THE KIDS COMMUNITY @ 284

Admission Packet:

- ☐ Enrollment Form
- ☐ 3 Emergency Contacts Form
- ☐ Transportation Plan Form
- ☐ Medication Consent Form
- ☐ Consent for child to leave the program (must be age 9 or older) Parent Authorization Form
- ☐ Consent for child to leave the program (must be age 9 or older) Child's Authorization Form
- ☐ Annual non-refundable registration fee $35 (On Community House website)

Tuition Payments:

- ☐ First and Last Weekly Tuition due by June 30, 2019
- ☐ Tuition Payment Credit Card information (for weekly automatic payments)

From Child's Physician:

- ☐ Documentation of physical examination and immunizations

If Applicable:

- ☐ Individual Health Care Plans/Medication/Epi Pen/Allergy Protocols
- ☐ Copy of IEP
- ☐ Medication Consent Form
- ☐ Custody Agreement Paperwork

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Enrollment Form

Child's Name________________________________ Date of Birth ___/___/____

Date of Admission___/____/____Age at Admission______

Grade Level__________ School______________________

Child's Home Address____

Home Phone Number____

Primary Language of Child and Parents _______________________________________

Physical Description of Child:

Hair color______ Eye color_________ Skin color_________

Sex____________ Height___________ Weight___________

☐ Photo Attached

Schedule:

- ☐ Before School Care
- ☐ After School Care
- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday

Parent/Guardian 1:

Name____

Relationship to Child____

Home Address____

Cell Phone_________________ Home __________________ Work_____________________

Email Address____

Place of Work and Address____

Parent/Guardian 2:

Name____

Relationship to Child____

Home Address____

Cell Phone_________________ Home __________________ Work_____________________

Email Address____

Place of Work and Address____

Additional Information: Child's Physician

Name____________________________Address______________________Phone_________________

Allergies/Special Diets? ____

Health conditions____

Individual Health Plan for child with a chronic condition? ______If yes, please attach.

IEP? ______ If yes, please attach.

Medications____________________________________ side effects____________________

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? _______ If yes, please attach.

Special limitations or concerns? -
____

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Emergency Contacts

Child's Name____

Emergency Contact 1:

Name____

Cell Phone_________________ Home ___________________ Work ___________________

Address____

Emergency Contact 2:

Name____

Cell Phone_________________ Home ___________________ Work ___________________

Address____

Emergency Contact 3:

Name____

Cell Phone_________________ Home ___________________ Work ___________________

Address____

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Transportation Plan and Authorization

Child's Name____

My Child will **arrive** at the program for BEFORE school care:

___Supervised walk

___Parent Drop off

___Public/Private Van

___School bus #____ /Stop location______________________

__________Other

My Child will **arrive** at the program for AFTER school care:

___Supervised walk from Winthrop Elementary School

My Child will **depart** from the program:

___Parent pick up

___Private transportation arranged by parent, picked up by: ___________________

___Other_________________________

Parent/ Guardian Signature: _________________________________ Date: ______________

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 **no**t 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)**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

CONSENT FOR CHILD TO LEAVE THE PROGRAM
(MUST BE AGE 9 OR OLDER)

Program Name: ____

Address: ____

____

I, _____________________________ authorize my child, ____________________
(Parent/Guardian's Name) (Child's name)

to leave the program. This permission is in effect from ___________ to __________.
(Date) (Date)

Activity/Location	Method of Transportation	Leave/Return Time	Restrictions

I understand that the program has the right to rescind the above privilege if my child's behavior warrants the limitation.

I recognize that my child will not be supervised by staff while s/he is away from the program.

I understand I am responsible for my child once s/he leaves the program.

____ ______________________
(Parent/Guardian Signature) (Date)

____ ______________________
(Program Staff Signature) (Date)

Program Name:____

Address:____

I______________________________________, understand that the permission I have received
(Child's Name)
to leave the program is a privilege granted to me. This privilege is based on my parent(s)/ guardian(s) and the staff's expectations of my ability to be responsible for my safety and well-being while I am away from the program.

By signing this contract I agree to the following:

I will always check in with a staff person when arriving and before departing from the program.

I will go only to the destinations agreed to by my parent(s)/guardian(s) and will inform staff of my destination each time I leave the program.

I will act in a safe and courteous manner while I am away from the program.

I will return to the program at or before the time designated by my parent(s)/guardians(s) or by the staff. If I am going to be returning late, I will call the program to inform them of when I will be returning and why I am late.

I will abide by all restrictions listed by my parent(s)/guardians(s) on the authorization and consent form.

Further, I will understand that if I do not abide by the agreements made above, both my parent(s)/guardian(s) and /or the program, as a consequence for my actions may take away my privilege to leave the program for a time period deemed appropriate by them.

____ ____________________
(Child's Signature) (Date)

As ________________________________ parent/guardian, I agree with this contract.
(Child's Name)

____ ____________________
(Parent/Guardian Signature) (Date)

____ ____________________
(Program Staff Signature) (Date)

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Tuition Payment

Name as it appears on the card: ____

Billing Address for the card: ____

Street (no PO Box): ____

City, State, Zip: ____

Phone Number: _____________________________________Email:___________________________________

Type: ____ (Visa, MC, AMEX or Discover)

Account number: ____ CVV #______________

Expiration Date: ________________

Description of charge: Tuition Payment

Daily rates: 2 days after school $75, 3 days after school $95, 4 days after school $120, 5 days after school $140, before school care $15 per day.

I agree to pay at the above rate that corresponds to my child's schedule. Payments are due weekly.

Signature: ____ Date: __________________