THE CHILDREN'S CENTER OF PITTSBURGH (TCCP)
THE GET-WELL ROOM FACT SHEET

What is the Get-Well Room?

The Get-Well Room is a separate area of The Children's Center of Pittsburgh, providing sick childcare for children, six months through 12 years of age. Supervised by a nurse, the Get-Well Room provides a warm, caring atmosphere for children who are unable to participate in their usual activities. The Get-Well Room is open from 8:00 a.m. to 5:00 p.m. on the days when TCCP is also open. Calls are taken after 7:00 a.m.

How do I use the Get-Well Room?

The Get-Well Room is open to everyone. You need not be affiliated with The Children's Center of Pittsburgh to use this service. However, in order for your child to use the Get-Well Room, you must first complete the Registration Form and have your child's physician complete the Health Appraisal. Both forms should be on file at The Children's Center of Pittsburgh before your child can use the Get-Well Room.

What illnesses or conditions are appropriate for the Get-Well Room?

Children who have mild fevers (103° or less), mild respiratory illnesses (such as chest colds, mild bronchitis, bronchiolitis, croup or asthma), diarrhea or occasional vomiting, or pain and fever from vaccinations can be comfortably cared for. Children with fevers higher than 103°, chicken pox, respiratory distress, continuous vomiting or diarrhea, or excessive lethargy or irritability that suggest the presence of a more serious illness are not appropriate candidates for the Get-Well Room.

When my child appears to be a candidate for the Get-Well Room, what procedures do I need to follow to enroll him or her for the day?

★If your child has a fever, take his or her temperature to see if it is 103° or less.

★Make a note of other symptoms.

★Call your pediatrician if you would normally do so for the child's condition.

★You **must call** the nurse at the Get-Well Room between 7:00 and 8:00 a.m.; the number is **(412) 641-1267**.
If you begin work at 7:00 a.m., you must call the **Get-Well Room at (412) 641-1267** or The Children's Center of Pittsburgh at (412) 641-1990 before 5:00 p.m. the preceding day.

★The nurse will ask about your child's condition to determine if he or she can be accommodated in the Get-Well Room.

★Please bring any medication prescribed for your child in the original, labeled container. Only medication provided by the child's parent/guardian will be administered.

What happens when we arrive at the Get-Well Room?

★The nurse will check your child's vital signs and determine if the condition still falls within medical guidelines for enrollment.

★You will be asked to complete a brief medical record form. This form will be used to track your child's progress during the day. You will receive a copy of this progress report when you arrive to pick up your child at the end of the day.

★Some parents work at facilities that have arranged to pay for all or part of the GWR fee. You will be asked for the names of employers so that the fee can be determined. **PAYMENT IS DUE UPON ARRIVAL ON THE DAY OF SERVICE.** Please pay with exact amount of cash or check. Credit and debit cards are accepted as well.

PLEASE CALL (412) 641-1990 FOR MORE INFORMATION

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Please mail the completed registration form and health appraisal to The Children's Center of Pittsburgh, 327 Craft Avenue, Pittsburgh, PA 15213 along with a $20.00 registration fee per family. Please make the check payable to The Children's Center of Pittsburgh. Rev. 7/11/2019

REGISTRATION/EMERGENCY INFORMATION/PARENTAL CONSENT

CHILD'S NAME	**Birthdate**
Address	
PARENT/LEGAL GUARDIAN NAME	**Home Telephone Number:** **Cell Telephone Number:**
Address	**E-Mail Address:**
Business Name	**Business Telephone Number:**
Address	
PARENT/LEGAL GUARDIAN NAME	**Home Telephone Number:** **Cell Telephone Number:**
Address	**E-Mail Address:**
Business Name	**Business Telephone Number:**
Address	
EMERGENCY CONTACT PERSON(S) - NAME & TELEPHONE NUMBER WHEN CHILD IS IN CARE **(1)**	
(2)	
PERSON(S) TO WHOM CHILD MAY BE RELEASED - NAME, ADDRESS & TELEPHONE NUMBER WHEN CHILD IS IN CARE **(1)**	
(2)	
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)
PARENT'S SIGNATURE AND DATE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT	
OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST-AID PROCEDURES**
Walks	Photographing or filming for publicity or news features
Transportation by the facility	

Date of Exam: _____

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: The Children's Center of Pittsburgh		
FACILITY PHONE: 412-641-1990	COUNTY: ALLEGHENY	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

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