Please attach/email a recent photo of your child.

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Office Use Only
Admit Date:

Infant/Toddler Enrollment Form

Child Information

Child's Name_______________________________________ Male/Female________ DOB____________ Age______

Home Address_______________________________________ Town/City/Zip_________________________________

Home Phone____ Primary Language___________________________

Parent/Guardian Information

Parent/Guardian Name____ Primary Language___________________

Home Address______________________________________ Town/City/Zip_____________________________

Home Phone____________________ Cell Phone____________________ Work Phone____________________

Name/Address of Business____

Email Address____

Parent/Guardian Name____ Primary Language___________________

Home Address______________________________________ Town/City/Zip_____________________________

Home Phone____________________ Cell Phone____________________ Work Phone____________________

Name/Address of Business____

Email Address____

Custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach.

Medical Information

Name of Physician/Clinic____ Phone #______________________

Address____

Health Insurance Co.____ Policy #____________________________

Chronic Medical Conditions____

Allergies____

Individual Health Plan for child with chronic health condition or severe allergy? If Yes, please attach.

Special limitations or concerns____

Regular medications given at home or school, reason for medication and their possible side effects______

____

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Emergency Contact/Release and Consent Form

Child's Name____

Emergency Contacts
These individuals are authorized for CHAPS to release your child into their care and of make decisions regarding your child's care in an emergency when you cannot be reached.

1. Name____ Relationship to child__________________

Address____ Phone #____________________________

2. Name____ Relationship to child__________________

Address____ Phone #____________________________

3. Name____ Relationship to child__________________

Address____ Phone #____________________________

Release Consent
Your child can be released from the program to the following individuals.
Please list if different from the above emergency contacts.

1. _______________________________________ 2. _______________________________________

3. _______________________________________ 4. _______________________________________

Arrival/Departure from Program
Check all that apply

My child will arrive to CHAPS by:
______ Parent
______ Other (school bus, etc.) _______________________________

My child will depart from CHAPS by:
______ Parent
______ Authorized Pick-ups
______ Other (school bus, etc.) _______________________________

Parent/Guardian Signature____ Date______________

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Permission Form

Medical Care Consent

I authorize the staff at CHAPS 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 CHAPS to transport my child to the nearest medical facility and to secure necessary medical treatment for my child.

Parent/Guardian Signature____ Date_______________

Topical Consent

I give the CHAPS staff permission to apply the following topical and non-prescription medications to my child. Topical creams are defined as skin lotions, sunscreen, bug spray, Chap Stick and diaper rash cream. I understand that I will need to provide and label these items for my child.

Parent/Guardian Signature____ Date_______________

Oral Health

The Department of Early Education and Care's regulations require educators to assist children in brushing their teeth whenever children remain in their care for more than four hours and/or consume a meal.

EEC licensed programs must comply with this regulation. However, parents may choose that their child(ren) not participate in tooth brushing while present at CHAPS.

Parents that would like to participate are responsible for bringing their child's labeled toothbrush and toothpaste to CHAPS. The toothbrushes will be stored on the countertops open to the air most likely in the restrooms. The teachers will assist the children once a day after the children have had lunch.

Please indicate below whether or not you would like your child to participate.

_____ I would like my child to participate in tooth brushing while at CHAPS.

_____ I DO NOT wish to have my child participate in tooth brushing while at CHAPS.

Parent/Guardian Signature____ Date_______________

Hudson Public Schools Consent

I give the staff at the CHAPS program permission to share information concerning my child with Hudson Public Schools Pupil Services and all other health and service providers concerning children.

I understand this information will only be used to develop an environment which is best suited to meet the needs of my child.

Parent/Guardian Signature____ Date_______________

Email Use

Email is an important communication tool that CHAPS uses for notices, reminders, monthly calendars and newsletters, daily notes, closing emergencies, school cancellations and special events. Please make sure the email addresses you provided under Parent Information are checked daily.

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Permission Form (cont)

Media Release

By signing this waiver and release form, I authorize the CHAPS program to use photographs, audio, or video of _________________________ (child's name) in the production of marketing materials, newsletters, websites, videotapes, Facebook, and any other advertisements or promotions that CHAPS may decide to develop now or in the future.

Parent/Guardian Signature____ Date________________

Photo Release

I give permission for my child to be photographed and/or videotaped for classroom purposes (i.e. art projects, slideshows)

Parent/Guardian Signature____ Date________________

I understand that other parents may wish to take pictures of their child at the CHAPS programs. CHAPS employees will discourage those individuals to respect the privacy of others but cannot guarantee that no photographs will be taken of my child.

Parent/Guardian Signature____ Date________________

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Tuition Agreement/Program Policy Compliance

Child's Name____

Tuition Agreement

- Please make checks payable to CHAPS
- Please note your child's name on the check
- Tuition is due on the first day of each week if weekly and on the first day of each month if monthly.
- A late fee of 5% will be added to the late payments.
  Payments made after the fifth day are considered late
- If payment continues to be delinquent, you will not be allowed to drop off your child without tuition.
- Failure to pay tuition may result in suspension, which may lead to termination.
- Tuition is paid each week/month regardless of personal vacations, school vacations and non-attendance for illness.

I agree to these conditions. I have attached a check/cash/money order for the $75.00 registration fee. I understand that the registration fee is non-refundable.

Parent/Guardian Signature_____________________________________ Date_____________

Program Policy Compliance

I have read and understand the policies and procedures included in the Children's After School Programs, Inc. Parent Handbook located on the CHAPS website. I understand that these are the policies and procedures that are followed by the CHAPS staff and I understand and agree to comply with these program policies and procedures.

Parent/Guardian #1 Signature_____________________________________ Date_____________

Parent/Guardian #2 Signature_____________________________________ Date_____________

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Child's Name____

Developmental History

Age Began Sitting_____________ Crawling_____________ Walking_____________ Talking_____________

Does your child pull up? _____________ Crawl?_____________ Walk with support? _____________

Speech Difficulties (please explain)____

Special Words to describe needs____

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 Information

Serious illnesses or hospitalizations (please describe)____

____

Describe any physical/chronic conditions, disabilities, including medically diagnosed allergies, if applicable.

____

Is your child presently or ever been diagnosed with a special need? (If yes, please explain)_____________

____

Does your child receive any special services?____

____

Eating Habits

Special characteristics or difficulties?____

Special Diet: _________________ Formula: ____________________ Breast Milk: ____________________

Have solid foods been introduced?_______Please Identify ____

____

What is your child's typical eating schedule?____

Please describe breast milk, formula and/or food preparation in detail_______________________________

____

Is your child fed held in lap? __________________ High Chair? _____________ Other?_________________

Does your child eat with a spoon? ____________ Fork? ____________ Hands? ____________

Toilet Learning

Is your child toilet trained? _____

What does your child use at home? (i.e.: potty chair, special seat)_________________________________

If no, has it been attempted? (please explain your child's current progress)__________________________

____

Does your child have accidents? ____

Are disposable diapers used? __________ Is there 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? ________________

What special words are used for urination and bowel movements?____________________

Sleeping Habits

Does your child sleep in a crib? ________ Bed? ________

What position does your child sleep? ______________________________________

Is your child swaddled or using a sleep sack to sleep? (Please specify)________________

Please specify your child's nap times. ____________________________________

____

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 of your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

What time does your child go to bed at night? __________ and get up in the morning? __________

What does your child take to bed?________________ mood upon awakening __________

Are there any sleep/wake time rituals? If so, please describe. ______________________

____

Play Habits

Does your child enjoy engaging in play with other children? _______________________

Is your child able to play alone? ____

Favorite toys ____

Fears (the dark, animals, loud noises etc.) ___________________________________

Reaction to strangers?____

How do you comfort and/or reassure your child when necessary? ____________________

How does your child prefer to be held?_____________________________________

Is there anything else we should know about your child? __________________________

____

____

____

Parent/Guardian Signature________________________________ Date____________

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Classroom Emergency Card Information

Child's Name____ Date of Birth________________________

Child's Home Address_______________________________________ Phone #_____________________________

Instructions to reach Parent/Guardian

1. _______________________________________ _______________________________________
(Name) (Address)
_______________________________________ _______________________________________
(Home Phone, Work Phone, Cell Phone) (Email)

2. _______________________________________ _______________________________________
(Name) (Address)
_______________________________________ _______________________________________
(Home Phone, Work Phone, Cell Phone) (Email)

Physician/Clinic

_______________________________________ _______________________________________
(Physician Name) (Phone)
_______________________________________ _______________________________________
(Address) (Insurance Co.)

Emergency Contacts

1. ____
(Name, Address, Phone)

2. ____
(Name, Address, Phone)

Release Consent Your child can be released from the program to the following individuals.
Please list if different from the above emergency contacts.

1. ______________________________________ 2. ______________________________________

3. ______________________________________ 4. ______________________________________

Medical Care Consent
I authorize the staff at CHAPS 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 CHAPS to transport my child to the nearest medical facility and to secure necessary medical treatment for my child.

Parent/Guardian Signature____ Date________________

Allergies____
Chronic Health Conditions____
Special Limitations or Concerns____