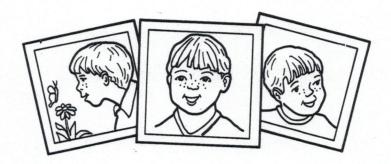
PERMISSION FOR PHOTOGRAPHS/VIDEOTAPING



Dear Parents:

Occasionally the Center staff or approved visitors take pictures of or videotape the children. These pictures (still or moving) are used to publicize and promote Center activities or events. Pictures may appear in local newspapers, center brochures, or on television. No additional notice may be given of picture-taking sessions.

A form is attached for parental approval/release for photographs. Please sign and date the attached form and return it immediately to the Center. No photos or video will be taken of children whose parents do not grant permission.

Sincerely,	
Center Director	
Permission for Photographs/Videotape	-
I do give permission for my child to be photographed or vide taped while at the Center or on Center-sponsored field trips for purposes of promoting the Center and its activities.	:0-
I do not give permission for my child to be photographed or videotaped while at the Center or on Center-sponsored field trips for purposes of promoting the Center and its activities.	

Parent(s)/Guardian Signature _

Parent/Provider fill in this part.

Fax 570-828-8241	(5	5 PA CODE §	§3270.131,	3280.131 AM	ID 3290.131					
HILD'S NAME: (LAST)	(FIR	RST)		PARENT/GUAR	DIAN:					
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HILD CARE FACILITY NAME: . 1	<i>i</i> 1		4 1							
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570 828.250C)	P	ike	WORK PHONE	•					
I authorize the child care staff and my child's	health profes	ssional to com	municate dire	ectly if needed	to clarify info	mation on t	his form a	bout my chi	ld.	
ARENT'S SIGNATURE:										
		DO NO	T OMIT A	NY INFORM	ATION					
This form may be updated by	a health pr	rofessional. I	nitial and da	ate any new	data. The chi	ld care faci	lity needs	a copy of	the form.	E ANV).
HEALTH HISTORY AND MEDICAL INFORMAT	ION PERTIN	NENT TO ROU	TINE CHILE	D CARE AND	DIAGNOSIS	TREATMEN	II IN EME	RGENCY (DESCRIBE, 1	FANT):
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CHILD'S ALLERGIES (DESCRIBE, IF ANY):										
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LIST ANY HEALTH PROBLEMS OR SPECIAL DESCRIBE THE PLAN FOR CARE THAT SHO	NEEDS AN	ND RECOMME	ENDED TRE	ATMENT/SEF	RVICES. ATT	ACH ADDI	IIONAL S	HEETS IF	NECESSART	10
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Parents may write immunization HEP-A MENINGOCOCCAL OTHER SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT MEDICAL CARE PROVIDER: ADDRESS: TITLE: DATE FORM SIGNED: LICENSE NUMBER: PHONE: CD 51 09/08