The Arlington Recreation Department

Kids Care Program

A School Aged Child Care Program

Gibbs Gym

41 Foster Street

Arlington, MA 02174

781-316-3880

Information Sheet

2016-2017 School Year

Child's Name _____

School Attending _____

Grade _____ Teacher _____

My child will attend the Arlington Kid Care Pre-School Program for the 2016-2017 school year.

Please check appropriate program:

5 Days: ____4 Days: ____ 3 Days: _____2 Days: _____

Please choose the days of attendance:

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

TOWN OF ARLINGTON

Joseph J. Connelly, Director of Recreation
Erin Campbell, Recreation Supervisor

PARK COMMISSIONERS
Donald Vitters
Leslie Mayer
Elena Bartholomew
Jennifer Rothenberg
Shirley Canniff

Recreation Department

ARLINGTON RECREATION KID CARE PROGRAM
PAYMENT FORM
2016 – 2017 SCHOOL YEAR

DATE: _____ CHILD'S NAME: _____

ADDRESS: _____

PHONE: HOME _____ WORK _____ CELL _____

EMAIL: _____

PROGRAM: ARLINGTON RECREATION KID CARE

I UNDERSTAND THAT THE ABOVE PROGRAM IS TO BE PAID ON AN AUTOMATIC MONTHLY PAYMENT BASIS AND THAT THE PAYMENTS ARE MADE ON OR NEAR THE FIFTEENTH OF EACH MONTH. THE INITIAL PAYMENT AT THE TIME OF REGISTRATION WAS FOR THE MONTH OF SEPTEMBER AND MONTHLY PAYMENTS WILL BEGIN IN SEPTEMBER FOR THE REMAINING NINE MONTHS. IF I WITHDRAW MY CHILD FROM THE PROGRAM ONCE IT BEGINS, THE NEXT MONTHS PAYMENT WILL BE FORFEITE.

I AUTHORIZE AUTOMATIC PAYMENTS TO BE MADE TO ARLINGTON RECREATION FOR THE KID CARE PROGRAM.

PLEASE CIRCLE: MASTERCARD VISA DISCOVER

CARD NUMBER: _____

EXPIRATION DATE: _____ SECURITY CODE 3 DIGITS _____

SIGNATURE: _____

PLEASE PRINT NAME AS IT
APPEARS ON THE CARD: _____

KID CARE PRESCHOOL

Child's Enrollment Form

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:_____

Parent/Guardian Information

Parent/Guardian Name: _____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Additional Information

Child's Physician:_____

Address:_____ Phone Number:_____

Allergies/Special Diets?_____

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

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?_____
_____

What are your child's strengths_____
_____
_____
_____

In what areas would you like to see your child grow?_____
_____
_____

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

_____
(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:_____
_____
_____

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)

Permissions (for each child enrolled)

General Permission-(Basic Transport)

(Parents should not sign this permission unless specific places where your child is allowed to go are listed by your educator.) By signing this form, I am allowing my child to be taken off the child care premises.

I, hereby give _____ permission to take my child _____
(educator/assistant)

off the premises of the family child care home for the following excursions: (specific places your child is allowed to go): _____
_____
_____

using the following forms of transportation: _____
_____
_____ _____

Parent/Guardian Signature Date

I do not want my child to be taken off the child care premises.

_____ _____
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

Child's Name

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:	MY CHILD WILL DEPART FROM THE PROGRAM:
___PARENT DROP OFF	___PARENT PICK UP
___SUPERVISED WALK	___SUPERVISED WALK
___UNSUPERVISED WALK	___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN	___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN	___PROGRAM BUS/VAN
___CONTRACT/VAN	___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT	___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER	___OTHER

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:	MY CHILD WILL DEPART FROM THE PROGRAM:
___PARENT DROP OFF	___PARENT PICK UP
___SUPERVISED WALK	___SUPERVISED WALK
___UNSUPERVISED WALK	___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN	___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN	___PROGRAM BUS/VAN
___CONTRACT/VAN	___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT	___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER	___OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

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

ARLINGTON RECREATON DEPARTMENT

KID CARE PRESCHOOL

GIBBS GYM

41 Foster St.

Arlington Ma.

Dear Parents,

From time to time photographs are taken of the children during Kid Care Preschool. These photographs are taken of the children during

These photographs are occasionally displayed here at the program site, in our newsletters and on occasion in our brochures and local newspapers. Occasionally when photographs are displayed or published the children are identified by name.

Please return this form to let us know if you would like your child photographed or not.

Please check the appropriate response and sign:

_____hereby allow my child/children_____

To be photographed.

_____hereby allow my child/children_____

To be photographed for display at the program site and the Kid Care Preschool newsletter.

_____hereby deny permission for my child/children_____to be photographed

Parent/Guardian Signature_____

Date_____

Dear Parents,

To save paper the Parent Handbook is online under Arlington Rec.com Kid Care Preschool. Once you have accessed it and read it please sign below. If you need a hard copy please let me know.

Kim Grubb

I have read and understand the policies of The Arlington Recreation Kid Care Preschool Handbook.

_____ _____

Parent/Guardian Signature Date