

GROUP CHILD CARE AND SCHOOL AGE CHILD CARE CHILD'S ENROLLMENT FORM

Program:	Group Child Care:	School Age Care:
Child's Name:	Eye Color:	Skin Color:
Home Address:	Hair Color:	Height:
Telephone:	Sex:	Weight:
Date of Admission:	Age at Admission:	
Date of Birth:	Primary Language:	
Identifying Marks:		
Allergies / special diets:		

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name:	Parent/Guardian Name:
Relationship to child:	Relationship to child:
Home Address:	Home Address:
Home Telephone #:	Home Telephone #:
Bus. Name:	Bus. Name:
Bus. Address:	Bus. Address:
Bus. Telephone #:	Bus. Telephone #:
Hours at Work:	Hours at Work:

ADDITIONAL INFORMATION:

Child's Physician/Clinic:
 Address: _____ Phone: _____

Chronic health conditions: _____

Special limitations or concerns: _____

SCHOOL AGE ONLY

Current School: _____ School Address: _____

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

EMERGENCY CARD INFORMATION

Child's Name: _____

Date of Birth: _____

Child's Home Address: _____

Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone#)

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

MEDICAL EMERGENCY TREATMENT

I hereby give _____
(Name of program)

permission to administer basic first aid and/or CPR to my child _____
(Name)

and/or take my child _____, to a hospital for medical
(Name)

treatment when I cannot be reached or when delay would be dangerous to my child's health.

(Parent Signature)

(Date)

INSURANCE INFORMATION (OPTIONAL)

Company Name: _____ Policy # _____

Participating Hospital: _____

Special Instructions: _____

**GROUP CHILD CARE AND SCHOOL AGE CHILD CARE
FIRST AID AND EMERGENCY MEDICAL CARE
CONSENT FORM
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 to give my child first aid 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: _____

Emergency Contacts (*In order to be contacted*)

1. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	
2. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	
3. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	

Health Insurance Coverage: _____	Policy #: _____
Parent(s) Name: _____	Phone(w) _____ Phone (h) _____
Parent(s) Name: _____	Phone(w) _____ Phone (h) _____

Parent/Guardian Signature

Date

CHILD CARE OF THE BERKSHIRES, INC
Magic Seasons School Age Program

Dear Parent(s),

As part of our ongoing commitment to provide high quality child care services to you and your family, we would like to make you aware of the services offered by our Resource Teacher.

Currently, Tammy Hoag is a Resource Teacher working at Monument Square Early Childhood Center. She visits classrooms on a regular basis works with children, offers support to teachers, and sometimes meets with families. Tammy has an AA in Human Services from Berkshire Community College and a BA in Sociology from MCLA. She has seventeen years experience teaching in child care settings.

Attached is a release for you to sign allowing her to come into the classroom and provide information and support.

Thank you for your cooperation.

Sincerely,

Kelly Phillips, Program Director

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Magic Seasons has a Resource Teacher. You (the parent(s) are being informed that the Resource will be in the classroom working directly with children as part of the learning experience, and also as support for the teachers. The Resource Teachers are obligated to adhere to the same guidelines concerning confidentiality as all CCB employees.

Guardian(s) Name: (print) _____ DATE: _____

Guardian Signature: _____

Child's Name: _____

_____ Yes, I give permission for my child to be in the classroom

_____ No, I do not give my permission.

**CHILD CARE OF THE BERKSHIRES, INC.
Magic Seasons School Age Program**

RELEASE FORM

(RESOURCE TEACHER/STUDENT TEACHER/INTERNS)

Magic Seasons has a Resource Teacher/students and or/interns from MSQ, MCLA,BCC, Early Intervention and Williams College.

You (the parents) are being informed that these people will be in the classrooms as part of their learning experience and also as a support for our teachers.

They will have direct contact with the children and the teachers.

They will be supervised by the teachers and are obligated to adhere to the same guidelines concerning confidentiality, as are the teachers.

Guardian Signature: _____ Date: _____

Guardian Signature (Print): _____

CHILD CARE OF THE BERKSHIRES, INC.
MAGIC SEASONS SCHOOL AGE PROGRAM
210 STATE STREET
NORTH ADAMS, MA 01247
664-4657

Permission Form for Topical Non-Prescription Medications

I do hereby give permission to the staff of Magic Seasons School Age Program to apply topical non-prescription medications (i.e.- Vaseline, A&D, desitin, sunscreen, ect) on my child _____ as needed.

Medication(s): _____

Instructions: We must follow the directions on the original container, unless otherwise authorized by a written order from the child's physicians.

Parent's Signature: _____

Date: _____

Note: This form is valid for one year.

Transportation Plan and Authorization
7.09(3) and 7.12(1)

Child's Name _____

My child will arrive at the program by:

- Unsupervised Walk
- Supervised Walk (who will walk the child _____)
- School Bus Drop Off
- Program Bus
- Program Van
- Parent Drop Off
- Other (describe _____)

My child will depart from the program by:

- Unsupervised Walk
- Supervised Walk (who will walk the child _____)
- School Bus Pick Up
- Program Bus
- Program Van
- Parent Pick Up
- Other (describe _____)

I give permission for my child to be released from the program at the end of the day as stated above and/or I give permission to the following people to receive my child at the end of the day. (If no one is authorized, please indicate below by writing "NO ONE")

*** If a child is protected by a restraining order please submit order to the provider.**

Name _____
Relationship _____
Address _____
Phone _____ Cell _____

Name _____
Relationship _____
Address _____
Phone _____ Cell _____

Name _____
Relationship _____
Address _____
Phone _____ Cell _____

Parent/Guardian Signature _____ Date _____

CHILD CARE OF THE BERKSHIRES, INC.
MAGIC SEASONS SCHOOL AGE PROGRAM
210 STATE STREET
NORTH ADAMS, MA 01247
664-4657

I hereby give the staff at Magic Seasons School Age Program permission to take my child _____ on walks or excursion by bus.

Parent's Signature: _____

Date: _____