Please attach/email a recent photo of your child

CHAPS, inc.
Quality child care for all ages

Office Use Only
Admit Date:

School Age Enrollment Form

Child Information

Child's Name: _____ Male/Female: _____ DOB: _____ Age: ____

Home Address: _____ Primary Language: _____

Parent Information

Parent/ Guardian Name: _____ Relationship to Child: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name/Address of Business: _____

Email Address: _____ Primary Language: _____

Parent/ Guardian Name: _____ Relationship to Child: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name/Address of Business: _____

Email Address: _____ Primary Language: _____

Additional Information

Child's Physician/Clinic: _____

Address: _____ Phone: _____

Allergies/Special Diets: _____

Chronic Health Condition: _____

Individual Health Plan for child with a chronic health condition or severe allergy? ❒ Yes ❒ No *If yes, please attach.*

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? ❒ Yes ❒ No
If yes, please attach.

Special limitations or concerns: _____

School Information

Child's School: _____ Phone: _____

Documentation of physical examination and immunizations are 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

Parent/Guardian Signature: _____ Date: _____

Revised 3/2021

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First Aid and Emergency Medical Care Consent Form

Child's Name: _____ Date of Birth: _____

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.

Child's Physician Name: _____

Address: _____ Phone: _____

Child's Allergies: _____

Chronic Health Conditions: _____

Health Insurance Coverage: _____ Policy # _____

Emergency Contacts *(in order to be contacted, if unable to reach both parents/guardians)*

Name: _____ Relationship to child: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Do you give permission for the child to be released to this person? ❒ Yes ❒ No

Name: _____ Relationship to child: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Do you give permission for the child to be released to this person? ❒ Yes ❒ No

Name: _____ Relationship to child: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Do you give permission for the child to be released to this person? ❒ Yes ❒ No

Parent/Guardian Signature: _____ Date: _____

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Transportation Plan and Authorization

Child's Name: _____

Child's Program(s): *(check all that apply)*

❒ Before School Program ❒ After School Program ❒ Full Days (School Vacations, In-Service Days, Summer, etc…)

My child will arrive at the CHAPS programs by:	Before School Program	After School Program	Full Days
Parent/Authorized Drop off	✓		✓
Unsupervised Walk from classroom* **CHAPS assumes responsibility once the children arrive to the designated location. Until then, children are under the care of Hudson Public School staff.*		✓	
Other:			

My child will depart from the CHAPS programs by:	Before School Program	After School Program	Full Days
Parent/Authorized Pick up		✓	✓
Unsupervised Walk to classroom* **Children are dismissed from the before school location to their classroom at 8:20am. At that time Hudson Public School staff assume responsibility.*	✓		
Other:			

Additional Authorized Pick-ups (if different from emergency contacts)

I give permission for the following people to release my child from the CHAPS program.

Name: _____ Relationship to child: _____

Address: _____ Cell Phone: _____

Name: _____ Relationship to child: _____

Address: _____ Cell Phone: _____

Name: _____ Relationship to child: _____

Address: _____ Cell Phone: _____

This permission is valid for one year from the date of signature. Any other transportation requests must be stated in writing and maintained in the child's file.

Parent/Guardian Signature: _____ Date: _____

Revised 3/2021

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Child's Name: _____

Topical Consent

I give my child permission to apply his/her own topical and non-prescription medications. These items can be defined as hand sanitizer, skin lotions, sunscreen, bug spray & lip balm. I understand that the CHAPS staff will assist the children if needed.

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**_____

Media Release

By signing this waiver and release form, I authorize the CHAPS program to use photographs, audio or video of my child 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**_____