CHAPS, inc.
Quality child care for all ages

C.H.A.P.S INC.
Children's Afterschool Programs Inc.
(978) 568-0274
www.hudsonchaps.com

Office Use Only

Admit Date: _____

****Please attach/email a recent photo of your child****

School Age Enrollment Forms

Child's Name: _____ Age: _____ DOB: _____

Home Address: _____Phone: _____

Program(s) Enrolling in: (check all that apply) ____ *After School* ____ *Before School* ____ *Summer*

1. Parent/ Guardian Name: _____Relationship to Child:_____

Home Address:_____Home Phone:_____

Name/Address of Business: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

May we use this email address to send you monthly newsletters and reminders? _____Yes _____No

2. Parent/Guardian Name:_____Relationship to Child:_____

Home Address:_____Home Phone:_____

Name/Address of Business: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

May we use this email address to send you monthly newsletters and reminders? _____Yes _____No

Additional Information

Child's School:_____Phone:_____

Physical Exam & Immunization on file at school? _____Yes _____No

May we share information with your child's school? _____Yes _____No

May your child's school share information with CHAPS? _____Yes _____No

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Parent/Guardian Signature: _____ Date:_____

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Child's Name _____ Date of Birth _____

Child's Physician/Clinic:_____

Address:_____Phone Number:_____

Chronic Health Conditions:_____

Allergies:_____

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

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

Special limitations or concerns:_____

Health Insurance Coverage:_____ Policy #_____

EMERGENCY CONTACTS ***(In order to be contacted, if unable to notify Parent(s)/Guardian(s).)***

Name:_____ Relationship to Child:_____
Address:_____
Home Phone:_____ Cell Phone: _____
*Do you give permission for child to be released to this person? YES NO

Name:_____ Relationship to Child:_____
Address:_____
Home Phone:_____ Cell Phone: _____
*Do you give permission for child to be released to this person? YES NO

Name:_____ Relationship to Child:_____
Address:_____
Home Phone:_____ Cell Phone: _____
*Do you give permission for child to be released to this person? YES NO

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:_____

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CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE CHAPS PROGRAM BY: (check all that apply)

_____ PARENT DROP OFF (Before School, Vacation, In-service Days & Summer)
_____ UNSUPERVISED WALK FROM CLASSROOM (After School)

_____ OTHER _____

MY CHILD WILL DEPART FROM THE CHAPS PROGRAM BY: (check all that apply)

_____ SUPERVISED WALK TO MORNING RECESS BY CHAPS STAFF (Before School)
_____ PARENT PICKUP (After School & Summer)

_____ OTHER _____

I give my permission for my child to be released from the program at the end of the day as stated above and/or I give permission to the following people to receive my child at the end of the day. (If different than emergency contacts on previous page)

1. NAME _____ RELATIONSHIP _____

   ADDRESS _____ PHONE _____

2. NAME _____ RELATIONSHIP _____

   ADDRESS _____ PHONE _____

3. NAME _____ RELATIONSHIP _____

   ADDRESS _____ PHONE _____

4. 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 year from the date of signature.

Parent/Guardian Signature: _____ Date: _____

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Child's Name_____

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/slideshow).

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. (Vacations, In-service days, etc…) 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: _____

Topical Consent

I give my child permission to apply his/her own topical and non-prescription medications. Topical creams are defined as skin lotions, sunscreen, bug spray & chap stick. Please note: The staff will assist the children if needed.

I understand that I will need to provide and label these items for my child.

Parent/Guardian Signature: _____ Date: _____