

Grace Trinity Academy
5200 Oxford Ave.
Philadelphia, Pa. 19124
Tel. 215-535-3885 Fax: 215-535-5017

Checklist for Required Documents

- ☐ Emergency Contact/Consent Form
- ☐ Copy of State Issued ID of Parent/Guardian
- ☐ Copy of Birth Certificate
- ☐ Health Assessment/Physical
- ☐ Immunization Record
- ☐ Copy of Medical Card
- ☐ Request for Medication Administration
- ☐ Child Pick-Up Authorization
- ☐ Tuition Agreement (signed & Dated)
- ☐ Getting to Know
- ☐ Parent Handbook (signed & Dated)

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5200 Oxford Ave.

Philadelphia PA 19124

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(An outreach ministry of Trinity United Church of Christ)

BACKGROUND:

Grace Trinity Academy is an outreach ministry of Trinity United Church of Christ. The facility, located at 5200 Oxford Ave., Philadelphia PA 19124 will address the childcare needs of parents by providing safe, affordable, and stable care in an enriching educational environment for the children in the community.

SERVICES DAILY SCHEDULE:

The Academy offers several types of programs, all of which will be exciting as well as educational. There will be an emphasis on social skills as the children are engaged in hands-on activities that will include math, science, language development, art, music, and more. The program will include full-time for Young and Older Toddler and Preschool; Before/After School for School Age students **ONLY** and Summer Camp programs from June through August. The Academy will offer full day care for the school age children in accordance with the calendar days provided by the director for public school.

The Academy will be open from 7a.m. through 6p.m. The daily schedule will include: breakfast, teacher directed activities, child directed activities, large, small and/or individual group time, **lunch- CBS Food Program**, age appropriate nap time, and gross motor outdoor/indoor activities. The daily schedule for school age children will include: snack time, homework assistance, teacher directed activities, child directed activities, large, small and/or individual group time and gross motor outdoor/indoor activities.

CLOTHING AND REST TIME BEDDING:

Children are expected to arrive at the Center dressed in appropriate play clothing and sneakers or any closed toe shoe. CHILDREN MAY NOT WEAR SANDALS, FLIP-FLOPS, CLOGS, OR DRESS SHOES—TOES MUST BE COVERED. If your child wears diapers or pull-ups, you are responsible for supplying at least (5) five days of diapers or pull-ups and a container of baby wipes. Your child's teacher will inform you when more diapers or pull-ups and wipes are needed. Every Toddler and Preschool child need to keep **at least one complete change of seasonally appropriate clothing** in their cubbies. These items need to be stored in a closed container the size of a shoe box with the child's first and last name on it for storage. **All clothing including jackets, hats, boots, etc. MUST be labeled with the child's FIRST name and INITIAL of the LAST name.**

If your child naps at the center they will need to have **1: crib size sheet** and **1: small blanket** for our age appropriate nap time. Bedding will be sent home every Friday to be laundered and returned on Monday morning.

HEALTH POLICIES:

Children need to be able to fully participate in the indoor and outdoor program each day that they attend school. If a child becomes ill while at school, you will be notified and asked to pick up your child at that time. Illness includes vomiting, diarrhea, and fever of 100.4 or higher or any contagious condition.

Medication will be administered only with written permission from a licensed physician and all medication must be in its original container from the pharmacy. Administration for Medication form will be given and Medication Logs must also be completed!

SUPERVISION:

Children will be supervised at all times, both indoors and outdoors. Appropriate staff/child ratios will be maintained at all times.

TRANSPORTATION & PICK UP ARRANGEMENTS:

The parents will provide transportation to and from the Center and students will be dropped-off in their classroom and signed in. Please be sure that your child's teacher or assigned teacher is aware of their arrival. Children will only be released to a parent/guardian or someone who is an authorized escort based on the most recent Emergency Contact form on file with the Director or a Verbal Release form is completed. All parent/guardian and/or escorts must have proper ID.

After school children will be picked up from their grade school transportation which will be located in the parking lot of Grace Trinity Academy.

The Classroom Staff and Director must be notified about: (1) Change of home address or phone number; (2) Change of employment, school or training program; (3) Change of emergency contact information; and/or (4) Change of person to whom child may be released.

IT IS IMPORTANT TO KEEP YOUR INFORMATION UPDATED IN CASE OF AN EMERGENCY. THE STAFF NEEDS TO BE ABLE TO REACH YOU AT ALL TIMES.

The WEEKLY cost is as follow for FULL-TIME and SCHOOL AGE ONLY effective July 1, 2025:

<u>School Age</u>	<u>Preschool</u>	<u>Old Toddler</u>	<u>Young Toddler</u>
(Kindergarten-6 th Grade)	(Age: 3yrs. - 5yrs.)	(Age: 24mos. – 36mos.)	(Age: 13mos. – 24 mos.)
<i>\$250/Week*</i>	<i>\$290/Week*</i>	<i>\$300/Week*</i>	<i>\$325/Week*</i>

The cost for Before/After School is as follows: \$90/Week* =Before School (7a.m.-9:00a.m.); \$150/Week* =After School (3p.m.-6p.m.); AND/OR \$225/Week =Before/After and 1/2 days ONLY and we accept all forms of child care subsidies.

PAYMENT POLICY:

Tuition or co-payments are due in full by **Friday night or Monday morning prior to services**. Full tuition or CCIS family co-payment is due regardless of illness, holidays, or inclement weather that the center is closed, **no pro-rated rates will be given at any time**. Each family will be given (1) one-week vacation credit per academic year, if tuition payments are CURRENT, and two weeks written notice. Payments may be made in the office or left in the locked box located next to the Director's office. Please make checks and money orders payable to: Grace Trinity or GTA.

There is a \$40.00 service charge on all returned (bounced) checks and payments will no longer be accepted in a check form once this occurs.

HOLIDAYS:

Grace Trinity Academy will be closed for the following holidays: *all classrooms, parent bulletin board, and copies will be provided upon request. 13 Federal holidays –Please ask for an additional calendar if needed*

WITHDRAWAL AND DISENROLLMENT:

Two weeks written notification is required for any schedule change or withdrawal. The center reserves the right to dis-enroll a child if deemed necessary for the safety of others. This may be done with written notification.

NONDISCRIMINATION POLICY:

Grace Trinity Academy does not discriminate on the basis of a person's religion, color, sex, age, national origin or disability regarding considerations such as enrollment and hiring.

CCIS SUBSIDY CONTACT INFORMATION:

For Childcare Subsidies-[Philadelphia Early Learning Resource Center for Region 18](#)
4601 Market Street, Philadelphia, Pa. 19139 Phone: 610-480-3190/Toll Free: 888-535-2209/Fax: 267-592-4178

GRACE TRINITY ACADEMY

5200 Oxford Ave, Philadelphia, PA 19124

Phone: (215) 535-3885

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 (As it APPEARS on Child's state / government issued "Birth Certificate")		DATE OF BIRTH	
ADDRESS			
PARENT'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER ()	
ADDRESS		E-MAIL ADDRESS	
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS			
PARENT'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER	
ADDRESS			
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS			
EMERGENCY CONTACT PERSON(S)		NAME	
		TELEPHONE NUMBER WHEN CHILD IS IN CARE	
PERSON(S) TO WHOM CHILD MAY BE RELEASED		NAME	
		ADDRESS	
		TELEPHONE NUMBER WHEN CHILD IS IN CARE	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER	
ADDRESS			
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION, SPECIAL SITUATION	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD			
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)	
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT			
OBTAINING EMERGENCY MEDICAL CARE		ADMIN. OF MINOR FIRST-AID PROCEDURES	
WALKS AND TRIPS		SWIMMING / WADING	
TRANSPORTATION BY THE FACILITY		I allow Photos/ Videos used for classroom ONLY	

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

Child's Name (Last):	Child's Name (First):	Child's Date of Birth:
Parent/Guardian Name:	Address:	Contact Phone #:
<p>PA child care providers must document that enrolled children have received age-appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007. The schedule is available at www.aap.org or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.</p>		
Health history and medical information pertinent to routine care and emergencies (describe, if any): <input type="checkbox"/> NONE		DATE OF MOST RECENT WELL-CHILD/PHYSICAL EXAM:
Allergies to food or medicine (describe, if any): <input type="checkbox"/> NONE		Do not omit any information. This form may be updated by health professional (initial and date new data).
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? <input type="checkbox"/> YES <input type="checkbox"/> NO - IF NO, PLEASE EXPLAIN YOUR ANSWER:		
LENGTH/HEIGHT _____ IN/CM %ILE _____		WEIGHT _____ LB/KG %ILE _____
		BLOOD PRESSURE (BEGINNING AT AGE 3) /
PHYSICAL EXAMINATION	<input checked="" type="checkbox"/> = NORMAL	IF ABNORMAL - COMMENTS
HEAD/EYES/EARS/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		
IMMUNIZATIONS	DATE	DATE
DTap/DTP/Td		
POLIO		
HIB		
HEP B		
MMR		
VARICELLA		
MENINGOCOCCAL		
PNEUMOCOCCAL		
INFLUENZA		
HEP A		
ROTAVIRUS		
OTHER/TB		
SCREENING TESTS	DATE OF TEST	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		
HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (attach additional sheets if necessary) <input type="checkbox"/> NONE		
MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:
ADDRESS:		
ZIP CODE:	PHONE:	LICENSE NUMBER:
		DATE FORM SIGNED:

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication / treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT		ADDRESS/ZIP		ROOM/BOOK NO.	
DATE OF BIRTH	SCHOOL/ORG.#	REGIONAL OFFICE		PID	
DIAGNOSIS:					
REASON MEDICATION MUST BE GIVEN IN SCHOOL:					
NAME OF MEDICATION/EQUIPMENT/TREATMENT:					
TIME(S) TO BE GIVEN IN SCHOOL:				DOSE:	
TOTAL DOSAGE PER 24 HRS:					
DATE BEGIN:		DATE END:			
INSTRUCTION FOR ADMINISTRATION/UTILIZATION:					
CONTRAINDICATIONS:					
SIDE EFFECTS:					
TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN:					
IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES <input type="checkbox"/> NO <input type="checkbox"/>					
IF YES, DESCRIBE: _____					
IS STUDENT TAKING ANY OTHER MEDICATION? YES <input type="checkbox"/> NO <input type="checkbox"/>					
IF YES, NAME OF MEDICATIONS: _____					
IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES <input type="checkbox"/> NO <input type="checkbox"/>					
PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS				TELEPHONE	
ADDRESS				EMERGENCY NUMBER	
SIGNATURE OF HEALTH CARE PROVIDER				DATE SIGNED	

To The Principal

- I authorize selected school personnel to administer the indicated medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.
- Medication is to be administered by the Certified School Nurse. In the absence of the Certified School Nurse, it may be administered by the Principal or his/her designees.
- Certified School Nurse will provide instruction for administration of medication or use of equipment to the Principal or his/her designees.
- My child may self-administer medication/equipment as determined appropriate by the school nurse.
- I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply, as needed, regarding this medication/equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE

- I have assessed this student and he/she has demonstrated competency and may self administer this medication/treatment () yes () no
- The administration of this medication/treatment was approved on: _____ DATE _____

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

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EMERGENCY CHILD RELEASE

I, _____ AUTHORIZE Grace Trinity Academy to release my child(ren) to the person(s) designated. This is consonance with the Soans Christian Academy Emergency Plan.

Child's Name

Designated Custodian(s) (Name & Relationship)

Your Signature

Relationship

Date

Print Name

Street Address

City

State

Zip Code

(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

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GENERAL INFORMATION

Child's Name: _____ Child's Date of Birth: _____
Admissions Date: _____ Withdraw Date: _____

Hours of Operation 7:00AM to 6:00PM

(Circle One): Young Toddler Older Toddler Preschool
Before School – ONLY After School – ONLY Before & After School Summer Camp: June – August ONLY

TUITION AGREEMENT CONDITIONS

1. Services to be provided as part of tuition include SEE PARENT HANDBOOK.
2. Extra services to be provided at an additional fee, if applicable are: N/A
3. Agree to update the Emergency Contact/ Parental Consent Form information whenever changes occur or every six (6) months at a minimum.
4. I agree to pay- a Registration Fee of \$25.00 at the time of enrollment. I understand this is a non-Refundable fee and not applicable toward tuition.
5. I understand that a deposit of _____ must accompany the approved enrollment application and will be applied to the child's first week's co-pay/tuition payment, if applicable.
6. I agree to pay by the preceding Friday, the sum of _____. I will automatically include a late fee of \$10.00 to the tuition payment when made after Monday at Noon. Should tuition remain unpaid, I will be asked to withdraw my child until the outstanding balance is paid in full. All legal and collection fees incurred in the collection of tuition are the responsibility of the parent/guardian.
7. If additional time or a change in schedule days is required during any given week. I understand that after prior approval is given, I may be required to pay an additional rate. If an occasion arises where fewer days are needed during the week, my usual week's tuition is still required.
8. I agree to pay a \$25.00 processing fee for any check that is returned by my bank for any reason, If more than two checks are returned, money orders or cash will be required.
9. I understand that in order for accurate emergency and bookkeeping records to be maintained, it is crucial that I sign my child in and out daily.
10. I understand that my will only be released to the following individuals:

11. I understand that if my child remains at the Center past the designated closing time, I will be charged and agree to pay an additional fee of \$1.00 for each additional minute after 6:00pm, or my part thereof, he/she remains.
12. I understand there will be no reduction in tuition. for holiday's, vacations (NO more than 1 week), illness, inclement weather, or any other absences from school. In the event my child contracts a contagious and/or infectious illness, I must notify the school and make alternative arrangements for my child's care until the danger to others has passed, I agree to notify the Center whenever my child is absent.
13. I understand the Center is opened all year, except for holidays declared by the Center Director.
14. I do _____ do not _____ give permission for my child to be ***photographed/ videotaped and the photos/tape to be displayed in the school.***
15. I/We ____ Grant I/We ____ DO NOT Grant permission for use of picture, voice, video, name, work and participation of this child/ student to be published on the center's website. (Center images are used on the internet to promote student activities and celebrate your child's work and participation. Rest assured, the center will safeguard all content and will not share/release any information without prior consent from you the parent/ guardian.)
16. I agree to give two weeks written notice before withdrawing my child from the school or changing my guaranteed days. My account must be current.
17. I consent to all terms of this Agreement and have received a signed and dated copy of this contract. I have read, understand, and accept the conditions of this tuition agreement as school policy and realize that these fees and conditions may be revised as necessary without prior notice. The school further reserves the right to dismiss the named student if it is determined that the school's program does not benefit the child or in the event of non-payment of fees.

Parent / Guardian (Print Name)

Parent / Guardian (Signature & Date)

Director's (Signature & Date)

Periodic Review (Parent/ Guardian Signature & Date)

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CIVIL RIGHTS COMPLIANCE
Parents / Guardians

In Accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as a resident of this agency, have the right:

To be provided services at this agency and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, including Limited English Proficiency, age or sex.

To file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, disability, ancestry, national origin, age or sex.

Complaints of discrimination may be filed with any of the following:

Grace Trinity Academy
5200 Oxford Ave.
Philadelphia, PA 19124

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite #5034
Philadelphia, PA 19107

DHS – BEO
Room #223, Health & Welfare Building
P.O BOX #2675
Harrisburg, PA 17105

Office of Civil Rights
U.S Department of Health & Human Services
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-9111

PA Human Relations Commission
Philadelphia Regional Office
110 North 8th Street
Suite #501
Philadelphia, PA 19107

Child's Name: _____

Parent / Guardia Signature

Date

Director Signature

Date

**GRACE TRINITY ACADEMY
PARENT/GUARDIAN HANDBOOK**

PARENT / GUARDIAN AGREEMENT FORM

READ CAREFULLY (Write your Initial on each statement)

1. _____ I/We agree to comply with the rules and regulations of the Grace Trinity Academy.
2. _____ I/We will immediately notify the Grace Trinity Academy if my child/children will be absent or lateness.
3. _____ I/We agree to give two weeks written notice to Grace Trinity Academy if my child / children will be withdrawing from the program.
4. _____ I/We agree to pick up my child at the agreed upon dismissal time designated on the enrollment form. Failure-to do so will result in late fee charges and possible termination from the program.
5. _____ I/We understand that tuition payments can be paid in advance, on Thursday and no later than Friday by 5:00 p.m. for the following week of care. Tuition payments are due no later than Monday morning for the current week.
6. _____ I/We agree to cooperate with Grace Trinity Academy staff to ensure that my child/children will have a rewarding learning experience.
7. _____ I/We understand that my/our failure to comply with any of the above statements could jeopardize my/our child's / children's enrollment at Grace Trinity Academy
8. _____ I/We agree to sign up to Class Dojo, and check the app **daily** for upcoming events, and any information or news provided by Grace Trinity Academy.

ORIGINAL: of the Parent/ Guardian Agreement Form and the Acknowledgement of Handbook is given to the PARENT / GUARDIAN. **COPY** is kept in the CHILD'S FILE.

ACKNOWLEDGMENT OF HANDBOOK

I acknowledge by my signature that I have received a copy of the Grace Trinity Academy Parent / Guardian Handbook I also acknowledge that it is my responsibility to read this handbook to ask questions if I do not understand, to observe and follow the policies and procedures as outlined herein. I understand further that from time to time the contents herein may change and that I will be responsible for keeping abreast of the changes as they occur after I have been informed of the changes.

Child's Name: _____

Date: _____

Parent/ Guardian Signature

Parent/ Guardian Signature

To better serve our community, Grace Trinity Academy will like to know the following information:

where did you hear about us: _____ (Google, Social Media, Etc.)

Referred By: _____ (Print Name)

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"GETTING TO KNOW YOU"

Child's Name: _____

Enrollment Date: _____

1. Tell me about your household. (Neighborhood, who lives there, names, and relationship to child)?
2. Does your child have any parents that do not live in the home?
3. Does your child visit this parent?
4. Are there any custody issues that we should discuss?
5. Does your child have any siblings (names and ages)?
6. Does your child have any special needs and do any of these special needs require special care by our teachers?
7. Does your child have an IEP (Individualized Education Plan) or ISFP (Individualized Family Service Plan)?
(Note: If yes, we would like a copy of the plan, so we can provide the best possible learning experience for your child.)
8. What program or individuals work with your child in regards to these special needs? Would you sign a release of information form with them, so they can speak with us about how to provide enhanced support to your child?
9. Does your child have any allergies?
10. How are your child's allergies treated?
11. Do you have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.)?
12. Any other medical or special needs?