

St. Luke's Day School, LLC
12640 Dunks Ferry Road
Philadelphia, PA 19154
215.632.8374
Ms_Sonia@aol.com

Hello!

Thank you for requesting information about St. Luke's where we are continuing over thirty years of excellence in education! We offer programs for three age groups: Infant/ Young Toddlers (6mon-2yr old), Older Toddlers/Young Preschool (2-3 & fully potty trained), and Preschool/Pre-K (3 & fully potty trained-5 yrs old). Part time and full-time programs are offered for all three classes. (For cost and schedule, please see the tuition chart enclosed.)

When enrolling, there is a **\$75.00 non-refundable registration fee** that holds your child's slot and allows us to establish an account for your family. **A two-week advance payment, or escrow,** is paid a month prior to coming and held for the last two weeks your child attends. Once you begin attending, **tuition payments are due each week, at drop off, on the first day your child is in.** There is a small grace period until pick up, on that same day, before you get a late fee. Tuition is due even if your child does not attend, unless you are using vacation time. Vacation time is not granted to anyone with CCIS.

Upon starting, you will receive the remainder of the enrollment packet as well as a Parent Handbook which you are asked to read and return the last page from stating that you have read it. This manual includes all information about the school rules and regulations as well as our days off, policies, etc.

Also, the first day your child attends, he/she will need the following: a fitted crib sheet (they fit our mats), a small blanket and a small pillow, crayons & markers (Crayola 8 Basic Colors Only Please), safety scissors, a glue stick, a small plastic art box and a full change of clothes, including socks and undies, in a labeled gallon size plastic bag. Children in the Infant/Young Toddlers Room also need a sippy cup, bib, wipes, & diapers (everything labeled). Any other items your child needs, specific to his/her classroom, will be needed after starting. If your child is in the infant/toddler room, he or she will not need an art box.

All classrooms have trained staff, and we are proud to say we have very little staff turnover with most of our staff members here for ten years or more and a few closing in on twenty-five! Our staff is loving, patient and kind. Many parents comment on the family-like atmosphere of the program of which we are very proud. We attend numerous trainings throughout the year to keep sharp and participate in the Keystone Stars program, a quality care initiative in Pennsylvania ensuring better early childhood programs.

I hope I have not overwhelmed you too much! I just want to provide as much information as possible to ensure a smooth and easy start to your time here at St. Luke's! I encourage you to call, email or stop in if you have any questions regarding our program! We look forward to welcoming you!

Sonia Klakowicz, Director

St. Lukes Day School LLC
Tuition Rates
2026

	Part Time *	Full Time
Infants/ Young Toddlers	\$275.00	\$320.00
Older Toddlers/Young Presch	\$260.00	\$300.00
Preschool/Pre-K	\$250.00	\$280.00

**** All tuition rates are weekly ****

St. Luke's is also happy to provide a generous 15% discount to families with more than one child enrolled in our program at a time. If this applies to you, simply add the weekly tuition costs for your child's age groups, and reduce it by 15%.

* Part time is 3 full days, or 5 mornings with pickup after lunchtime.

APPLICATION FOR ST. LUKE'S DAY SCHOOL, LLC

Date of Admission _____ Date of Departure _____
Infants/Young Toddlers (PT/FT) _____ Older Toddlers/Preschool (PT/ FT) _____ Preschool/Pre-K (PT/FT) _____

Child's Name _____ Birthdate _____

Address _____
Street, City, State _____ Zip Code _____

Mother's/Legal Guardian's Name _____

Mother's Social Security Number _____ Mother's Email _____

Mother's/Legal Guardian's Address _____

Mother's/Legal Guardian's Home/Cell Phone _____ Work Phone _____

Mother's/Legal Guardian's Business Name & Address _____

Father's/Legal Guardian's Name _____

Father's Social Security Number _____ Father's Email _____

Father's/Legal Guardian's Address _____

Father's/Legal Guardian's Home/Cell Phone _____ Work Phone _____

Father's/Legal Guardian's Business Name & Address _____

Person to be contacted if parents are not available: (Please inform them they're listed here)

Name	Phone #	Relationship to Child
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Physician and/or Source of Medical Care:

Name	Address	Phone #
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Special Concerns/Disabilities, if any: _____.

Any special Medical/Dietary information necessary for management in an emergency situation— Examples; allergies, medications, special conditions, etc.

_____.

Signature of Director

Signature of Parent/Guardian

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Upon acceptance of enrollment at St. Luke's Day School, you are responsible for the following, prior to your child's attendance:

* A one-time, non-refundable registration fee of \$75.00 per child must be paid at the time of application;

* Two week's advance tuition is due. This money will be held as "escrow" and applied to your child's last two weeks in the school. **You must notify the school Director, in writing, two weeks prior to your child's last day.** This will ensure that you receive the full amount of time allotted by your escrow. Failure to give two weeks' notice will result in you losing your escrow;

* You must return all paperwork, signed and dated, including:

Application

Emergency Contact Form

Health Assessment (Completed by your child's physician within 30 days of the start)

Consent Form

Emergency Code Form

Civil Rights Compliance

Signature Page from Parent Policy Manual

Please sign and date below to acknowledge that you have received the enrollment procedures above, and that you fully understand each of them.

I, _____, fully understand and accept the enrollment procedures.

Child's Name _____

Parent's Signature _____ Date _____

EMERGENCY CONTACT / PARENTAL CONSENT FORM

CHILD'S NAME			BIRTHDATE		
ADDRESS					
MOTHER'S NAME/LEGAL GUARDIAN				HOME TELEPHONE NUMBER	
ADDRESS					
BUSINESS NAME				BUSINESS TELEPHONE NUMBER	
ADDRESS					
FATHER'S NAME/LEGAL GUARDIAN				HOME TELEPHONE NUMBER	
ADDRESS					
BUSINESS NAME				BUSINESS TELEPHONE NUMBER	
ADDRESS					
EMERGENCY CONTACT PERSON(S)		NAME		TELEPHONE NUMBER WHEN CHILD IS IN CARE	
PERSON(S) TO WHOM CHILD MAY BE RELEASED		NAME		ADDRESS	
TELEPHONE NUMBER WHEN CHILD IS IN CARE					
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER				TELEPHONE NUMBER	
ADDRESS					
SPECIAL DISABILITIES (IF ANY)			ALLERGIES (INCLUDING MEDICATION REACTION)		
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION			MEDICATION, SPECIAL CONDITIONS		
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD					
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS			POLICY NUMBER (REQUIRED)		
REQUIRED EACH ITEM BELOW TO <u>OBTAINING EMERGENCY MEDICAL CARE</u>			INDICATE PARENTAL CONSENT (PLEASE SIGN BOTH BOXES) <u>ADMIN. OF MINOR FIRST - AID PROCEDURES</u>		

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

AGREEMENT

CHILD CARE CENTERS * GROUP DAY CARE CENTERS * FAMILY DAY CARE HOMES

A fee of \$	Per - Day, Week, etc. Per Week	Will be paid - Daily, Weekly, etc. Weekly	By - Mother, Father, Other, Specify Parents/Guardians
This will include cost of - Care, Transportation, Meals, etc. - Specify Meals to be served Academic program, Care, Breakfast, Lunch, PM Snack			
Transportation will be supplied by Parents / Guardians		Medical Care, if required, will be paid by Parents / Guardians	
Child will arrive at - Time	Depart - Time	Usually accompanied by - Mother, Father - Other	A fee of \$15.00 Per Min. - Hr. (Not applicable - Title XX) ** See Below **
Person(s) designated by parents to whom child may be released - specify all persons other than parents			

Any additional conditions and/or services as agreed upon by both parties:

**** Late Pick-up Policy:** Any child picked up between 6:01 PM and 6:10 PM will be charged a \$15.00 fee. An additional fee of \$5.00 will be charged for each five (5) minute increment. The fee must be paid by the following Monday and may be included in your tuition payment. Any fees which are not paid by the following Monday will continue to incur late fees until the fee is paid.

*** Tuition is due on Monday, of each week.** ALL TUITION MUST BE RECEIVED BY 6 PM WEDNESDAY OF EACH WEEK. IF PAYMENT IS NOT RECEIVED BY 6:00 PM ON WEDNESDAY, YOU WILL BE REQUIRED TO PAY A \$10.00 LATE FEE. UNTIL YOUR LATE FEE IS PAID, YOUR ACCOUNT WILL CONTINUE TO ACCRUE FEES.

Signature - Administrator, Director, Caregiver

Date

Signature - Parent or Guardian

Date

DATE OF CHILD'S ADMISSION - ENROLLMENT

DATE OF CHILD'S WITHDRAWAL

SIX MONTH REVIEW (Please **DO NOT SIGN BELOW**, until you are asked to... Thank You)

I agree to update the Emergency Contact/Parental Consent Form information whenever changes occur or every six months at a minimum.

Parent's Signature

Date

**CIVIL RIGHTS COMPLIANCE
PARENT AWARENESS**

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, Limited English Proficiency (LEP) age, sexual orientation, 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, Limited English Proficiency (LEP), age, sexual orientation, or sex.

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

St. Luke's Day School
12640 Dunks Ferry Road
Philadelphia, PA 19154
215-632-8374

PA Human Relations Commission
711 Phila. State office Building
1400 Spring Garden Street
Philadelphia, PA 19130

Department of Public Welfare
Bureau of Equal Opportunity
Room 521, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office
1105B Phila. State Office Bldg.
1400 Spring Garden Street
Philadelphia, PA 19130

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

Parent/Guardian Signature

Date

Staff Signature

Date

DATE: January 02, 2026

SUBJECT: Nondiscrimination in Services Statement

TO: Parents

FROM: Sonia Klakowicz, Director/Owner

Admissions, the provisions of services, and referrals of clients shall be made without regard race, color, religious creed, disability, ancestry, national origin, Limited English Proficiency (LEP), sexual orientation, 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 provision of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/ student (and/or guardian) who believes they have been discriminated against may file a complaint of discrimination with:

St. Luke's Day School, LLC
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Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office
1105B Phila. State Office Bldg.
1400 Spring Garden Street
Philadelphia, PA 19130

PA Human Relations Commission
711 Phila. State office Building
1400 Spring Garden Street
Philadelphia, PA 19130

Office for Civil Rights

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

Department of Public Welfare
Bureau of Equal Opportunity
Room 521, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

CONSENT FORM
TYLENOL/WALKING TRIPS/CONFIDENTIALITY OF RECORDS

St. Luke's Day School has my permission to administer TYLENOL to my child, _____, when medically necessary. I understand that a representative of the school will contact me to obtain verbal permission before administering.

Parent/Guardian Signature _____ Date _____

My child, _____, has permission to go on walking trips with St. Luke's Day School, LLC. (Generally, around the building.)

Parent/Guardian Signature _____ Date _____

I realize my child's records are kept confidential. However, it sometimes becomes necessary for the staff to examine them in order to provide the best care for my child.

I hereby give consent for the St. Luke's Day School, LLC staff (teacher or director) to refer to my child's records when necessary.

Child's Name _____

Parent/Guardian Signature _____ Date _____

**ST. LUKE'S DAY SCHOOL
EMERGENCY CARE RELEASE FORM**

Child's Name _____

SCHOOL EMERGENCY CARE

In case of extreme medical emergency, I give school authorities permission to take whatever emergency action deemed necessary, including securing the assistance of pre-hospital emergency medical services. Further, I accept full responsibility for any and all costs involved in rendering such services.

Parent/Guardian Signature _____ Date _____

PRE-HOSPITAL EMERGENCY CARE

In case of extreme medical emergency, I give pre-hospital emergency medical personnel permission to take whatever emergency medical actions deemed necessary and I authorize transport of my child to the hospital. Further, I accept full responsibility for any and all costs involved in the rendering of such pre-hospital emergency services.

Parent/Guardian Signature _____ Date _____

HOSPITAL EMERGENCY CARE

In case of extreme emergency, I authorize either of the following persons to act on my behalf, until my arrival, in approving whatever emergency actions are deemed necessary by hospital personnel. Further, I accept full responsibility for any and all costs involved in the rendering of such emergency room and hospital treatment. (Insurance information is listed below.)

Emergency Contact #1 _____ Relationship _____

Address _____ Phone _____

Emergency Contact #2 _____ Relationship _____

Address _____ Phone _____

INSURANCE INFORMATION

Name of Health Plan _____ Group # _____

Name of Policy Holder _____ Employer _____

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:
☐ 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.

DO NOT OMIT ANY INFORMATION This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.						
HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): ☐ NONE						
DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. ☐ NONE						
CHILD'S ALLERGIES (DESCRIBE, IF ANY): ☐ NONE						
LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES. ☐ NONE						
IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? ☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:						
HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO			NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.			
			VISION (subjective until age 3)			
			HEARING (subjective until age 4)			
			LEAD			
RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD						
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						
MEDICAL CARE PROVIDER:				SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT		
ADDRESS:						
		PHONE:		LICENSE NUMBER:		DATE FORM SIGNED: