



# UPPER PERKIOMEN SCHOOL DISTRICT BEFORE AND AFTER SCHOOL CARE PROGRAM

## ENROLLMENT PACKAGE

2026–2027 SCHOOL YEAR



### FLEXIBLE CARE

Before and after school care that fits your schedule.



### SAFE & NURTURING

A secure environment with caring and trained staff.



### ENRICHING ACTIVITIES

Homework help, games, crafts, and fun learning.



### CONVENIENT LOCATIONS

Programs at Hereford and Marlborough Elementary Schools.



PROGRAMS AT HEREFORD AND MARLBOROUGH ELEMENTARY SCHOOL

*Also serving 4/5 Center students*



# LifeSpan

Day Care You Can Trust For Children.

Dear LifeSpan Families,

Please let me introduce myself and thank you for choosing LifeSpan for your before/after school needs. My name is Nicole Fetherman and I am the Executive Director of all the programs at LifeSpan serving the Upper Perkiomen School District.

Since 1987, LifeSpan has been providing before and after school care for the Quakertown School District. In addition to these programs, we host a full day summer camp. We proudly provide care for approximately 165 children from East Greenville and the surrounding communities.

LifeSpan provides a reliable service for working parents while giving you peace of mind knowing your children are being well cared for in a safe environment. Before and After School Programs have become an extension of the home. LifeSpan takes pride in our caring staff who provide guidance, assist with school work, and provide supervised extra learning opportunities for peer interaction and socialization. All staff complete comprehensive backgrounds checks and many are certified teachers.

With our programs being located within the school buildings, this serves nicely to collaborate academic programming with the school district and can reach more children in need of academic support.

LifeSpan's programs are licensed by the Department of Human Services and follow their guidelines for program operation. Our programs participate in Pennsylvania's Keystone STARS quality initiative with all programs rating a STAR 4 quality rating. We strive to continually improve our programs through this voluntary program.

**LifeSpan's Program Activities include the following:**

- ❖ Collaborative academic programs with the school district
- ❖ Homework supervision
- ❖ Curriculum based activities
- ❖ Organized Games/Active Play
- ❖ Creative Arts/Dramatic Play
- ❖ STEM activities (Science, Technology, Engineering and Math)
- ❖ Breakfast and Snacks
- ❖ Monthly activity calendars and Special Events

## Hours of Operation

On regularly scheduled school days the program opens at 6:30 am and runs until the school bell rings. LifeSpan staff will be on site from the time school closes approximately 3:30 p.m. until 6:00 p.m.

- ❖ Delayed openings—8:30 a.m. and remain until the beginning of school day.
- ❖ Early dismissal--will run from dismissal until 6:00 pm unless district decides otherwise
- ❖ In-service/holiday care days:
  - The following in-service days will be held at Hereford Elementary School: 9/4/26, 9/21/26, 10/12/26, 11/3/26, 2/12/26, 4/16/26, 5/18/26
  - The following days LifeSpan will be closed: 8/28/26, 9/7/26, 11/26/26, 11/27/26, 12/25/26, 1/1/27, 1/18/27, 2/15/27, 3/26/2027
  - Pre-Registration sheets will be required for sign up. They will be handled closer to the date of the in-service/holiday care day.
  - Breakfast and snack will be provided on these days, but a packed lunch is required for all students.

\*When the UPSD schools close due to severe weather or snow, no care is provided.

LifeSpan takes pride in our reputable history of exceptional service to families. We look forward to a stimulating 2024/2025 school year and learning more about your family.

Sincerely,

Nicole Fetherman  
Executive Director  
2460 John Fries Highway Quakertown, PA 18951  
215-536-9036  
215-538-9435 (fax)  
nfetherman@lq.org  
[www.lifespanchildcare.org](http://www.lifespanchildcare.org)





# LifeSpan

Day Care You Can Trust For Children.

Dear LifeSpan Parents,

This letter is to assure you of our concern for the safety and welfare of children attending LifeSpan. Our Emergency Plan, which is located at each facility, provides for complete response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- Immediate evacuation: students are evacuated to a safe area on the grounds of the facility in the event of a fire, etc.
- In-place sheltering: sudden occurrences, such as weather or hazardous materials related incidents, may dictate that taking cover inside the building is the best immediate response.
- Evacuation: total evacuation of the facility may become necessary if there is a danger in the area. If requested by local authorities, children will be taken to a relocation facility as follows.

LifeSpan at Hereford/Marlborough

LifeSpan Day Care – East Greenville  
399 Washington St. East Greenville PA

- Modified Operation - may include cancellation, postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems that make it unsafe for children, but may be necessary in a variety of situations.

Please listen to Channel 69 Storm Center for announcements relaying any of the emergency actions listed above.

We will rely on the telephone as the primary means of notification and communication. Calls can be made to LifeSpan cell phones concerning emergency status using the following numbers:

LifeSpan Day Care – Quakertown  
LifeSpan Day Care - Allentown  
LifeSpan Day Care – E. Greenville

215-536-4417  
267-733-3419  
610-216-7170

The form designating persons to pick up your child is included with this letter for you to complete and have returned to the day care facility as soon as possible. This form will be used every time your child is released. Please ensure that only those persons you list on the form attempt to pick up your child. Please feel free to contact the facility director with any questions or concerns.



# LifeSpan

Day Care You Can Trust For Children.

## Enrollment Application

Date: \_\_\_\_\_ Child's Birth Date: \_\_\_\_\_  
Child's Name: \_\_\_\_\_  
Parents/Guardians: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Work Number: \_\_\_\_\_ \*Email: \_\_\_\_\_

Facility Child attends: Hereford Elementary Marlborough Elementary 4<sup>th</sup>/5<sup>th</sup> Grade enter

Child's Schedule for Care: Full Time (5 days) ☐ Part Time (2-4 days) ☐  
Drop In (1 day/as needed) ☐

Days Child will be Attending: Monday ☐ Tuesday ☐ Wednesday ☐  
Thursday ☐ Friday ☐

### *School Age Program Only*

Grade: \_\_\_\_\_

Program Interest: ☐ Before School ☐ After School  
☐ Before & After School ☐ Holiday/Non-Instructional Days

Location: \_\_\_\_\_

Select your child's home school:

☐ Hereford Elementary ☐ Marlborough Elementary

Other: \_\_\_\_\_

Where did you hear about us?

Were you referred by someone? \_\_\_\_\_ If so, by whom? \_\_\_\_\_

Office Use Only: Deposit \_\_\_\_\_ Amount \_\_\_\_\_  
Anticipated Start Date \_\_\_\_\_ Class \_\_\_\_\_ H \_\_\_\_\_ M \_\_\_\_\_  
Form Reviewed & Entered by \_\_\_\_\_

## LIFESPAN SCHOOL AGE RATES - UPSD

2460 John Fries Highway  
Quakertown, PA 18951  
215-536-4417

EFFECTIVE July 1st, 2026

|                                           |                             |                             |          |     |
|-------------------------------------------|-----------------------------|-----------------------------|----------|-----|
| <b>BEFORE &amp; AFTER<br/>SCHOOL CARE</b> | Before                      | 6:30 a.m. to 8:30 a.m.      | \$ 35.00 | Day |
|                                           | After                       | 3:00 p.m. to 6:00 p.m.      | \$ 35.00 | Day |
|                                           | Before & After              | 6:30 a.m. to 6:00 p.m.      | \$ 49.00 | Day |
|                                           | Drop In                     | (in addition to daily rate) | \$ 6.00  | Day |
|                                           | Early Dismissal/Delay       | (in addition to daily rate) | \$ 12.00 | Day |
|                                           | Holidays/In-service<br>days |                             | \$ 60.00 | Day |

### Annual Registration Fees:

\$75.00 for 1 child

\$100.00 for 2 children

\$125.00 for 3 or more children

**Late Fees: \$1.00 per minute after 6:00 p.m.**

UPSD will provide bussing to and from 4<sup>th</sup>/5<sup>th</sup> grade center to homeschool elementary locations. Contact UPSD transportation for details/concerns.

## AGREEMENT

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                   |                                                                                                   |                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------|
| NAME OF CHILD                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                   | START DATE                                                                                        |                                |
| FEE AMOUNT    \$                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | PER<br>DAY <input type="checkbox"/> WEEK <input type="checkbox"/> | PAYMENT TO BE MADE ON MONDAYS<br>WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> |                                |
| SERVICES TO BE PROVIDED AS PART OF THE DAY CARE FEE (EXAMPLES: TRANSPORTATION, CARE, MEALS, ETC.)                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |                                                                                                   |                                |
| FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> DROP IN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                            |                                                                   |                                                                                                   | ROOM ASSIGNMENT                |
| MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/>                                                                                                                                                                                                                                                                                                             |                                                                   |                                                                                                   |                                |
| CARE <input type="checkbox"/> MEALS    TRANSPORTATION      DEVELOPMENTAL ASSESSMENTS GIVEN 2 TIMES A YEAR                                                                                                                                                                                                                                                                                                                                                                         |                                                                   |                                                                                                   |                                |
| SCHOOL AGE      PKC                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                   |                                                                                                   |                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                   |                                                                                                   |                                |
| CHILD'S ARRIVAL TIME                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CHILD'S DEPARTURE TIME                                            | PERSONS DESIGNATED BY PARENTS TO WHOM CHILD MAY BE RELEASED                                       |                                |
| LATE FEE    \$1.00                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PER MIN-HR    MINUTE                                              |                                                                                                   |                                |
| EXTRA SERVICES TO BE PROVIDED AT AN ADDITIONAL FEE (IF APPLICABLE)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                   | TUITION RATE                                                                                      |                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                   | CHILD CARE WORKS/TITLE XX                                                                         |                                |
| REGISTRATION FEE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   | PRE-K COUNTS                                                                                      |                                |
| DEPOSIT (Last week of care):                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                   | CONTRACTUAL ALLOWANCE                                                                             |                                |
| PROMOTION (Optional):                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                   | LQ EMPLOYEE DISCOUNT (FACILITY)                                                                   |                                |
| Payment Method:    TE      Check      Cash      Credit Card                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                   | <b>TOTAL DUE WEEKLY</b>                                                                           |                                |
| <p>I, the Parent/Guardian;</p> <p><input type="checkbox"/>      _____ Received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)</p> <p><input type="checkbox"/>      _____ 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)</p> <p><input type="checkbox"/>      _____ Received a copy of the Parent Handbook.</p> |                                                                   |                                                                                                   |                                |
| Signature – Operator                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                   | Date                                                                                              | Signature – Parent or Guardian |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                   |                                                                                                   | Date                           |

|                           |                                |  |      |
|---------------------------|--------------------------------|--|------|
| DATE OF CHILD'S ADMISSION | <b>PERIODIC REVIEW</b>         |  |      |
| DATE OF WITHDRAWAL        | SIGNATURE – PARENT OR GUARDIAN |  | DATE |
|                           |                                |  |      |

# Allergy Posting

Dear parents,

In order to post medical/allergy information about children, staff must obtain written permission from the parent.

Please sign this form stating that Lifespan has permission to post your child's name on our medical/allergy posting.

Thank You, Lifespan

\*\*\*\*\*

Child's Name: \_\_\_\_\_

Allergy/Medical Condition: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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:                                                                                                                                                                |             |                  |

Parents may write immunization dates; health professional should verify and complete all data.

|                                                                                                                                                                                                                                                                                                                                 |             |             |                                                                                                                                                                                                                                                                     |                                                       |             |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------|-----------------|
| <b>DO NOT OMIT ANY INFORMATION</b><br>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):<br><input type="checkbox"/> 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.<br><input type="checkbox"/> NONE                           |             |             |                                                                                                                                                                                                                                                                     |                                                       |             |                 |
| CHILD'S ALLERGIES (DESCRIBE, IF ANY):<br><input type="checkbox"/> 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.<br><input type="checkbox"/> 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?<br><input type="checkbox"/> YES <input type="checkbox"/> 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 <a href="http://WWW.AAP.ORG">WWW.AAP.ORG</a> )<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO                        |             |             | <b>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.</b> |                                                       |             |                 |
|                                                                                                                                                                                                                                                                                                                                 |             |             | VISION (subjective until age 3)                                                                                                                                                                                                                                     |                                                       |             |                 |
|                                                                                                                                                                                                                                                                                                                                 |             |             | HEARING (subjective until age 4)                                                                                                                                                                                                                                    |                                                       |             |                 |
|                                                                                                                                                                                                                                                                                                                                 |             |             | LEAD                                                                                                                                                                                                                                                                |                                                       |             |                 |
| <b>RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD</b>                                                                                                                                                                                                                             |             |             |                                                                                                                                                                                                                                                                     |                                                       |             |                 |
| <b>IMMUNIZATIONS</b>                                                                                                                                                                                                                                                                                                            | <b>DATE</b> | <b>DATE</b> | <b>DATE</b>                                                                                                                                                                                                                                                         | <b>DATE</b>                                           | <b>DATE</b> | <b>COMMENTS</b> |
| 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:                                                |             |                 |
|                                                                                                                                                                                                                                                                                                                                 |             |             |                                                                                                                                                                                                                                                                     | LICENSE NUMBER: DATE FORM SIGNED:                     |             |                 |



## Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

### ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) \_\_\_\_\_ to initiate credit card charges to the below-referenced credit card account (**Section A**) OR, initiate debit entries to my (our) checking or savings account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

#### COMPLETE ONE SECTION ONLY

##### SECTION A (Credit Card)

|                      |                 |
|----------------------|-----------------|
| Cardholder Name      | Phone #         |
| Cardholder Address   | City State Zip  |
| Account Number       | Expiration Date |
| Cardholder Signature | Date            |

##### SECTION B (Bank Account)

|                                           |                                   |                                   |                                  |     |
|-------------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|-----|
| Your Name                                 | Phone #                           |                                   |                                  |     |
| Address                                   | City State Zip                    |                                   |                                  |     |
| Bank or Credit Union Name                 | Bank or Credit Union Address      | City                              | State                            | Zip |
| Routing Transit Number (see sample below) | Account Number (see sample below) | <input type="checkbox"/> Checking | <input type="checkbox"/> Savings |     |

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

#### For Official Use Only

Date Received \_\_\_\_\_

Employee Signature \_\_\_\_\_

|                                                               |                                  |              |
|---------------------------------------------------------------|----------------------------------|--------------|
| John Sample<br>Mary Sample<br>123 Nice Street<br>Anytown, USA | BANK OF THE WEST<br>555-555-5555 | 00226        |
| Pay to the order of: <u>Attach Voided Check Here</u> \$ _____ |                                  |              |
| Deposit slips not accepted _____ Dollars                      |                                  |              |
| 123456789012                                                  | 10003308                         | 0226         |
| Routing Number                                                | Account Number                   | Check Number |

A service of



procare  
SOFTWARE®



# LifeSpan

Day Care You Can Trust For Children.

I have received, read and understand the billing policies and procedures as outlined in the attached document for my family's participation in LifeSpan programs.

Family Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please provide an updated email address for program communications, newsletters and notifications and special announcements.

Email: \_\_\_\_\_

Email: \_\_\_\_\_

Please return to the front office upon enrollment.



# LifeSpan

Day Care You Can Trust For Children.

## **“GETTING TO KNOW YOU”**

We are asking that parents and children involved in our programs participate in a brief survey and questionnaire that will help us create a better understanding of your child, your family and your expectations of our program. We respect and understand your right to privacy and the purpose of this survey is to ensure that your children are receiving the best care possible for each individual child. Please answer the questions honestly and know that your responses will only be reviewed by the director and staff directly involved with the care of your child. Please feel free to contact us to discuss any information you may not be comfortable answering on the survey. If you would prefer to discuss the survey in person with the director and staff, an appointment can be arranged at your convenience.

The first section is general information about your family and life at home. The second section is for you to do with your child. This section will allow us to better understand your child's likes and dislikes which will aid us in designing a program better suited to the preferences of the children within the group. The third section pertains to your child's educational experiences, possible limitations, health and safety issues and general well being. The information you provide here will aid us in providing the most effective environment, learning experiences and appropriate atmosphere for your child to spend their out of school time.

We thank you in advance for your cooperation and the time dedicated to completing the survey. Please return to the office upon completion.

Thank you,

LifeSpan Staff



**LifeSpan**

Day Care You Can Trust For Children.

# Getting to know you-Kindergarten/School-age

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

## Section 1 - Family Information

**Tell us about your family:** Does your child have siblings? Are there nicknames that your child uses to refer to his/her self or other family members?

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**Section 2 - What makes your child happy?** Does your child have a particular hobby, collection, or interest that we could tie into our learning to help your child make meaningful connections and share his/her experiences?

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**Section 3 - Goals for the school year** (social, emotional, cognitive) Are there specific areas that you would like to see us strengthen throughout the school year?

---

---

Is there an academic area that you feel your child enjoys that you'd like to see us continue to elaborate on this year?

---

---

How does your child get along with others? Is he/she shy? Outgoing? A team player? A Leader?

---

---

Is your child exceptional in any way?

---

---

---

#### **Section 4: Parent Involvement**

Does your schedule allow you to read to the class, speak about your favorite hobby, or help organize parties or class events?

---

---

Would you like to schedule a "Getting to Know You" meeting with the Director to discuss your child's needs further?

\_\_\_\_yes    \_\_\_\_not at this time





# LifeSpan

Day Care You Can Trust For Children.

## **Homework Contract**

LifeSpan School Age Programs offers and encourages children to do homework while attending the after school program. Homework help is available daily. Parents are still responsible to check their child's homework to ensure all assignments have been completed properly. Please note below your preferences in regards to homework for your child.

Child's Name \_\_\_\_\_

- ☐ Should complete all assignments
- ☐ Should attempt to complete assignments
- ☐ Should save homework for home
- ☐ OTHER (please specify your preference)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



# LifeSpan

Day Care You Can Trust For Children.

## Photo Permission Form LifeSpan Release

Of consideration of my engagement as a model, and for other good and valuable consideration herein acknowledged as received, I hereby grant to LifeQuest, his/her heirs legal representatives and assigns, those for whom Photographer is acting, and those acting with his authority, and permission the irrevocable and unrestricted right and permission to take, copyright in his own name or otherwise, and use, reuse and republish photographic portraits or pictures of me or in which I may be included in whole or part, or composite or distorted in character or form without restriction as to changes or alterations, in conjunction with my own or a fictitious name, or reproductions thereof in color or otherwise, made through any medium at his studios or elsewhere, and in any or all media now or hereafter known for illustration, promotion, art editorial, advertising, trade, stock sales, or any other purpose whatsoever, without further compensation. I also consent to the use of any published matter in conjunction therewith.

I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in conjunction therewith or the use to which it may be applied.

I hereby release, discharge and release LifeQuest, his/her heirs, legal representatives and assigns, and all persons acting under his permission or authority or those for whom he is acting, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photograph or in any subsequent processing thereof, as well as any publication thereof, including without limitations any claims for libel or invasion of privacy.

I hereby warrant that I am of legal age and have the right to contract in my name. I have read the above authorization, release, and agreement, prior to its execution, and am fully familiar with the contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

☐ I Agree

☐ I Disagree

Child's Name

Date

Parent/Guardian Name

Parent/Guardian Signature

Witness \_\_\_\_\_

### CHILD PICKUP AUTHORIZATION

I, \_\_\_\_\_, authorize LifeSpan School & Daycare to release my child (ren) to the person(s) designated. This is in consonance with the LifeSpan Emergency Plan.

| <u>Child(ren) Name(s)</u> | <u>Designated Person(s)<br/>Name &amp; Relationship</u> |
|---------------------------|---------------------------------------------------------|
| _____                     | _____                                                   |
| _____                     | _____                                                   |
| _____                     | _____                                                   |

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***Note: Parents/Guardians should designate themselves as a designated person. Friends, neighbors and other relatives may also be designated.***

Do you have a custody order, restraining order, protection from abuse or other court order that affects your child?    ☐ Yes    ☐ No

If yes, LifeSpan must be provided with a copy of the most recent order and all amendments thereto. The orders of the court will be strictly followed. In the absence of a court order on file with LifeSpan, both parents shall be afforded equal access to their child as stipulated by law. LifeSpan cannot, without a court order, limit access of one parent by the other parent, regardless of the reason.

## COMMONWEALTH OF PENNSYLVANIA

TO: Parents and/or Guardians

FROM: Site Director

SUBJECT: Nondiscrimination in Services

Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provisions of aides, and the use of alternate service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any parent and/or their guardian, who believes they have been discriminated against, may file a complaint with any of the following:

LifeSpan School and Daycare  
399 Washington ST.  
East Greenville, PA 18041

Commonwealth of Pennsylvania  
DHS Bureau of Equal Opportunity  
801 Market Street, Suite 5034  
Philadelphia, PA 19107

Department of Human Services  
OCDEL, Southeast Region  
801 Market Street  
Suite 5132 Southeast Regional Office  
Philadelphia PA 19107

LifeSpan at Hereford Elementary  
1043 Gravel Pike  
Hereford, PA 18056

U.S. Dept. of Health and Human Services  
Bureau of Equal Opportunity  
Room 223 Health & Welfare Building  
PO Box 2675  
Harrisburg, PA 17105

LifeSpan at Marlborough Elementary  
1450 Gravel Pike  
Green Lane, PA 18054

PA Human Relations Commission  
Philadelphia Regional Office  
11 N. 8<sup>th</sup> Street, Suite 501  
Philadelphia, PA 19107

LifeSpan serving Fourth/Fifth Grade Center  
510 Jefferson St.  
East Greenville PA 18041

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**



# LifeSpan

Day Care You Can Trust For Children.

## Parent Handbook 2024-2025

The LifeSpan Parent Handbook can be found on the LifeSpan Child Care website, under the “For Our Parents” tab. The Parent Handbook contains policies and procedures for all parents to review. The web address is <https://www.lifespanchildcare.org/>

I have been given information about where to find the LifeSpan Parent Handbook. I understand that if I have questions, at any time, regarding the handbook, I will consult with the Executive Director.

Parent’s Signature: \_\_\_\_\_

Parent’s Printed Name: \_\_\_\_\_

Child’s Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INDIVIDUALIZED EDUCATION PLANS (IEP) AND  
INDIVIDUALIZED FAMILY SERVICE PLANS (IFSP)  
INFORMATION SHEET**

Because of the diverse set of needs of the children in our program, it is important to gather as much information about the best ways to educate each child. IEP's and IFSP's are created by service providers working with children with special needs and include this information. The Keystone STARS Performance Standards therefore require each early learning provider to request copies of IEP's and IFSP's for the children in their care. Because of the importance of the IEP/IFSP to a child's learning, the program should have a copy before the child begins to attend, if possible.

The information found on an IEP/IFSP is protected by privacy laws including the Health Insurance Portability and Accountability Act (HIPPA). Releases of information may also be required to speak to members of a child's treatment team. Professional development regarding privacy issues, and HIPPA in particular, is highly recommended.

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

Please circle an option below:

I am providing a copy of my child's IEP or IFSP.

I am not providing a copy of my child's IEP or IFSP.

This is not applicable to my child.

Parent/Guardian Signature \_\_\_\_\_

Printed Name \_\_\_\_\_ 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                                                                  |                                           | BIRTHDATE                          |
| ADDRESS                                                                       |                                           |                                    |
| MOTHER'S NAME/ LEGAL GUARDIAN                                                 |                                           | HOME NUMBER                        |
| ADDRESS                                                                       |                                           | CELL NUMBER                        |
| BUSINESS NAME                                                                 |                                           | WORK NUMBER                        |
| BUSINESS ADDRESS                                                              |                                           | EMAIL ADDRESS                      |
| FATHER'S NAME/ LEGAL GUARDIAN                                                 |                                           | HOME NUMBER                        |
| ADDRESS                                                                       |                                           | CELL NUMBER                        |
| BUSINESS NAME                                                                 |                                           | WORK NUMBER                        |
| BUSINESS ADDRESS                                                              |                                           | EMAIL ADDRESS                      |
| EMERGENCY CONTACT PERSON(S)                                                   |                                           | PHONE NUMBER WHEN CHILD IS IN CARE |
| 1                                                                             |                                           |                                    |
| 2                                                                             |                                           |                                    |
| 3                                                                             |                                           |                                    |
| PERSON(S) TO WHOM CHILD MAY BE RELEASED                                       | ADDRESS                                   | PHONE NUMBER                       |
| 1                                                                             |                                           |                                    |
| 2                                                                             |                                           |                                    |
| 3                                                                             |                                           |                                    |
| NAME OF CHILD'S PHYSICIAN/ MEDICAL CARE PROVIDER                              |                                           | PHONE NUMBER                       |
| PROVIDER ADDRESS                                                              |                                           |                                    |
| SPECIAL DISABILITIES (IF ANY)                                                 | ALLERGIES(INCLUDING MEDICATION REACTIONS) |                                    |
| MEDICAL/ DIETARY INFO NECESSARY IN EMERGENCY SITUATION                        | MEDICATIONS/SPECIAL CONDITIONS            |                                    |
| ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD                              |                                           |                                    |
| HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS            |                                           | POLICY NUMBER (REQUIRED)           |
| PARENT 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 FACILITY                                                    | WADING                                    |                                    |

\_\_\_\_\_  
SIGNATURE OF PARENT OF GAURDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OF GAURDIAN

\_\_\_\_\_  
DATE



## CHILD CARE REQUEST FORM



### STUDENT / PARENT INFORMATION

### REQUESTED START DATE: \_\_\_\_\_

Student Name: \_\_\_\_\_ School Attending: \_\_\_\_\_

Grade: \_\_\_\_\_ Home Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### MORNING REQUEST:

Child Care Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Child Care Address: \_\_\_\_\_

Pick Up from Home: M T W T H F

Pick Up From Child Care: M T W T H F

### AFTERNOON REQUEST:

Child Care Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Child Care Address: \_\_\_\_\_

Drop off at Home: M T W T H F

Drop off at Child Care: M T W T H F

The Upper Perkiomen School District shall transport students in grades **K-5** who are picked up or dropped off at a destination other than their home on a daily basis, for the purpose of child care. Transportation will not be provided for any day care facility located within a walking boundary of a school, or located outside of the district. The parent of students in child care must submit a written request to the Transportation Department **yearly** for review and approval by **June 1st** of the preceding school year.

### **The following conditions must also be met:**

1. In order to be effective for the beginning of each school year, the Child Care Request Form with parent signature must be submitted by **June 1st**. Late requests and requests made during the school year, may take up to 2 weeks to complete.
2. Such students must board or disembark at an existing stop on the regularly scheduled bus route. We will not reroute buses to accommodate child care requests.
3. There must be space available on the bus.
4. Such students will be accepted on a first come, first-served basis.
5. Such students may not continue to ride the bus if other students, eligible for transportation under the foregoing provisions, are assigned to the bus causing the bus to reach its rated capacity.
6. All requests must be for a minimum of two weeks.
7. A request to ride an alternate bus, for a temporary situation, will not be issued.
8. Subject to the foregoing, not more than three (3) requests for change in location to accommodate a modification of child-care arrangements may be sought during a school term. Split schedule requests will only be accommodated one (1) time per school year.
9. Eligible stops are accredited child care centers that are within 3 miles of the student's Elementary school boundary; all other stops, family/neighbor/friend, must be within the student's Elementary school boundary.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(I have read the policy rules and request the change in accordance with the rules listed above)*

## LifeSpan School & Daycare Authorization to Release Student Records

I hereby authorize LifeSpan School & Daycare

\_\_\_\_\_

To send /release the records indicated below to:

Upper Perkiomen School District

\_\_\_\_\_

\_\_\_\_\_

Those records checked, if available, may be released:

1. \_\_\_\_\_ Official Administrative Record (name, address, birth date, classroom/grade level completed, grades, and attendance records)
2. X Health Records including immunization information
3. \_\_\_\_\_ Child Assessments (Ounce Scale, Work Sampling, Dibels, PALS , Math, Ages and Stage), other developmental screenings.
4. \_\_\_\_\_ Teacher Observations and Ratings
5. X Confidential Records (individually administered test results and behavioral, psychological, psychiatric and neurological reports, IEP's/IFSP's)
6. X Student Assistance information (behavior reports, incident reports, referral forms, parent questionnaires, and release of information)
7. X Verbal/phone and email discussion regarding the educational support and care of my child.

\_\_\_\_\_  
Student's Full Name

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Student's Date of Birth

\_\_\_\_\_  
Date

# LifeSpan School & Daycare Authorization to Release Student Records

*I hereby authorize*

Upper Perkiomen School District

\_\_\_\_\_

\_\_\_\_\_

*To send /release the records indicated below to:*

LifeSpan School & Day Care

\_\_\_\_\_

\_\_\_\_\_

*Those records checked, if available, may be released:*

1. \_\_\_\_\_ Official Administrative Record (name, address, birth date, classroom/grade level completed, grades, and attendance records)
2. X Health Records including immunization information
3. \_\_\_\_\_ Child Assessments (Ounce Scale, Work Sampling, Dibels, PALS , Math, Ages and Stage), other developmental screenings.
4. \_\_\_\_\_ Teacher Observations and Ratings
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6. X Student Assistance information (behavior reports, incident reports, referral forms, parent questionnaires, and release of information)
7. X Verbal/phone and email discussion regarding the educational support and care of my child.

\_\_\_\_\_  
*Student's Full Name*

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Student's Date of Birth*

\_\_\_\_\_  
*Date*