



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 19, 2020	

Child Enrollment Form for Emergency Child Care Program

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

TRANSPORTATION PLAN / AUTHORIZED PICK-UP

My child will arrive to the program by:	My child will depart the program by:
<input type="checkbox"/> Parent Drop-Off <input type="checkbox"/> Supervised Walk <input type="checkbox"/> Unsupervised Walk <input type="checkbox"/> Public/Private Van <input type="checkbox"/> Bus <input type="checkbox"/> Private Transportation Provided by Parent	<input type="checkbox"/> Parent Pick Up <input type="checkbox"/> Supervised Walk <input type="checkbox"/> Unsupervised Walk <input type="checkbox"/> Public/Private Van <input type="checkbox"/> Program Bus/Van <input type="checkbox"/> 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

<u>Day</u>	<u>Arrival Time</u>	<u>Departure Time</u>	<u>Day</u>	<u>Arrival Time</u>	<u>Departure Time</u>
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 _____ 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 _____ home which is _____ 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)

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
Department of Early Education and Care

MEDICATION CONSENT FORM

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)

The Commonwealth of Massachusetts
 Department of Early Education and Care

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 <input checked="" type="checkbox"/>

Did you check the label 3 times? _____

If child refused medication explain why? _____





FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

March 24, 2020

To All Child Care Families

From: Michelle Anamisis, Youth Development Director

RE: Emergency Child Care Info

We want to reinforce our commitment to providing a safe experience for everyone who enters our YMCA childcare facility. We have been approved to provide emergency childcare programming at The Westfield YMCA from March 23rd- April 6th. Our program will be limited 40 children per day, from 7:00AM-6:00PM. If you have a stay at home options, we asked you use this in order to keep our program assessable for families that have no other option. There is no cost to families for this program.

Right now everything is so uncertain, but we want to ensure you that we will be providing your child(ren) with a fun, safe learning environment.

Things to bring with you:

- Completed enrollment packet
- Any medications your child will need in our care (form attached to packet)
- Blanket for rest preschool Only
- Weather appropriate outdoor clothes
- Lunch & snacks(nothing that needs to be heated up)
- Water bottle (label with child's name)
- Socks & Sneakers
- Change of clothes

Please no outside toys or electronics. Please also limit anything from home unless absolutely necessary.

For the protection of our parents/caregivers, children and staff, drop off and pick up will occur at the back door to our centers. When you arrive for drop off and pick up a staff member may be outside if not please call or text 413-317-3177 and a staff will meet you. We will have picnic tables set up in the parking lot for parents to fill out the packets and if it is raining we will provide clip boards to fill out in your cars.



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Only children and staff will be able to enter the center. Anyone picking up your child must be listed on the pick-up list and have a photo ID verification. We will not release any child without photo verification

We are taking the following precautions at the Y to address concerns of the Coronavirus:

- We will be taking the temperature of all children & staff entering the program to help create a healthier center. Any child with a registered temperature of 100 or higher will not be allowed to attend that day and not return for 24 hours, symptom free.
- Children will wash their hands immediately upon entering the classroom
- Our maintenance department and YMCA staff are continuing to sanitize and disinfect all child care rooms and facilities throughout the day with particular emphasis on high traffic and high touch areas.

Thank you for your time. If you have any concerns or questions, please contact me at (w)413-568-8631 ext.306 ©413-387-7320 or manamisis@westfieldymca.org. We appreciate everyone's support as we strive to protect the health & safety of all our children and families and work together in the days ahead.