowledge that I have read this Shaken Baby Syndrome/Abusive Head Trauma/Child Maltreatment Policy. I acknowledge that a copy of this policy is available to me.

Parent/Guardian Signature:_____ Date:_____

Parent Signature Form

The Family Handbook for St. Thomas Kids

I have received a copy and read the Family Handbook for St. Thomas Kids. I understand and acknowledge the information provided. I understand that the Family Handbook is subject to revision at any time, at the discretion of the director and members of the board.

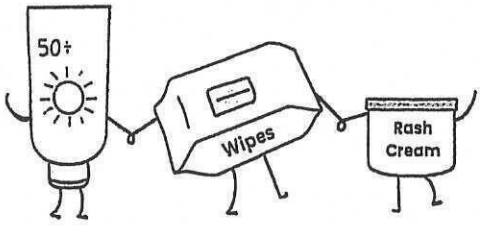
Name_____

Signature_____

Date_____

Parental Authorization for Non-Prescription Medication

Child Information



Name : _____

Date of birth: _____

Non-Prescription Medication Supplies

Please note you are responsible for providing the products necessary for authorizing the care of your child, and these products should be submitted in their original containers, accompanied by specific instructions.

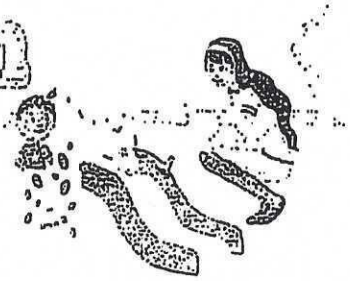
Product		
Diaper Rash cream	yes	no
Baby wipes	yes	no
Sunscreen	yes	no
Saline Nasal Solution	yes	no
Other :	yes	
Other :	yes	

Duration of Authorization: This authorization will remain in effect until the conclusion of the child's attendance.

Parent / Guardian Signature: _____

Signature date: _____

Photo Release Form



I, _____ , the parent or legal guardian of _____
PARENT/GUARDIAN NAME CHILD'S NAME

grant _____ permission to use photos of my child,
CENTER NAME

and agree to the following:

I understand that my child, whose name is listed above, may be photographed at the center during normal daycare hours, field trips or activities. I understand that these photographs may be used in promoting child care services in either print or on the Internet.

With my signature below I grant permission for my child to be photographed, or their images recorded for print or electronic use in promoting the Center's services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

_____
PARENT/GUARDIAN SIGNATURE

_____
PARENT/GUARDIAN NAME

_____
CHILD'S NAME

_____
PHONE NUMBER

_____
DATE