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	BIRTH DATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE 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 REACTIONS)
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)

PARENTS 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.

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Application

Child's Name:_____ _____
First Middle Last Nickname

Birth date:_____/___/_____ Sex: ____Male _____Female

Home Address:_____Zip:_____ Phone:_____

Mother's Name:_____

Home Address:_____Zip:_____Phone( )_____

Work Address:_____Zi:_____Phone:_____

Occupation:_____Marital Status: _____M _____S

Father's Name:_____

Home Address:_____Zip:_____Phone( )_____

Work Address:_____Zi:_____Phone:_____

Occupation:_____Marital Status: _____M _____S

PERSONS TO BE CALLED IN CASE OF EMERGENCY:

NAME:_____RELATIONSHIP TO CHILD:_____

ADDRESS:_____ZIP:_____PHONE:_____

NAME:_____RELATIONSHIP TO CHILD:_____

ADDRESS:_____ZIP:_____PHONE:_____

CHILD'S PHYSICIAN: DR._____PHONE: _____

HEALTH INSURANCE COVERAGE:_____POLICY/ID NO._____

Please list any allergies, medications, handicaps or other notes that staff should be made aware of:_____
_____

Application Date:__/__/__ Enrollment Date:__/___/__ Withdrawal Date:__/__/__

Parent's Signature:_____ (over please)

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Application

PARENT PERMISSION

I Hereby grant permission for my child, _____to use all the play equipment and participate in all of the activities of the school. I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks, or for field trips in an authorized vehicle.

Does your child require any special care while being transported (i.e. seizures, motion sickness)? Please give instructions for special care:

_____

_____

_____

I hereby grant permission for the Director, or Acting Director to take whatever steps are necessary to obtain emergency medical care if warranted.

Signed:_____, Mother Date:___/___/_____

Signed:_____, Father Date:_____/___/_____

The Mt. Washington Children's Center admits students of any race, color, national and ethic origin to all the rights, privileges, programs

CHILD AND ADULT CARE FOOD PROGRAM
INFANT ENROLLMENT FORM

Directions: This enrollment supplement must be completed for all infants in care at the time of enrollment to determine responsibility for providing infant formula as part of the Child and Adult Care Food Program (CACFP). Please have the parent sign and date two forms. Send one to your sponsoring organization and keep the other as part of the infant's enrollment file.

Infant Name: _____ Date of Birth: _____

Home/Center Site: _____

Home/Center will offer the following iron-fortified formula: _____

PARENT CHOICE: (Please check one)

_____ The Center/Home will furnish infant's formula.

_____ The Parent will furnish the infant's formula/breast milk.

_____
Indicate Type of Formula or Breast Milk

If the above type of formula does not meet CACFP requirements, please attach a copy of the physician's medical statement recommending this type of formula.

Are there any special circumstances or conditions indicated by the infant's physician?

_____

_____

_____

As the parent of the above-named child, I understand that I may change my decision regarding furnishing infant formula with proper notice.

_____ _____
Parent's Signature Date

_____ _____
Signature of Center Director/Home Provider Date

Mt. Washington Children's Center Infant Menu

(6 weeks to 12 months)

Child's Name:_____ Date of Birth:_____

Please circle and initial all items that the Center can feed your child:

MEAT	CEREAL	VEGETABLES	FRUITS	SNACKS
Chicken	Rice	Carrots	Pears	Cracker
Beef	Oatmeal	Sweet Potatoes	Peaches	Fruit
Ham		Mixed Vegetables	Apple Sauce	Cheerios
		Green Beans	Banana	
		Squash		
		Peas		

My Child is allergic to the following food:_____

FORMULA – *Please complete choice one or choice two:*

1. I will provide my own formula/breast milk. I understand that I must provide 4 - 6 8oz bottles daily to meet the Child Care and Adult Care Food Program Infant Meal Pattern minimum daily requirements. **I also understand that Mt. Washington Children's Center will not feed my infant formula with cereal mixed in it without specific doctor's instructions in writing.**

   _____I will provide breast milk. I will provide _____formula.

2. I want the Center to provide **Carnation Good Start with Iron. I understand that I must provide at least 4 clean bottles and nipples every day.**

I understand that Mt. Washington Children's Center is required to follow the Child and Adult Care Food Program Infant Meal Pattern, which I have received a copy of, and cannot and will not vary from this pattern. I also understand that any additional foods I want my child to have I will provide.

Parent's Signature: _____ Date: _____

Directors Signature: _____ Date: _____

ELN Child & Family Information

Child Demographics

Child's First, Middle, and Last Name:_____

Ethnicity:_____Hispanic ___Non Hispanic ___Other

Race: Please check all that apply
__American Indian/Alaskan Native ___Asian __White
_____AfricanAmerican/Black ___Native Hawaiian/Pacific Islander
__Other
Gender: _____Female ____Male

Date of Birth: ___/____/_____

Last 5 digits of Social Security Number:_____
Is English the first language of the child _____Yes _____No

Parent/Legal Guardian Information

Mother/Legal Gaurdian's First, Middle, and Last Name_____
Date of Birth:_____

Relationship to child:____ Biological____ Adoptive __Foster__Stepparent__Other__
Does mother/legal guardian have custody of the child? Y N (please circle)

Does child live with mother/legal guardian? Y N Part of the time

Mother/legal guardian street address:_____

City:_____State:_____Zip Code:_____

County:_____School District:_____

Phone Number:_____Email Address:_____

Child Health Information:

Child's birth weight:____Normal (5.8 lbs. or greater) ___Low (between 3.4/5.7 lbs.)
Very low (less than 3.4 lbs.)_____ _____Unknown

What type of insurance does the child currently have? ____CHIP ____Medical Assistance _____Private Insurance ____None __Unknown

Has a doctor diagnosed the child with any of the following? _____Anemia __Asthma ____Diabetes ____Obesity ___None

Based on the American Academy of Pediatric Standards, are the child's immunization up to date? Y N (please circle)

Does the child see a physician regularly? Y N
Does the child see a dentist regularly ? Y N

Household Information

How often do the members of the household read to the child?____At least once a day ___At least once a week ___At least once a month __Less than once a month

How many children's books are in the home (may include library books)? __fewer than 5 ___5-10 __11-20 __More than 20

Is the child homeless? Y N
Is the child adopted ? Y N

How many siblings (related by blood, marriage, or adoption) reside in the child's household?_____

Including the child, how many people live in the household?_____

In the household, how many people are over the age of 18?_____

Language(s) spoken in the home:_____/_____/_____

What is the annual household income level? ___$5,000 or less

__10,001-15,000 __15,001-20,000 ___20,001-25,000 ___25,001-30,000

__30,001-$35,000 ___35,001-40,000 ___40,001-45,000 ___45,001-50,000

__50,001-60,000 ___60,001-70,000 ___70,001-100,000 ___over 100,000

Mother/legal guardian's highest level of education:
__Up to 8th. Grade __9th-11th grade __High School Diploma/GED/Vocation Tech Program after high school __Some College __Associates Degree __Bachelors Degree __Graduate/Professional degree

Mother/Legal guardian employment status: (please check all that apply)

___Full Time (30 hrs/week and over) ___Part time (fewer than 30 hrs/week)

___More than one part time __Seasonal __Full time Student __Part time Student

__Unemployed

Father/Legal Gaurdian's First, Middle, and Last Name_____
Date of Birth:_____

Relationship to child:____ Biological____ Adoptive __Foster__Stepparent__Other__
Does mother/legal guardian have custody of the child? Y N (please circle)

Does child live with mother/legal guardian? Y N Part of the time

Mother/legal guardian street address:_____

City:_____State:_____Zip Code:_____

County:_____School District:_____

Phone Number:_____Email Address:_____

Father/legal guardian's highest level of education:
__Up to 8th. Grade __9th-11th grade __High School Diploma/GED/Vocation Tech Program after high school __Some College __Associates Degree __Bachelors Degree __Graduate/Professional degree

Father/Legal guardian employment status: (please check all that apply)

___Full Time (30 hrs/week and over) ___Part time (fewer than 30 hrs/week)

___More than one part time __Seasonal __Full time Student __Part time Student

__Unemployed

Which of the following outreach activities has any member of the household received in the last year? *Please check all that apply*

___Emergency/Crisis Intervention ___Housing Assistance (subsidies, utilities, etc)

__Transportation Assistance ___Mental Health Services __English as a Second

Language ___Job Training ____Substance Abuse Prevention or Treatment

___Domestic Violence Services ____Health Education ____Marriage Education

____Child Abuse and Neglect _____Parenting Education ___Assistance to Families of

Incarcerated Individuals ___Assistance in obtaining health insurance ___Assistance

In identifying health care providers ___Unknown ___None ____Child Support

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

INFANTS
0-12 Months

Name _____ Date of Birth_____

Basic Development

How old is your baby?_____ Does she / he hold head steady?_____ If an object is placed in front of your baby, does she/he look at it? _____ reach for it? _____ Hold it? _____

Age when baby began: rolling over _____ sitting _____ crawling _____ standing_____ walking _____

Is your baby a good climber? _____ Does she/he fall easily?_____ Does your baby babble or coo? _____

Does your baby cry a lot?_____Does your baby say any words yet? _____ What are they? _____

Eating Habits

What is your baby's eating schedule? _____

_____

Is your baby breast fed or bottle fed?_____Is there a specific kind of milk or formula that you give your baby? _____

If breast fed, what arrangements have you made about day care? _____

How many teeth does your child have to date? _____ Is she/he eating any solid foods _____

What kind? _____

If taking solids: What are your baby's favorite foods? _____

What foods are refused? _____ Does your baby have any eating problems? (colic, spitting up etc.) _____

Have you found any food allergies? _____

over

Toileting

What type of diapers do you use? _____Does your baby get frequent diaper rash? _____

Do you use oil? _____ powder? _____ lotion?_____ cream?_____ other?_____

Is your baby's skin highly sensitive? _____ Are bowel movements regular? _____

How many per day? _____ What time? _____ What words do you use for bowel movement? _____ urination? _____

Sleeping Habits

How do you know when your baby is tired? _____

Does she/he nap during the day?_____ from _____ to _____and _____to _____ what is your baby's sleeping schedule at night? _____

How do you get your baby to sleep? _____

Does your baby sleep in a crib? _____ Does she/he have any problems with sleeping? (light sleeper, crying out etc.) _____

_____

Does your baby prefer to sleep on his/her back or stomach? _____ Does she/he usually cry before going to sleep? _____

For how long? _____

Social Relationships

Does your baby smile? _____ Does your baby fear strangers? _____ Does your baby like to be held and cuddled? _____

By nature is your baby: Friendly?_____ Aggressive? _____ Shy _____ Withdrawn? _____ Independent? _____

Does your child need special attention from adults? _____ Has your child had experience with other children? _____

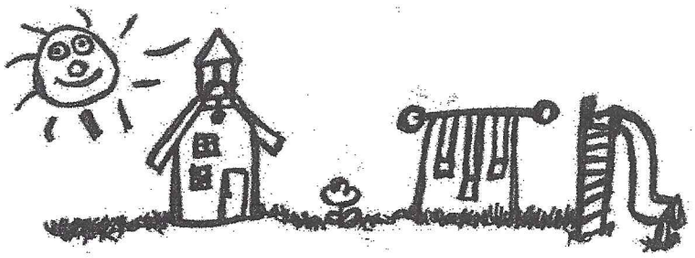
What makes your baby angry or upset? _____ How does she/he express this? _____

How do you deal with it? _____

Is there anything special you would like use to know about your baby that hasn't been covered by this form? _____

_____

_____



In response to the growing focus on child care issues, specifically concerning the liability and insurance, the Board of Directors of Mt. Washington Children's Center has expanded the Department of Public Welfare's policy concerning the release of children to parents or other designated adults who appear to the center's staff to be in an impaired condition.

An impaired condition specifically relates to alcohol, mind-altering chemicals or other medical conditions that render a person unable to operate a motor vehicle and thereby endanger the safety of the child who would be transported by the impaired person.

If, in the judgment of the responsible personnel at the center, a parent or designated person appears to be unable to safely transport a child, the center personnel will ask the parent or designated person to arrange for alternative transportation. If the person is unwilling to provide such alternative transportation, the matter will be referred to the Pittsburgh Police before the child is released for transport.

The board recognizes that this is a stringent policy, but we are morally and perhaps could be even legally responsible if we would release a child to an impaired person.

Hopefully, the necessity to implement the policy will not arise, but should it, cthe parents/designated person must be apprised of the policy.

This will be an addendum to the Policy and Practice of the Mt. Washington Children's Center which is in your child's school file.

Please sign and return this paper to the center as soon as possible to avoid misplacing it.

_____
Mother 's Signature

_____
Father's Signature

_____
Guardian Signature

MOUNT WASHINGTON CHILDREN'S CENTER
200 Southern Avenue, Pittsburgh, PA 15211
412-381-1515
mwcc15@yahoo.com

MT. WASHINGTON CHILDREN'S CENTER
200 SOUTHERN AVENUE
PITTSBURGH, PA. 15211

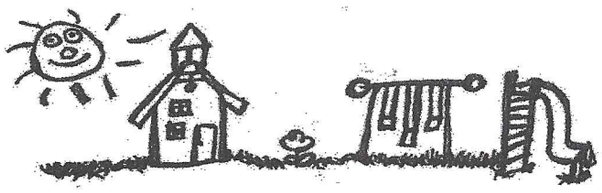
I give my permission to the Mt. Washington Children's Center staff to apply

Sunscreen _____
Lotion _____
Diaper Cream _____

To: _____
Child's Name

Items must be supplied by parents.

_____ _____
Signature Date



PARENT HANDBOOK CONFIRMATION FORM

I, the undersigned, understand what I have read and agree to the policies and procedures as written in the Mt. Washington Children's Center Parent Handbook to ensure the health and wellbeing of my child(ren), other children in care, and those responsible for their childcare.

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

THIS FORM MUST BE SIGNED IN ORDER TO ENTER THE PROGRAM.

MOUNT WASHINGTON CHILDREN'S CENTER
200 Southern Avenue
Pittsburgh, PA 15211
Ph. 412-381-1515

Mt. Washington Children's Center has prepared an emergency evacuation plan for our facility. The plan outlines procedures for site evacuation, severe weather, and security incidents. This plan is posted in each classroom if you would like to read it in its completed form. Below is an outline of how the MWCC children will follow the plan for the defined emergencies:

Site Evacuation- The Center is evacuated in the event of a fire, gas leak etc. either at the site or in its close proximity to the site which require evacuation of our site.

- We evacuate to the St. Justin's Plaza 120 Boggs Avenue
- Children will walk to the site. The Director will coordinate that portion of the evacuation.
- Attendance records will accompany the class and head counts will be taken prior to leaving the site and upon relocation.
- Parents will be notified as soon as the children have been safely relocated

Severe Weather- In the event that a Sever Weather /Tornado Warning is broadcast as an imminent danger to the MWCC the following action will be taken:

- All personnel will be notified to take shelter in the designated area. Our designated area is the hallway, bathrooms, and Directors office. All doors will be closed and areas of the doors kept clear to prevent injury
- A weather radio will be relocated to the safe area
- Classroom flashlight and current attendance roster will accompany the teacher to the safe area
- Head count will be taken to ensure all children are present in the safe area and then reported to the Director
- When the storm has passed, and clear has been given, the building will be inspected for damage. If damage is present there will be restricted access to the damaged area and arrangements will be made to get the children home. If no damage is present everyone may return to normal activities.

Security Incidents-These are procedures for increased security at MWCC when advised by local law enforcement or emergency management agencies. When an alert message is received by the Center to increase security or lock down the following will occur:

- All staff will be notified that a lock down is in effect
- All children and staff will be recalled from outside activity to the security of the building
- All outside doors will be locked
- All windows will be closed and locked
- A head count will betaken to ensure all children are present and information will be given to the Director
- Parents/Guardians will be notified of the situation and advised on how to proceed
- When lock down is in effect no one may enter or exit the building except law enforcement agents until all clear has been given
- Parents will not be able to pick up their children until law enforcement has given the clear.

Hopefully we will never have to use any of these plans, but they are in place to keep your child safe. If you have any questions please ask the Director at drop-off or pick-up or call on the telephone.

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Dear Parents:

A component of our education program includes screenings in the following areas of development: cognitive, motor, social-emotional, speech/language, and hearing. These screenings must be completed within 45 days of your child's initial entry into the program. The assessment is done thru the Ages and Stages.

Information about the screening tools we use is on the back of this letter. You will receive a "results" letter after each screening is completed.

I give permission for my child, _____, to be screened in the following areas:

___ **All 4 areas of development (Cognitive, Speech& Language, Social-Emotional, and Hearing)**

___ Overall Development (cognitive, motor, and language) ONLY
___ Speech & Language Development ONLY
___ Social-Emotional Development ONLY
___ Hearing ONLY *Does your child have tubes? ____YES ____NO

___ I do NOT want my child to receive ANY developmental screenings

___ **My child has a current IEP through Pittsburgh Public Schools, Early Intervention Program or Allegheny Intermediate Unit/DART.**

Parent/Guardian Signature: _____

Screening tools briefly look at children's skills in comparison to other children, their own age, nationwide. These tools give us a snapshot of where a child is at one particular moment in time. Some children demonstrate skills in everyday situations that are not exhibited during the screening process. Other children may make accurate guesses that give misleading scores. If you have any concerns about your child's development that are not indicated on the screening, please call us and we can discuss your concerns and resources that may be available. Please remember to keep the lines of communication open with your child's classroom teachers. Throughout the year they will be identifying individual goals for your child to work on to build his/her skills.

If you have any questions about the screening process, your child's results, or the agencies we collaborate with, please call us. Also, please feel free to contact us at anytime if you need assistance with referrals for evaluations or additional services for your child.

Mt. Washington Children's Center
200 Southern Avenue
Pittsburgh, PA 15211

Overall Developmental (Cognitive, Motor, and Language)
We use the Speed DIAL 4 (a Shorter version of the *Developmental Indicators for the Assessment of Learning-Third Addition)* and/or the ESI-R (Early Screening Inventory, Revised) for our developmental screening. These screenings give information about developmental skills such as how your child uses his/her body (motor skills), knowledge of basic concepts like colors (conceptual skills), and use of her language. The skills listed above have proved important in predicting a child's success in a classroom. These screening tools can help identify if your child's skills are appropriate for his/her age or if further testing may be appropriate.

Speech & Language
We have two contracted agencies to provide the speech/language screenings to Head Start Children in accordance to the Head Start Performance Standards. Rehabilitation Specialists, Inc. will be providing these screenings at the following sites: Overbrook, Hazelwood, Loreto, Rochelle St, and all ECE sites. River Speech and Educational Services will be providing these screenings at the Dorseyville site.

Social-Emotional Development
For our social-emotional screening we use the Preschool and Kindergarten Behavior Scale, Second Edition, also known as the PKBS-2. This screening tool looks at social skills, such as how he/she gets along with the teachers, other children, and how independent he/she is, and problem behaviors, such as acting out behaviors (kicking, hitting, biting, etc.) and/or internal behaviors (excessive shyness, separation anxiety, etc.). This is a checklist that is completed by your child's teachers based on their observations of your child in the classroom. The results allow the teachers to plan activities according to each child's strengths and weaknesses, as well as determine whether or not extra assistance may be needed in the classroom.

Hearing Screenings
A hearing screening has two parts. Tympanometry is a measure of your child's middle ear that can indicate fluid build-up, ear infection, and/or ear wax. Pure tone screening is a measure of how your child hears sounds of different frequencies.

If your child has allergies, tubes in his/her ear, or a cold, it can cause him/her to fail the hearing screening. A failed hearing screening can also mean that your child has an ear infection or possible hearing loss. If your child pulls on his/her ear, runs a fever, complains of ear pain, or doesn't seem to hear you on a frequent basis, please call your doctor.

Rehabilitation Specialists, Inc. will be providing the hearing screenings for all sites.

ATTACHMENT 6
CHILD PICK-UP AUTHORIZATION

I, _____ authorize Mt. Washington Children's Center to release my child(ren) to the person(s) designated. This is consonance with the Mt.Washington Children's Center Emergency Operations Plan.

Child's Name	**Designated Custodian Name and Relationship**
_____	_____
_____	_____
_____	_____

_____

Your Signature Relationship Date

_____

Print Name

_____

Address

(Home Phone) _____ (Work) _____ (Cell) _____

NOTE: Parents and guardians should designate themselves as designated custodians. Friends, neighbors and other relatives may also be designated.
PLEASE PRINT CLEARLY.

MOUNT WASHINGTON CHILDREN'S CENTER
200 Southern Avenue, Pittsburgh, PA 15211