Kiddie Time Educational Child Care Center

Child's Enrollment Form

Child Information

Child's Name:_____ Date of Birth:_____

Date of Admission:_____ Primary Language:_____

Child's Schedule: MON_____ TUE _____ WED_____ THU_____ FRI_____

Parent/Guardian Information

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Address:_____ Address:_____

_____ _____

Cell Phone:_____ Cell Phone:_____

Home Phone:_____ Home Phone:_____

Email Address:_____ Email Address:_____

Others in Family Relationship:_____

Parent/Guardian Business Information

Business Name:_____ Business Name:_____

Business Address:_____ Business Address:_____

Business Phone:_____ Business Phone:_____

Hours at Work:_____ Hours at Work:_____

Email Address:_____ Email Address:_____

Medical Information

Eye Color:_____ Hair Color:_____ Race:_____

Sex:_____ Height:_____ Weight:_____

Identifying Marks:_____

Allergies/Special Diets?_____

Health Insurance Provider: _____

Physician Information

Child's Physician/ Clinic Name: _____

Address:_____ Phone Number:_____

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? _____

_____ _____

Parent/Guardian Signature **Date**

FOR CENTER USE

Center: _____ Date of Admission: _____ Age of Admission: _____

Date Registration Fee Received: _____ Director's Initials: _____

KIDDIE TIME
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION 606 CMR 7.11(2)(b)

Name of child: _____

MEDICATION TYPE:

☐ Prescription ☐ Oral/Non-Prescription ☐ Topical ointment

Prescription Medication Name: _____ Non-Prescription _____ Topical Non-Prescription _____

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_____

Prescription Medications: must have a current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
Oral Non-prescription Medications: require a written order from the child's medical provider and the parent/guardian specifying the product, dosage, time, start date and end date and reason for a period not to exceed ***one week***.
As Needed Children's Medications: require a written order from the child's medical provider and the parent/guardian for a period not to exceed ***6 months***. Authorization must list the reason, dosage, start date and end date.
Non-prescription Topical Children's Ointments: can be applied with authorization from the parent/guardian according to manufacturer's instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children.
Prescription Topical Children's Ointments: require a written order from the child's medical provider and parent/guardian to be applied to ***open, oozing sores***. Authorization must list the reason, dosage, start date and end date.
Medications for Chronic Illnesses: require a written order from the child's medical provider and parent/guardian. Authorization for prescription medications will not exceed the period indicated on the prescription label; however, will not exceed ***one year***. Non-prescription medications must have a written order from the medical provider and parent/guardian; list the reason, dosage, times of administration, start date and end date, for a period not to exceed ***one year***.
Diaper Cream, Sunscreen and Insect Repellant: can be applied with authorization from the parent/guardian according to manufacturer's instructions for a period not to exceed ***one year***. Directions must be designated for use for children.

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider for a period not to exceed ***seven consecutive days***.

Note: All medications must be provided in the original container, labeled with the child's full name and any medication spoon/device to administer the medication must be provided. Non-prescription medications must be designated for use for children.

I further agree to indemnify and hold harmless Kiddie Time Corp., and their agents and employees, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Dosage: _____

Date(s) medication to be given: _____ Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

_____ _____
Print Name of Licensed Physician Signature of Licensed Physician

_____ _____ _____
Address Phone Date/ License #

Parent/ Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above
☐ I have administered at least one dose of the medication to my child/student without adverse effects.

Parent/Guardian Signature_____Relationship_____ Date ____/____/____

*For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**

Kiddie Time Educational Child Care Center

Informed Consent

Child's Name:_____

Access

I will have access to the center without notice when my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement

Child Release

For a child's safety, Kiddie Time (KT) will release a child only to parent(s)/legal guardian(s) or to the third parties I authorized below. Parents/guardians are required to provide a current copy of any relevant Custody Order. Third party pick-up is subject to the following rules:

- At least two people other than the parents/guardians must be listed and designated as emergency contacts by checking the corresponding box below. Emergency contacts will be contacted if parents/guardians cannot be reached.
- If the person picking up is listed below, but does not pick up the child regularly, I will notify the center **verbally, in advance**. Verbal authorization is not permitted for any person not listed on this form.
- If the person picking up is **NOT** listed below, I must notify the center/school **in writing, in advance**. (Note: In RI, parents/guardians must also provide notice in person and in writing.)
- Photo identification will be required if the third party does not pick up the child regularly or is unknown to the staff member releasing the child.

THE FOLLOWING PEOPLE (WHO ARE NOT PARENTS/GUARDIANS) ARE AUTHORIZED TO PICK UP MY CHILD.

	Emergency Contact 1	**Emergency Contact 2**	**Emergency Contact 3**
NAME			
ADDRESS			
CITY/TOWN/STATE/ ZIP			
RELATIONSHIP TO CHILD			
DAYTIME PHONE			
CELLPHONE			
EMAIL			
CONTACT IN THE EVENT OF AN EMERGENCY?			

Walk Permission

Weather permitting, children may go on walks supervised by staff in the surrounding area. Infants and young toddlers are Transported in a buggy or stroller. Children may be taken to the areas listed below, which are not part of our licensed premises. Preschool and school-age children may take field trips. A separate **Field Trip Permission Slip**, describing the activity, will be sent home for signature.

☐ I give permission for my child to participate in walks. Parent Initial _____

Photography and Video Permission

Kiddie Time (KT) regularly takes photographs and videos of children enrolled for its business purposes. Kiddie Time (KT) retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment. They may be shared with you and other families on a Kiddie Time (KT) website, by e-mail, by posting in the center, or in a parent newsletter. They may be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. They may be used for other center, general business, and marketing purposes, including online. Kiddie Time (KT) takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner.

☐ I give permission for Kiddie Time (KT) to take photographs and videos of my child and use these materials for its business purposes.

Children's Injuries

If my child sustains a minor injury during care, I will receive an Occurrence Report when I pick-up describing the incident. I will be contacted immediately if the injury produces any swelling, is on the face or head, or requires medical attention.

Emergency Medical Care

If emergency medical attention is needed for my child, the center will attempt to contact me or the emergency contacts listed (if I cannot be reached). I authorize Kiddie Time (KT) to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility, or to my preferred facility, if possible.

Staff is trained in pediatric first aid and CPR and I authorize staff to administer the same. My child's health information may be viewed by staff, on a need to know basis, and state licensors for compliance.

Child Illness

If my child becomes ill, I will be called. I may be required to pick up my child as soon as possible (within 90 minutes at most). A Child must remain out of the center until he/ she is symptom free for 24 hours, unless a doctor's note is provided which states that the child is 1) not contagious; and 2) can participate in group care. The Family Guide contains Kiddie Time (KT) full Child Illness Policy, including protocols for contagious illnesses.

_____

CHILD'S HEALTH INSURANCE PROVIDER

_____

NAME OF INSURED

_____

POLICY NUMBER

Family Guide Acknowledgement

By signing below, I acknowledge and agree that: 1) in addition to this Informed Consent, I received the Kiddie Time (KT) Handbook, as well as any center specific information and relevant state policies; 2) it is my responsibility to read and familiarize myself with all these materials and address any questions with center management; and 3) I will abide by these materials.

I have read, understand, and accept the conditions noted above.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Annual parent/guardian review and signature is required by Kiddie Time (KT) and some state licensing agencies. If any changes are necessary, a new form will be completed.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

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: _____

* 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) _____

_____

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)

Kiddie Time

Toothpaste and Tooth Brushing Permission Slip

As part of our daily program children will brush their teeth as required by the National Association for the Education of Young Children (NAEYC).

- Fluoride toothpaste is not recommended for children two years and under unless they are able to spit it out.
- Children's or adult brands can be used for children over two years with or without fluoride.
- All products require a valid expiration date, where applicable.
- All containers must be labeled clearly with the child's full name.

I give Kiddie Time permission to allow my child (*name of child)* _____

to brush his/her teeth while at the center. I will provide (name of toothpaste) _____

_____ Toothpaste labeled with my child's full name.

Special Instructions

_____

_____

_____

_____

_____

Permission shall not exceed one year from date of signature.

_____ _____

Parent Signature Date

KIDDIE TIME

Parent Release - Sunscreen and Insect Repellent

Sunscreen and insect repellent should be applied to a child at least once at home to test for any allergic reaction. Aerosol sprays and combined sunscreen and insect repellent are prohibited.

Sunscreen/sunblock must provide UVB and UVA protection with an **SPF of 15 or higher**. Sunscreen **may not** be used on infants under **6 months** of age unless accompanied by a note from the child's medical provider.

Insect repellent may only be used if recommended by public health authorities or requested by a parent/guardian. The repellent must contain a concentration of **30% DEET or less** and may be applied *no more than once a day*. Insect repellant **may not** be used on infants under **2 months** of age.

All sunscreen/sunblock and insect repellent provided by a parent/guardian must be:

- provided in the original container;
- clearly labeled with the child's full name;
- within the expiration date; and
- Appropriate for the age of the child.

I give Kiddie Time (KT) permission to apply *(name of sunscreen)* _____

and/or *(name of insect repellent)* _____

to my child *(a separate form is required for each child)*, _____

From: _____/_____/_____ To: _____/_____/_____ (not to exceed one year).

Special Instructions

Sunscreen/Sunblock: _____

_____

_____

Insect Repellent:_____

_____

_____

_____ _____

(Parent/Guardian Signature) (Date)

Print Name: _____

Reviewed 6/2016

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT PICK UP
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT PICK UP
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

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

EMERGENCY CARD INFORMATION

Child's Name:_____
Date of Birth:_____

Child's Home Address:_____

_____ Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1._____
(Name, Address, Phone #)

2._____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone#)

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

MEDICAL EMERGENCY TREATMENT

I hereby give _____
(Name of program)
permission to administer basic first aid and/or CPR to my child _____
(Name)
and/or take my child _____, to a hospital for medical
(Name)
treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____
(Parent Signature) (Date)

INSURANCE INFORMATION (OPTIONAL)

Company Name:_____ Policy #_____
Participating Hospital:_____
Special Instructions:_____