

# GROUP CHILD CARE AND SCHOOL AGE CHILD CARE CHILD'S ENROLLMENT FORM

Program:	Group Child Care:	School Age Care:
<b>Child's Name:</b>	Eye Color:	Skin Color:
Home Address:	Hair Color:	Height:
Telephone:	Sex:	Weight:
<b>Date of Admission:</b>	Age at Admission:	
Date of Birth:	Primary Language:	
Identifying Marks:		
Allergies / special diets:		

**PARENT/GUARDIAN INFORMATION:**

Parent/Guardian Name:	Parent/Guardian Name:
Relationship to child:	Relationship to child:
Home Address:	Home Address:
Home Telephone #:	Home Telephone #:
Bus. Name:	Bus. Name:
Bus. Address:	Bus. Address:
Bus. Telephone #:	Bus. Telephone #:
Hours at Work:	Hours at Work:

**ADDITIONAL INFORMATION:**

Child's Physician/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Chronic health conditions: \_\_\_\_\_

Special limitations or concerns: \_\_\_\_\_

**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:* \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**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: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_

Chronic Health Conditions: \_\_\_\_\_

**Emergency Contacts (*In order to be contacted*)**

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 #:
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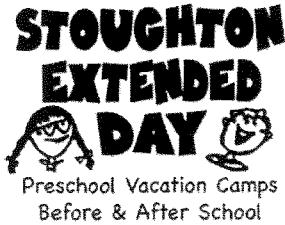
Parent(s) Name:	Phone(w)	Phone (h)
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Parent(s) Name:	Phone(w)	Phone (h)
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\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**



P.O. Box 257, 137 Walnut Street, Stoughton, MA 02072-0257 781-344-5512 Fax 781-341-0885

**Child(ren)'s Name:** \_\_\_\_\_

### **Photo Permission**

**I do / do not (circle one)** give permission for the above stated child(ren) to be photographed as part of the Stoughton Extended Day program which may be used for promotional material, web page displays, and any other materials associated with Stoughton Extended Day Program, Inc.

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Swimming Permission**

**I do / do not (circle one)** give permission for the above stated child(ren) to go swimming with any Stoughton Extended Day programs.

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Sunscreen and Bug Repellent Release**

**I do / do not (circle one)** give permission for the above stated child(ren) to have sunscreen and/or bug repellent applied by SED staff. You, the parent or guardian, must supply the sunscreen/bug repellent in the original container(s) labeled with you child's name. SED will make every effort to apply the sunscreen and /or bug repellent as directed. However, SED has no control over which products or brands are provided and their effectiveness. You must understand that if your child does get burned or bitten, neither SED nor its staff may be held responsible. You should also apply the sunscreen/bug repellent to your child before arriving at camp.

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*We also need a copy of your child(ren)'s immunizations from your child's Physician. Please include that in your registration packet.**

**TRANSPORTATION PLAN AND AUTHORIZATION**

[7.09(3) AND 7.12(1)]

**CHILD'S NAME:** \_\_\_\_\_

**MY CHILD WILL ARRIVE AT THE PROGRAM BY:**

- \_\_\_\_ UNSUPERVISED WALK
- \_\_\_\_ SUPERVISED WALK (WHO \_\_\_\_\_)
- \_\_\_\_ SCHOOL BUS DROP OFF
- \_\_\_\_ PROGRAM BUS
- \_\_\_\_ PROGRAM VAN
- \_\_\_\_ PARENT DROP OFF
- \_\_\_\_ OTHER (DESCRIBE \_\_\_\_\_)

**MY CHILD WILL DEPART FROM THE PROGRAM BY:**

- \_\_\_\_ PARENT PICK UP
- \_\_\_\_ UNSUPERVISED WALK
- \_\_\_\_ SUPERVISED WALK (WHO \_\_\_\_\_)
- \_\_\_\_ PROGRAM BUS
- \_\_\_\_ PROGRAM VAN
- \_\_\_\_ OTHER (DESCRIBE \_\_\_\_\_)

I give permission for my child to be released from the program at the of the day as stated above and/or I give my permission to the following people to receive my child at the end of the day. **(If no one is authorized, please indicate below by writing "NO ONE")**

1. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

2. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

3. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITING AND MAINTAINED IN THE CHILD'S FILE OR THE ABOVE PLAN MUST BE IMPLEMENTED. THIS PERMISSION IS VALID FOR ONE PROGRAM YEAR FROM THE DATE OF SIGNATURE.**

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_