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:_____

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Northern Berkshire: 22 Brickyard Court, North Adams, MA 01247 P: 413-663-6529
Bennington Recreation Center: 655 Gage Street Bennington, VT 05201 P: 802-442-1053

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**

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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)

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THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

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

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

Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting: _____ crawling: _____ walking: _____ talking: _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____ *When? _____

*How do you handle this time? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations:_____

Special physical conditions, disabilities:_____

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

_____

_____

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail: _____

_____

Favorite foods: _____

Foods refused: _____

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* Is your child fed held in lap?_____ High chair?_____

* Does your child eat with spoon?_____ Fork?_____ Hands?_____

TOILET HABITS

*Are disposable or cloth diapers used? _____*Is there a frequent occurrence of diaper rash?_____

*Do you use: oil:_____ powder:_____ lotion:_____ other:_____

*Are bowel movements regular?_____ How many per day?_____

*Is there a problem with diarrhea?_____ Constipation? _____

*Has toilet training been attempted?_____

*Please describe any particular procedure to be used for your child at the center: _____

_____

*What is used at home? Pottychair? _____ Special child seat? _____ Regular seat? _____

*How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____

Does your child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____

Does your child become tired or nap during the day (include when and how long)? _____

_____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

When does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) _____

_____

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SOCIAL RELATIONSHIPS

How would you describe your child? _____

_____

Previous experience with other children/day care:_____

_____

Reaction to strangers:_____ Able to play alone?_____

Favorite toys and 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 childcare experience? _____

_____

DAILY SCHEDULE

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. _____

_____

_____

_____

Is there anything else we should know about your child? _____

_____

_____

_____ _____

(Parent/Guardian Signature) (Date)

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THE COMMONWEALTH OF MASSACHUSETTS
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Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:	**MY CHILD WILL DEPART FROM THE PROGRAM**:
___PARENT DROP OFF	___PARENT PICK UP
___SUPERVISED WALK	___SUPERVISED WALK
___UNSUPERVISED WALK	___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN	___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN	___PROGRAM BUS/VAN
___CONTRACT/VAN	___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT	___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER	___OTHER

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:	**MY CHILD WILL DEPART FROM THE PROGRAM**:
___PARENT DROP OFF	___PARENT PICK UP
___SUPERVISED WALK	___SUPERVISED WALK
___UNSUPERVISED WALK	___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN	___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN	___PROGRAM BUS/VAN
___CONTRACT/VAN	___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT	___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER	___OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

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

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WALKING PERMISSION SLIP

_____ **I DO** _____ **I DO NOT**

… give my child, _____, permission to attend spontaneous outings within walking distance of the Berkshire Family YMCA her classroom teachers. I understand that a separate field trip policies and permission slip which requires vehicle transportation will be sent home prior to the field trip with a field trip description.

Child's name: _____

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

AUDIO/VIDEO RELEASE

_____ I consent and authorize _____ I do not consent and authorize

… the use and reproduction of any and all photographs or video footage taken of my child, _____, for the Berkshire Family YMCA. I understand that I receive no reimbursement for allowing my child's photo to be taken or for the use of the photo video.

Child's name: _____

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

SUNSCREEN PERMISSION SLIP

I give Berkshire Family YMCA staff permission to apply sunscreen to my child for protection from the sun.

Child's name: _____

Name of sunscreen: _____

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

SWIMMING POOL PERMISSION

In order for us to allow your child to participate during our swim time, we need you to sign below. There is always a lifeguard on duty and staff members in the pool area. Thank you.

Child's name: _____

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

ENROLLMENT AGREEMENT

- ☐ I have read and understand the parent handbook policies.
- ☐ I agree to make weekly childcare payments every Friday at the Welcome Center at my local Berkshire Family YMCA branch.
- ☐ I agree to make payments a week in advance to ensure placement for my child, failure to do so will result in a late fee of $20.
- ☐ Consistent late payments will result in termination of my child's slot.

Child's name: _____

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

Department of Early Education and Care
THE COMMONWEALTH OF MASSACHUSETTS

Family Child Care, Small Group, Large Group and School Age Child Care Licensing

POLICY STATEMENT: Oral Health

606 CMR 7.11 (11)(d): Educators must assist children in brushing their teeth whenever they are in care for more than four hours or whenever they consume a meal while in care.

Background and Regulatory Intent:

This regulation is intended to increase awareness of the importance of good oral health practices for the Commonwealth's children. National research indicates that dental caries (tooth decay) is the most chronic childhood disease, five times more common than asthma. If untreated, dental caries results in cavities, pain, infection and, in some instances, devastating consequences for a child's overall health, including sickness and mortality. Primary (baby) teeth have a much thinner layer of enamel compared to adult teeth. Therefore, young children are more at-risk for tooth decay, which usually progresses more quickly than it does in adult teeth. Untreated dental caries can inhibit learning, speech, and eating, leading to problems in school and poor nutrition. U.S. children lose more than 51 million school hours due to dental-related illness, according to a 2000 report of the Surgeon General.

The Catalyst Institute's 2008 study on the oral health of Massachusetts' children found that more than one-in-four kindergarten children had evidence of dental decay, with nearly half of those children having untreated dental decay. The proportion of children from low-income families with untreated decay was at least double that of comparable groups.[1]

Dental caries and oral disease are almost entirely preventable. According to the Centers for Disease Control and Prevention (CDC), "When done routinely and properly, tooth brushing can reduce the amount of plaque which contains the bacteria associated with gum disease and tooth decay."

Application of this requirement to licensed programs:

- This regulation applies to all licensed programs that children attend for more than four hours per day.
- This regulation also applies to all licensed programs where children have a meal (not a snack)[2] while in care, regardless of the length of time the children are in care.

[1] White BA, Monopoli MP, Souza BS. Catalyst Institute *The Oral Health of Massachusetts' Children* January, 2008

[2] 606 CMR 7.12(10)(b) requires that children in care for less than four hours receive nutritious snacks. Children in care for more than four hours must receive meals in addition to snacks.

- Programs where children eat more than one meal must assist children with tooth brushing only once during the program day.

- Tooth brushing need not follow a meal; it can be scheduled at any time that best fits the program's curriculum.

- This regulation does not apply to licensed school age programs when children are in care only before and/or after school. It does, however, apply during school vacation weeks and the summer months if children attend for more than four hours per day or have at least one meal during the program day.

- A program that relies on parents to provide tooth brushes or tooth paste for their children must have extra supplies on hand should a child forget to bring the needed supplies to the program.

- Programs that elect to charge parents a fee to cover the cost of tooth brushing supplies must limit their fee to a nominal amount. Fees must not be applied in a manner that may discourage parents from having their child participate in tooth brushing. Programs that elect to charge fees must be "soundly administered" as required by 606 CMR 7.04(1). Any fee information must be included in the written fee schedule provided to parents, as required by 606 CMR 7.08(6)(g). **Please note** that programs may not charge parents receiving a subsidy through an EEC contract or voucher additional fees, beyond the parent fee established by EEC.

- Programs must encourage children to brush their teeth and assist them in doing so. Children must not be forced to brush their teeth.

Parental choice regarding this requirement:

This regulation creates an opportunity to provide families with resources and information about the importance of good oral health. It is also an opportunity to educate young children regarding good dental hygiene practices. However, EEC supports and respects parental choice.

- Individual parents who do not want their child (ren) to brush their teeth while in care must make a request for non-participation in writing. Programs may use the attached sample form. This request must be maintained in their child's record.

    - Like other information in a child's record, this request to opt out of tooth brushing must be updated annually as required by 606 CMR 7.04(9).

- Licensees should inform parents of this non-participation option and give them an opportunity to decide whether their child should brush teeth while in care.

- Licensees cannot require, compel, or solicit parents' decision not to have their child participate in tooth brushing because of the program's reluctance to implement this requirement. Programs must be prepared to assist children with tooth brushing as required by this regulation.

Oral Health Non-Participation Form

In January 2010, EEC issued new regulations for child care programs that include a requirement that educators assist children with brushing their teeth if children are in care for more than four hours or if children have a meal while in care [606 CMR 7.11(11)(d)]. This regulation is intended to:

- Help children learn about the importance of good oral health
- Provide information and resources regarding good oral health to child care programs and families
- Help address the high incidence of tooth decay among young children in Massachusetts, which is associated with numerous health risks.

EEC licensed programs must comply with this regulation. However, parents may choose that their child (ren) not participate in tooth brushing while present at the child care program.

You do not need to fill out this form to have your child(ren) participate in tooth brushing while they are in child care. However, if you do not want your child to brush his or her teeth while s/he is attending the child care program, please fill out the information found below. A separate form must be filled out for each child in care. This form must be renewed annually and will be kept in your child's record at the program. Should you change your mind and wish for your child to participate in tooth brushing, this form may be withdrawn at any time by requesting in writing that it be removed from your child's file. Thank you.

I do not wish to have my child participate in tooth brushing while in care at

_____
(Name of Program)

Child's Name: _____

Parent/Guardian's Name: _____

Signature: _____

Date: _____

If you have any questions or concerns, please call:

_____ at _____
(Contact Person at Program) (Phone Number)

CHILD CARE REGISTRATION FORM
(Please fill out form for each participating child.)

Child's First & Last Name: _____
Child's DOB: _____ Start Date: _____
Parent(s)/Guardian's Name: _____ DOB: _____
Home Ph#:_____Work Ph#:_____Alt. Ph#:_____
Address: _____Town/State/Zip: _____
Parent(s)/Guardian's Email Address:_____

Child Care Locations: (Check one)
□ Pittsfield Branch □ Northern Berkshire Branch □ Lenox □ Taconic

Classroom: (Check One)
□ Infant (Pittsfield Only) □ Toddler □ Preschool

Full Day Rates: (Check One)
□ Infant: $61.94 □ Toddler: $56.80 □ PreK/Preschool: $43.20

Days of Attendance: (2-Day Minimum)
□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

Drop Off Time: □ 6:30AM □ 7:00AM □ 7:30AM □ 8:00AM □ 8:30AM □ 9:00AM

Pick Up Time: □ 3:30PM □ 4:00PM □ 4:30PM □ 5:00PM □ 5:30PM

Payment Type: (Check One)
□ **Private Pay** □ **Voucher*** □ **Financial Scholarship***
*Attach a copy of voucher or award letter.

AGREEMENT
When payment is required, you must pay a $50 deposit which will be applied to your first week of care. Payment is expected each week by Monday morning. Failure to make a payment may result in the termination of your child's participation in our program. Schedule changes require a written one-week notice. Termination of a program requires a written two-week notice. If you fail to give a two-week notice of termination, you will be responsible for two weeks of payments beyond the last day of attendance. If you have a voucher that expires or does not cover all days in attendance, you are subject to be billed according to the set prices by the Y for the program attended.

Parent/Guardian's Signature:_____ **Date:** _____

FOR OFFICE USE ONLY □ Daxko □ Weekly Billing □ Folder