Marple Sports Arena
611 S. Parkway Blvd. Broomall PA 19008
610-338-0111 X1

AFTERSCHOOL ENROLLMENT

Pick Up	Yes	No

FAMILY INFORMATION

Parent/Guardian #1

Last Name First Name Mi

Relation

Address

City State Zip

Home Phone Work Phone

Cell Phone Email

Parent/Guardian #2

Last Name First Name Mi

Relation

Address

City State Zip

Home Phone Work Phone

Cell Phone Email

CHILD INFORMATION

First Child

School

Months After School Care Needed (circle)

S O N D J F M A M J

Last Name First Name Mi

Gender Grade Birth Date (m/d,/y)

Emergency Contact 1 (other) Phone Pick Up Y N

Emergency Contact 2 (other) Phone Pick Up Y N

Dr.'s Name Phone

Insurer Provider Policy #

Last Phys. Allergies/Spec. Accomodations

Second Child

School

Months After School Care Needed (circle)

S O N D J F M A M J

Last Name First Name Mi

Gender Grade Birth Date (m/d,/y)

Emergency Contact 1 (other) Phone Pick Up Y N

Emergency Contact 2 (other) Phone Pick Up Y N

Dr.'s Name Phone

Insurer Provider Policy #

Last Phys. Allergies/Spec. Accomodations

* If additional people are authorized to pick up your child/children, please attach a list. It is your responsibility to notify your child(ren)'s school of the days that your child(ren) will be attending **MSA.** You also must notify MSA when your child(ren) will be absent from **Marple Sports Arena.**

EMERGENCY AUTHORIZATION

State law requires that we have written authorization from a child's legal guardian to seek medical help in the event of a medical emergency. Signing the statement at the bottom of this letter will provide us with that authorization. Our policy, in the event of a medical emergency, is to contact you first. If we can't contact you, we will try to contact any others you may designate. In the event that we are unable to contact you or your designated representative(s), or if the medical emergency warrants immediate response, we will act on your behalf and in the best interest of the child. By signing below, I agree that I have received and read a Marple Sports Arena handbook. I further agree to follow the policies, procedures, and practices placed before me within the Marple Sports Arena Handbook.

Please Sign Here: _____ **Date:** _____

OFFICE USE ONLY

Reg. Fee $_____ **First Day School:**_____ **Time School Dismissed:**_____

Tuition $_____ **Enrolled By:**_____ **Grade:**_____

Before and/or After Care Agreement

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

NAME OF CHILD:		SCHOOL:
FEE AMOUNT:	Per Month Due 1st	Payment due 1st of Month-late fees assessed on 6th
Before Care: $209 ☐	After Care $260 ☐	Before & After Care $439 ☐

Services to be provided as part of the fee:

Transportation to MSA (After Care)
Morning and/or Afternoon Snack and Drinks
Individual Homework Help (After Care)
Supervised Activities
Transporation to school (Before Care)
Early dismissal included w/After Care-pack lunch
School Holiday Camps @ $35

School Dismissal Time:	School Start Time:	Latest parent pick up 6:30pm- Late fee $1 per minute after 6:35pm

Person(s) authorized to pick up your child:

Three month minimum enrollment required. One month is required to cancel.
Failure to report your child's absense($10)- Late fee $25 if not paid by 5th,second late fee on 11th

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/Guardian Date:

Date of Child's Admission:	Periodic Review	
	Initial & Date	Initial & Date
Date of Withdrawal:	Signature-Parent/Guardian	Date

Transportation Authorization

Before and/or After School Program:

I hereby grant permission for my child to be transported ***to or from*** his/her school by ***the Marple Sports Arena*** staff.

_____
(Name of Child)

_____
(Name of School)

_____
(School Dismissal/Pick up Time- After Care only)

_____
(School Start Time-Before Care only)

_____
(Start Date)

_____
(Parent Signature)

After Care only: Please remember that it is your responsibility to notify us before Noon if your child is absent from school. This is important so that our bus drivers do not waste time waiting for your child as they are on a tight schedule.

Please notify by ***email*** or call 610.338.0111 x1

Patricia Henning phenning@marplesportsarena.com

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 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.