The Commonwealth of Massachusetts
Department of Early Education and Care

FORM	
Subject: Child Enrollment Form for Emergency Child Care Program	**Emergency Child Care**
Effective Date: March 23, 2020	

Child Enrollment Form for
Emergency Child Care Program at
Berkshire Family YMCA

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:_____

Reason Eligible

DCF Involved: ☐ DTA/TAFDC Involved: ☐ Homeless: ☐ Critical worker: ☐

Explain: _____

Parent/Guardian Information

Parent/Guardian #1:

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Occupation: _____

Employer Name:_____

Employer Address:_____

Employer Phone Number:_____

Hours at Work:_____

Parent/Guardian #2:

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Occupation: _____

Employer Name:_____

Employer Address:_____

Employer Phone Number:_____

Hours at Work:_____

Additional Information

Child's Physician:_____

Address:_____ Phone Number:_____

Special Diet?_____

Allergies: ☐ If yes, describe: _____

Epipen: ☐ If yes, describe _____

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? _____

_____

I acknowledge that this care is being provided in a state of an emergency pursuant to Governor Baker's Executive Order. EEC's Emergency Child Care Program is not subject to EEC licensure and does not require that the program meet all requirements in EEC regulations. I recognize that this child care is being offered on a temporary basis.

_____ _____

Parent/Guardian Signature **Date**

The Commonwealth of Massachusetts
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Child's Enrollment Form for Emergency Child Care Guidance for Document Collection

Required Child Documentation and Forms:

1. Completed Child Enrollment Packet and Face Sheet (see sample)
2. First Aid and Emergency Medical Care Consent Form (see sample)
3. Individual Health Care Plan Form (IHCP) (see sample)
4. Medication Consent Form (see sample)
5. Medication Administration Record (for program use - see sample)
6. Custody Agreement (receive from parent/guardian, if applicable)

TRANSPORTATION PLAN / AUTHORIZED PICK- UP

My child will arrive to the program by:	My child will depart the program by:
__Parent Drop-Off __Supervised Walk __Unsupervised Walk __Public/Private Van __Bus __Private Transportation Provided by Parent	__Parent Pick Up __Supervised Walk __Unsupervised Walk __Public/Private Van __Program Bus/Van __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 child care 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

Day	Arrival Time	Departure Time	Day	Arrival Time	Departure Time
Monday	_____	_____	Friday	_____	_____
Tuesday	_____	_____	Saturday	_____	_____
Wednesday	_____	_____	Sunday	_____	_____
Thursday	_____	_____			

If applicable: Name of School Child Attends: _____

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

Notes:

_____

_____

_____

Child's Name _____

Parental Signatures

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 [redacted] 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: _____

Child's Name _____

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** _____

*Note: 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: _____
* 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: baby 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 program
_____
What is used at home? Potty chair? _____ 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 the 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 physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your educator. Your educator will place your infant on his/her back unless there is a written physician's order that specifies otherwise.**

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 walking etc) _____
_____

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.): _____
_____

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 child care 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: _____

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 a [redacted] home which is [redacted] 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:

_____
_____
_____

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)

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:

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

Plan is maintained by:

__ 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: _____

Commonwealth of Massachusetts
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MEDICATION CONSENT FORM [redacted]

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)**

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MEDICATION ADMINISTRATION RECORD

(This record must be maintained in the children's file when completed)
606 CMR 7.11 (1-3)

FOR STAFF USE:
Who trained the staff? _____
Has the Medication Consent form been completed? ____
Have the "5 rights" been addressed? ____
Is the medication in a safety cap container? ___
Is the original prescription label on the medication container? ___
Is the name of the child given below on the container? ___
Is the date on the prescription current (within the month for antibiotics and within the expiration date for medications which are so labeled; within the year otherwise? ___
Is the dose, name of drugs, frequency of administration given on the label consistent with parental instructions?___

Medication can be administered only if the answers to all questions above are "Yes"

CHILD'S NAME_____**MEDICATION**_____

DATE	TIME	MEDICATION	DOSE	ROUTE	STAFF SIGNATURE	MISDOSES ERRORS	CHILD REFUSAL ☑

Did you check the label 3 times?_____

If child refused medication explain why?_____

[redacted]