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Central Massachusetts

PROGRAM

___ Roosevelt After School 2:15-5:30

___ Wawecus After School 2:15-5:30

DAYS *(Please circle)*

M T W Th F

School Age Child Care **Enrollment Form**

CHILD INFORMATION

Child's Name:_____ Date of Birth:_____

Age at Admission:_____ Date of Admission:_____

Child's Home Address:_____

Home Phone Number:_____

Primary Language:_____ Identifying Marks:_____

Eye Color:_____ Hair Color:_____ Skin Color:_____

Sex:_____ Height:_____ Weight:_____

ADDITIONAL INFORMATION

Child's Physician:_____

Address:_____ Phone Number:_____

Allergies/Special Diets?_____

Individual Health Plan for child with a chronic health condition? If yes, please attach._____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach._____

Special limitations or concerns? _____

_____

SCHOOL INFORMATION

Current School:_____

School Address:_____ School Phone Number:_____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school. ***Parent/Guardian initials:***_____

_____ _____

Parent/Guardian Signature **Date**

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School Age Child Care
Contact Information / Authorized to Release

Child's Name:_____ Date of Birth:_____

PARENT / GUARDIAN CONTACT INFORMATION

*Parent/Guardian Name:*_____Relationship to Child:_____
Home Address:_____
City:_____State:_____Zip:_____
Reachable Phone Number:_____
Email Address:_____
Business Name:_____
Business Address:_____
Business Phone Number:_____ Hours at Work:_____

*Parent/Guardian Name:*_____Relationship to Child:_____
Home Address:_____
City:_____State:_____Zip:_____
Reachable Phone Number:_____
Email Address:_____
Business Name:_____
Business Address:_____
Business Phone Number:_____ Hours at Work:_____

EMERGENCY CONTACTS (*In order to be contacted*)

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

_____ _____

Parent/Guardian Signature **Date**

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School Age Child Care
First Aid and Emergency Medical Care Consent

102 CMR 7.09(3)

Child's Name:_____ Date of Birth:_____

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____

Address: _____

Phone Number: _____

Child's Allergies: _____

Chronic Health Conditions: _____

Health Insurance Coverage_____ Policy _____

Transportation Plan and Authorization

MY CHILD WILL ARRIVE AT THE PROGRAM:

___Supervised Walk

___Unsupervised Walk

___Public/Private/Van

___Precious Cargo Transportation

___Contract/Van

___Private Trans. Arranged By Parent

___Other

MY CHILD WILL DEPART FROM THE PROGRAM:

___Supervised Walk

___Unsupervised Walk

___Public/Private/Van

___Precious Cargo Transportation

___Contract/Van

___Private Trans. Arranged By Parent

___Other

_____ _____

Parent/Guardian Signature **Date (Valid for one year)**

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Individual Health Care Plan Form

All programs must maintain as part of a child's record, an Individual Health Care Plan (IHCP) for each child with a chronic medical condition which has been diagnosed by a licensed health care provider. Examples include students with severe allergies, asthma, diabetes, and that require medication.

To be completed by Health Care Practitioner:

Child's Name:_____ Date: _____

Name of Chronic Health Care Condition: _____

Symptoms: _____

_____

Medical Treatment required while at the program: _____

_____

Potential Side effects of treatment _____

_____

Potential consequences if treatment is not administered: _____

_____

To be completed by Health Care Practitioner: Staff Training

All educators in the after-school program must be trained to identify symptoms and administer all required treatment. Training must be specific to each student and must be authorized by the child's health care practitioner. Training must be completed prior to enrollment in the after-school program.

Training Must Include: _____

_____

Authorized Trainers (Student's parents or Health Care Practitioner): _____

_____

Name of Licensed Health Care Practitioner (please print):_____

_____ _____

Licensed Health Care Practitioner authorization **Date (Valid for one year)**

_____ _____

Parent/Guardian Signature **Date (Valid for one year)**

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School Age Child Care
Medication Consent Form

Child's Name:_____

Name of Medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)_____**

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and Prescribing Health Care Practitioner _____

Phone Number of prescribing Health Care Practitioner: _____

Child's Health Care Practitioner Signature _____Date_____

I, _____, (parent or guardian) gives permission to authorize educator(s) to administer medication to my child as indicated above.

_____ _____

Parent/Guardian Signature **Date (Valid for one year)**