Arlington Recreation Department
Kid Care Afterschool
A School Aged Child Care Program

Information Sheet

Child's Name: _____

School Attending: _____

Grade: _____ **Teacher:** _____

Allergies: _____

Medications: _____

Administered at Program? _____

Office Use Only

Date Received: _____

Days Registered:

Monday Tuesday Thursday Friday

The Commonwealth of Massachusetts
Department of Early Education and Care

Child's 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:_____

Parent/Guardian Information

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

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 Age Only

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**

Additional Approved Pick up Contacts

Please list any other adults that have permission to pick up your child during this school year.

First & Last Name _____

Contact # _____

First & Last Name _____

Contact # _____

First & Last Name _____

Contact # _____

First & Last Name _____

Contact # _____

First & Last Name _____

Contact # _____

First & Last Name _____

Contact # _____

KID CARE AFTERSCHOOL
DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Child's Name:_____ Date of Birth: _____

DEVELOPMENTAL HISTORY

Any Speech Difficulties?_____

Language Spoken at Home:_____

EATING HABITS

Special Characteristics or Difficulties:_____

Favorite Foods:_____

Foods Refused:_____

TOILET HABITS

Is Your Child Ever Reluctant to Use The Bathroom?_____

Does Your Child Have Accidents?_____

SOCIAL RELATIONSHIPS

How Would You Describe Your Child?

_____

_____

Previous Experience with Other Afterschool Programs:

_____

_____

Favorite Toys/Activities:_____

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

How Do You Comfort Your Child?_____

What is the Method of Behavior Management/Discipline at Home?

_____

_____

What Would You Like Your Child to Gain From This Experience?

_____

_____

_____ _____

Parent/Guardian Signature Date

The Arlington Recreation Department

Kid Care After School Program

Dear Parents and Guardians,

From time to time we take photographs of the children during Kid Care activities. We use these photographs in our monthly newsletter, which is displayed at the program onsite and emailed out to families. **None of these photos will be posted online or used outside of the Kid Care newsletter.**

Please return the form to let us know if you would like your child photographed or not.

Please check the appropriate response and sign:

I, _____ hereby allow for my child/children

_____ to be photographed.

I, _____ hereby **do not** allow for my child/children

_____ to be photographed.

Parent/Guardian Signature: _____

Date: _____

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small and Large Group Transportation Plan and Authorization

Child's Name_____Grade_____

My Child Will Arrive at The Program

__Parent Drop Off
__Supervised Walk
__Unsupervised Walk
__Public/Private Van
__Private Transportation Arranged By Parent
__Contracted Bus
Arranged By The Arlington Recreation
Kid Care After School Program
__Other

My Child Will Depart From The Program

__Parent Pick Up
__Supervised Walk
__Unsupervised Walk (with consent form)
__Public/Private Van
__Private Transportation Arranged By Parent
__Other

Parent/Guardian Signature_____Date_____

REFER TO FIRST AID AND MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION

PROGRAM RESPONSIBILITIES

Providing Information To EEC The program must make available any information requested by the EEC to determine compliance with any EEC regulations governing the program, by providing access to its facilities, records, staff and references.

Reporting Abuse or Neglect. All center staff members are mandated reporters. They are required by law to report suspected abuse and neglect to either the EEC or to the Licensee's program administrator. The licensee must have written policies and procedures for reporting and must provide the written policy to you upon enrollment.

Notification of Injury The licensee must notify you immediately of any injury that requires emergency care. The licensee must also notify you, in writing, within 24 hours, if any first aid is administered to your child.

Availability of EEC Regulations. The program must maintain a copy of the regulations, 102CMR 7.00: Standards for the Licensure or approval of Group Day Care and School Age Child Care Programs, on the premises of the center and must make them available to any person upon request. If you have a question about any of the regulations, please request The Arlington Recreation Kids Care Director to show them to you.

I have read and understand the policies of The Arlington Recreation Kid Care as stated in this handbook.

_____ _____

Parent/Guardian Signature. Date

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

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: _____

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___

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent /Guardian Signature Date (valid for one year)

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

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 **not** 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 phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
For topical, non-prescription **NOT** applied to open wound / broken skin **(parent signature only)**

This form only applies to students with...

• asthma • epilepsy • diabetes • serious allergies • anaphylaxis • physical disabilities • ADD/ADHD

EEC Individual Health Care Plan Form

Name of child:	Date of Birth:
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

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

Parental/Guardian Signature: _____Date:_____

Program Administrator Signature: _____ Date:_____

For Older Children ONLY (9+ years of age)

In accordance with 606 CMR 7.11(3)(b-c) and with written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent's Signature: _____ Date: _____

Program Administrator's Signature: _____Date: _____