School Age Child Care Enrollment Form

GENERAL INFORMATION

Check the Before School or After School Site where you would like to enroll your child:

*** Bird St. ☐ ASP * Higginson-Lewis ☐ BSP ☐ ASP *Ellis ☐ BSP ☐ ASP**

*** Vacation Weeks Only ☐**

FOR OFFICE USE ONLY:

☐ VOUCHER FEE_____ **☐ FULL FEE** _____ ☐ Allergies/meds_____

☐ Parent Handbook **☐ DEPOSIT PAID**_____ **DATE OF ADMISSION:** _____

CHILD'S NAME: _____

Gender_____ Date of Birth _____ Age at Admission: _____

Home Address: _____ City: _____

State: _____Zip: _____Apt. #: _____Telephone #: _____

Parent / Guardian 1:
Name_____
Address_____
City, zip_____
Phone #_____
Relationship_____
Occupation_____
Work Hours_____to_____
Business Name_____
Address_____
City_____Ph #_____

Parent / Guardian 2:
Name_____
Address_____
City, zip_____
Phone #_____
Relationship_____
Occupation_____
Work Hours_____to_____
Business Name_____
Address_____
City_____Ph #_____

Child's Identifying Information:
Sex:_____ Weight:_____ Height:_____
Skin color:_____ Hair color_____ Eye color:_____
Identifying marks:_____

School Information:
School_____Grade:_____
Address:_____Zip:_____
Teacher's Name:_____Guidance Counselor:_____
Does SACC have permission to speak with your child's teacher:___yes____no_____call me first

EMERGENCY INFORMATION

Is there documentation of a physical exam, immunization record, and lead screening on file at your child's school? Yes:____ No:____

Child's Physician's Name_____phone_____
***** Health Insurance Carrier_____policy #_____

Child's Dentist's Name_____
Address_____city_____state_____

Emergency Contacts other than a parent/guardian:

Name:_____Relationship to my child:_____
Street Address:_____
Home Phone:_____Work Phone:_____

Name:_____Relationship to my child:_____
Street Address:_____
Home Phone:_____Work Phone:_____

ALLERGIES / CHRONIC HEALTH CONDITIONS: Is your child allergic to anything or have ANY chronic health conditions? ____ No ___Yes

Allergy:_____
Symptoms:_____
Medication:_____

Chronic Health Conditions:_____
Symptoms:_____
Medications**:**_____

RESTRICTIONS: Does your child have any food restrictions? _____No _____Yes
What Kind?_____

Authorization and Consent Form

I understand the staff at the Community Center is trained in the basics of first aid and I authorize them to give my child first aid as needed. 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 community center staff on duty to transport my child to the nearest medical care facility and secure medical treatment necessary including, but not limited to; hospitalization, injections, anesthesia, or surgery.

_____**Date**_____
Parent/Guardian Signature

CONSENT TO RELEASE CHILD

I give my consent to Bird Street Community Center to release my child to the following persons, in addition to me, the parent / guardian. The following are authorized to take my child from the program.

Name:_____Relationship to my child:_____
Street Address:_____
Home Phone:_____Work Phone:_____

Name:_____Relationship to my child:_____
Street Address:_____
Home Phone:_____Work Phone:_____

Name:_____Relationship to my child:_____
Street Address:_____
Home Phone:_____Work Phone:_____

TRANSPORTATION & PICK UP AUTHORIZATION:

I understand Bird Street Community Center's SACC program does not provide transportation to or from program. If there is a change in the transportation authorization, including people designated to pick up my child, I will notify the agency in writing. **PLEASE CHECK:**

DROP OFF: _____Unsupervised Walk from Classroom _____Guardian DROP Off
_____BPS Bus w/unsupervised walk (estimated arrival time: _____)
_____Other: Describe:_____

PICK UP: _____Unsupervised Walk _____Guardian PICK UP
_____Other: Describe:_____

I give my child permission to leave at her/his own choice _____yes ___no

_____**Date**_____
Parent/Guardian Signature

OFF-SITE CONSENT FORM

If the children participate in field trips, they will use public transportation, bus companies, walk or the agency van. I give my permission for my child to participate in all of the regularly scheduled on-going activities at the following off-site facilities: Neighborhood parks (within 1 mile distance), libraries, and pools.

This program will provide in writing a list of scheduled activities. I understand that any other destination within the program will require my written permission in advance. I understand that the staff has the right to rescind/restrict the above privileges if my child's behavior warrants it or if she/he does not honor the code of discipline.

***Parent/Guardian Signature*_____*Date*_____**

Program Communication with Parents

Please list an active email that you monitor regularly. We will periodically email you regarding program updates, parent information, account status and closures due to severe weather conditions.

Parent Email:_____

ADDITIONAL INFORMATION

Are you willing to volunteer your talents or time? Yes No

Photo consent:

I hereby give permission for SACC to photograph my child for advertisement, local newspaper articles, brochures, fund raising activities for the program, etc:_____yes_____no_____call me first

Payments & Policies:

I understand that the weekly fee is due each week in advance, unless other arrangements have been made with the Program Administrator. I understand that the fee for School Age Child Care is tuition based and I may not deduct in the event of my child's absence-for sickness, vacations, or suspension. When full day programs are offered in the event of school vacations, I understand that my fee will increase on those days, but not for snow emergencies or severe weather conditions. I have received a Parent Manual and reviewed the policies and understand them to the best of my ability.

CODE OF CONDUCT

I have discussed with my child the following rules and consequences for non-compliance, while attending the SACC program at Bird Street Community Center:

☐ Will not cause physical injury to another person, action was not necessary to protect oneself.

☐ Will not commit assault and battery on an employee leading to injury.

☐ Will not harm or attempt to harm another person with a weapon.

☐ Will not posses any firearm, knife, razor blade, club, explosive, mace or tear gas or other dangerous object.

☐ Will not posses, sell, distribute, or use any non-prescribed controlled substance, drug or alcoholic beverage.

☐ Will not endanger the physical safety of another by the use of force or threat of force.

☐ Can not attempt or threaten to steal private property.

☐ Can not steal private property.

☐ Can not engage in acts of harassment, physical contact or offensive insults or comments.

☐ Can not use profanity, racial slurs or obscene language in a persistent and abusive manner.

☐ Can not substantially disrupt activities in a repeated, aggravated, or flagrant manner.

☐ Can not pull or report a false fire alarm or 911 call.

☐ Can not falsely identify self.

☐ Can not be in a part of the building or grounds off limits.

☐ Can not excessively leave the activity without permission.

☐ Can not be found to be using tobacco products.

***Parent/Guardian Signature*_____Date_____**

New Policy: Children age seven or older may, with written parental consent, use the bathrooms (**not available to the public**) without constant visual supervision as long as they have a buddy. Children that are ages 5 & 6 must be supervised in the bathroom at all times. By signing below you are giving your child permission to use the bathroom with a buddy.

***Parent/Guardian Signature*_____**

PARENT INFORMATION & INCOME VERIFICATION

LAST NAME	FIRST NAME	MI	GENDER Male Female
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (Home)	Telephone Number (Cell)	AGE	DATE OF BIRTH

	FAMILY SIZE				*FAMILY INCOME*		
	Household size including you		**Very-Low Income**		Low-Income		Low-Moderate Income
	1. PERSON		$15,600		$25,950		$40,800
	2. PERSONS		$17,800		$29,700		$46,650
	3. PERSONS		$20,050		$33,400		$52,500
	4. PERSONS		$22,250		$37,100		$58,300
	5. PERSONS		$24,050		$40,050		$63,000
	6. PERSONS		$25,800		$43,050		$67,650
	7. PERSONS		$27,600		$46,000		$72,300
	8. PERSONS		$49,400		$48,950		$77,000

	SOURCE OF INCOME						
	Check all that apply						
	AFDC		SSI/SSDI		FOOD STAMPS		REFUGEE ASSITANCE
	BPS FR. LNCH PROGRAM		CHILD SUPPORT		ALIMONY		GEN. ASSISTANCE
	UNEMPLOYMENT		PUBLIC HOUSING		EMPLOYMENT		BPS FREE LUNCH

	NEIGHBORHOOD						
	Check area you live						
	ALLSTON/BRIGHTON		CHARLSTOWN		BACKBAY		CHINATOWN
	DOWNTOWN		EAST BOSTON		FENWAY		HYDE PARK
	JAMAICA PLAIN		MATTAPAN		NORTH END		ROSLINDALE
	ROXBURY		S. BOSTON		DORCHESTER		W. ROXBURY

	ETHNICITY/RACE						
	OTHER		WHITE non Latino		BLACK non Latino		LATINO
	AMERICAN INDIAN		ALASKIN NATIVE		AFRICAN		PACIFIC ISLANDER
	HAITIAN		CAPE VERDEAN		AFR. AMERICAN		ASIAN

	CHARICTERISTICS						
	Check all that apply						
	OTHER		TAFDC RECIPIENT		VETERAN STATUS		HANDICAPPED
	REFUGEE		FEM. HEADED HOUSEHOLD		PUBLIC HOUSING		Male HEADED HOUSEHOLD

I hereby confirm that the information that I have provided on this form is true and accurate to the best of my knowledge.

***Parent/Guardian Signature*_____*Date*_____**

CHILDS PROFILE

Child's Name_____Gender_____Age_____

The information provided on these pages will assist our staff in providing a positive experience for your child. APPLICATIONS CANNOT BE PROCESSED UNLESS THE CHILD'S PROFILE IS COMPLETELY FILLED OUT.

1. At home my child usually plays:
   a. With a large group of friends
   b. With a small group of friends
   c. Alone
   d. With older children
   e. With younger children

2. My child is interested in:
   a. Sports
   b. Music
   c. Board Games
   d. Video games
   e. Arts & Crafts
   f. Reading
   g. Journaling
   h. Other:_____

3. My child is:
   a. Happy to be in the After School Program
   b. A little apprehensive about the After School Program
   c. Has been to the ASP before
   d. Has never been to any ASP

4. When my child gets angry he/she:
   a. Sulks
   b. Fights
   c. Throws things
   d. Runs off
   e. Soils his/her clothes
   f. Bites
   g. Spits
   h. Other:_____

5. Please indicate with a check your child's current general disposition and behaviors that most frequently occur:

___Quiet ___Affectionate
___Active ___Easily frustrated
___Irritable ___Frequently cries
___Happy ___Seeks constant attention
___Curious ___Tantrums
___Withdrawn
___Has difficulty with siblings
___Makes friends easily
Other:_____

6. I usually discipline my child by:___
   _____
   _____

7. One specific goal I would like my child to accomplish this year is:___
   _____

8. Is your child on an Individual Educational Plan (IEP)? : _____
   If so, do we have permission to view this information to provide additional support:_____
   _____

9. Does your child have a disability we need to know about to better accommodate his/her services in our program:_____ Explain:
   _____
   _____

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: _____

Physicians Phone Number: _____

Child's Allergies: _____

Chronic Health Conditions:_____

Emergency Contacts (*In the event you can not be reached***)**

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**

MEDICATION CONSENT FORM
102 CMR 7.05(2)(c)

Name of child: _____

Name of medication: _____

Prescription: _____ Non-Prescription: _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Name and phone number of prescribing physician:

_____

Directions for storage: _____

I, _____ (parent or guardian), give permission to authorized staff member(s) to administer medication to my child as indicated above.

_____ _____
Parent/Guardian Signature **Date**

Doctor's Signature _____
(for non-prescription medication)

Department of Early Education and Care
THE COMMONWEALTH OF MASSACHUSETTS

Small Group, Large Group and School Age Child Care Licensing

POLICY STATEMENT: Individual Health Care Plans

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 as required by 606 CMR 7.11(3)(a)-(c). An IHCP ensures that a child with a chronic medical condition receives health care services he or she may need while attending the program.

Programs must develop an IHCP in collaboration with the parents/guardians, school age child who is
9 years or older (when appropriate), program educators and the child's licensed health care practitioner, who must authorize the IHCP.

The IHCP must include the following:

* **description of the chronic condition which has been diagnosed by a licensed health care practitioner**
* **description of the symptoms of the condition**
* **outline of any medical treatment that may be necessary while the child is in care**
* **description of the potential side effects of the treatment**
* **outline of the potential consequences to the child's health if the treatment is not administered**

An educator must have successfully completed training relative to a child's ICHP. This training must be given by the child's health care practitioner or, with the child's health care practitioner's written consent, by the child's parent or the program's health care consultant. The training must specifically address the child's medical condition, medication and other treatment needs. Some examples of an ICHP would include children with asthmatic conditions, allergic reactions, ADHD, or diabetic conditions. IHCP's are *not* required for children *without* chronic conditions needing oral or topical medications.

In the event of an *unanticipated*, non-life-threatening condition requiring treatment (as specified in the IHCP) the educator must make a reasonable attempt to contact the

parents/guardians prior to administering the unanticipated medication or beginning the unanticipated treatment. If parent/ guardians cannot be reached immediately, they should be notified as soon as possible after the medication or treatment has been administered to the child.

Educators must ensure that they document the administration of all medications and medical treatments in the child's medication/treatment log.

Written parental and licensed health care practitioner authorization shall be valid for one year, unless withdrawn sooner and must be renewed annually, *or when the child's condition changes*, for administration of medication and/or treatment to continue.

Additional information regarding Individual Health Care Plans:

- **Educators with written parental consent and authorization of a licensed health care practitioner may develop and implement an Individual Health Care Plan that permits older school age children *who are 9 years or older* to carry their own inhalers and epinephrine auto-injectors and use them as needed, without the direct supervision of an educator. All educators must be aware of how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an IHCP provides for a child to carry his or her own medication, the licensee must maintain an on-site back-up supply of the medication for use as needed.**
- **A copy of the IHCP must be maintained in the child's file. It is recommended that a copy of the IHCP also be located in the classroom.**
- **There must be one person trained in the implementation of a child's IHCP whenever the child is in the care of the program.**
- **In addition to a licensed health care practitioner, training to implement an IHCP may also be given by the child's parent or the program's health care consultant with the licensed health care practitioner's written consent.**

Additional medication requirements to consider:

- **Emergency medication such as Epipens must be immediately available for use. For example, Epipens must be brought with children for outdoor play or walks as required by 7.11(2)(f). Training by a licensed health care practitioner for the specific administration of an Epipen is *highly* recommended but not required.**
- **All staff who administer medication of any kind must be trained in medication administration as required by 7.11(1)(b)2.**

Child's Photo

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply….

Plan was created by:

Plan is maintained by:

__ Parent
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Older school age child (9+ yrs. of age)
__ Other: _____

__ Director
__ Assistant Director
__ Child's Educator
__ Other: _____

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

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

Licensed Health Care Practitioner authorization:_____Date:_____

Parental/Guardian consent:

_____

Date:

_____

For Older Children ONLY (9+ years of age)

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 Signature: Date:

Administrator's signature: Date: