



Children's Records must be maintained for at least five (5) years after a child has left the program

School Age After School Program

Enrollment Packet

***PHOTO OF CHILD (*Optional) PLUS PHYSICAL DESCRIPTION**

Eye Color _____
 Hair Color _____ Sex _____
 Height _____ Weight _____
 Other: _____

Please fill out these forms completely. If a question does not apply to your child, write N/A (not applicable). The forms must be in the educator's possession on or before the first day your child begins care. Please notify your educator if any of the information changes.

General Information

Date of Admission _____ Age at Admission: _____
 Child's full name _____ Date of Birth _____
 Address: _____ City: _____ Zip: _____
 Telephone Number: _____ Nickname _____
 Primary Language of Child _____ Primary Language of Parents _____
 Allergies/Special Diets _____
 Name of Parent(s)/Guardian(s) _____
 Home address (if different) _____
 Telephone Number: _____
 Email Address: _____

Parent(s)/guardian(s) business address/location during child care:

Parent/Guardian: _____	Parent/Guardian: _____
Where: _____	Where: _____
Telephone: _____	Telephone: _____
Cell Phone: _____	Cell Phone: _____
Instructions: _____	Instructions: _____

Emergency Contact/Authorized pick-up person

In the event of an emergency when I may not be reached, the Educator may contact the following individuals (in the order given) whom I authorize to take my child from the child care premises.

(1) Name: _____ Address _____

Telephone _____ Cell Phone _____

(2) Name: _____ Address _____

Telephone _____ Cell Phone _____

Child's Name _____

TRANSPORTATION PLAN / AUTHORIZED PICK- UP

My child will arrive to the program by:	My child will depart the program by:
<input type="checkbox"/> Parent Drop-Off <input type="checkbox"/> Supervised Walk <input type="checkbox"/> Unsupervised Walk <input type="checkbox"/> Public/Private Van <input type="checkbox"/> Bus <input type="checkbox"/> Private Transportation Provided by Parent	<input type="checkbox"/> Parent Pick Up <input type="checkbox"/> Supervised Walk <input type="checkbox"/> Unsupervised Walk <input type="checkbox"/> Public/Private Van <input type="checkbox"/> Program Bus/Van <input type="checkbox"/> Private Transportation Provided by Parent

In the space below, please note any important information regarding transportation of your child to and from the program (i.e.--indicate who will be supervising children during transport or prior to their arrival at the program, who supervises the walk from a bus stop, etc.)

I additionally authorize the following individual to take my child from the program premises. (Please let me know at the beginning of the day when your child will be picked up by one of the authorized individuals.)

Name _____ Address _____

Telephone _____ Cell Phone _____

Name _____ Address _____

Telephone _____ Cell Phone _____

Anticipated Days/Time of Attendance

<u>Day</u>	<u>Arrival Time</u>	<u>Departure Time</u>	<u>Day</u>	<u>Arrival Time</u>	<u>Departure Time</u>
Monday	_____	_____	Tuesday	_____	_____
Wednesday	_____	_____	Thursday	_____	_____
Friday	_____	_____			

If applicable: Name of School Child Attends: _____

Copies of any custody agreements, court orders, restraining orders (if applicable)

Notes:

Child's Name _____

Written Acknowledgement of Receipt of Parent Handbook

I acknowledge that I have received a copy of the provider's parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook).

Parent/Guardian _____

Date _____

Parental Visit Notice

I understand that I may visit this family child care home unannounced at any time during the hours that my child is in care.

Parent/Guardian _____

Date _____

Child's Physician or Health Care Professional

Name: _____ Telephone: _____

Address: _____

Information on allergies, special diets, chronic health conditions, special limitations, concerns including medications child is taking at home/school and possible side effects:

Medical Insurance Information (OPTIONAL)

Subscriber's Name: _____ Policy #: _____

Type of Insurance: _____

[] Copy of Insurance Card

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: _____

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care programs require this information to be on file to address the needs of children while in care.

CHILD'S NAME _____ **DATE OF BIRTH** _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:

Regular medications: _____

SOCIAL RELATIONSHIPS

How would you describe your child? _____

Previous experience with other children/child care: _____

Reaction to strangers: _____ Able to play alone: _____

Favorite toys and activities: _____

Fears (the dark, animals, etc.): _____

What is the method of behavior management/discipline at home? _____

What would you like your child to gain from this child care experience? _____

Parent/Guardian Signature: _____ Date: _____

Permissions (for each child enrolled)

General Permission-(Basic Transport) (Parents should not sign this permission unless specific places where your child is allowed to go are listed by your educator.) By signing this form, I am allowing my child to be taken off the child care premises.

I, hereby give _____ (director/educator) permission to take my child _____ off the premises of the program for the following excursions: (specific places your child is allowed to go _____

using the following forms of transportation: _____

Parent/Guardian

Signature Date

I do not want my child to be taken off the program premises.

Parent/Guardian

Signature Date

Permission - (Transport to Medical Facility and Receive Emergency Medical Treatment)

Medical Emergency Treatment (Department of Early Education and Care recommends checking with your local hospital about the acceptability of this statement)

I, hereby give _____ permission to administer basic first aid and/or _____ (educator/assistant)

CPR to my child _____, and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

Parent/Guardian

Signature Date

Topical Medication/Ointments (Please list only those medications/ointments which you will allow the educator(s) to administer to your child's skin): Ex: sunscreen, insect repellent (bug spray), diapering ointment.

Parent/Guardian Signature

Date

Emergency Card Information

REMINDER: This emergency card information is for the educator's first aid kit. The educator(s) must take first aid materials when leaving the child care premises.

Child's Name: _____ Date of Birth: _____

Child's Home Address: _____

Phone: _____

Instructions to Reach Parent or Guardian

1. _____
(Name, Address, Home and Cell Phone #)

2. _____
(Name, Address, Home and Cell Phone #)

Contact Information for Physician or Health Care Professional

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

Emergency Contact Person(s)

1. _____
(Name, Address, Home and Cell Phone #)

2. _____
(Name, Address, Home and Cell Phone #)

Emergency Medical Treatment

I hereby give _____ permission to
(Name of educator/assistant)

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

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

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

Parent/Guardian

Date

Medical Insurance Information (Optional)

Subscriber's Name: _____

Type of Insurance: _____

Policy Number: _____

Copy of insurance card

Other pertinent medical information: _____

Dear Physician: _____
(Child's Name)

is enrolled in an After School program which is licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one (1) year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone # _____

Name of Parents: _____

Address: _____

Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance:

Has this child been screened for lead poisoning? Yes _____ No _____

(*At least one (1) time between ages 9-12 months; Annually-Ages 2 & 3; at Age 4 if High Risk for Lead Poisoning)

If Yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care educator? If so, please detail below:

Physician's Signature: _____ Date: _____

Comments: _____

Please return this form and the child's immunization record to: Program Director