WHIZ KIDS LEARNING CENTER

ENROLLMENT PACKET

FOR

_____

GROUP CHILD CARE AND SCHOOL AGE CHILD CARE ENROLLMENT FORM

Program Name:Whiz Kids Group Child Care:____ School Age Care:____

CHILD INFORMATION:

Date of Admission:_____ Age at Admission:_____

Child's Name:_____ Date of Birth:_____
nickname (if any) _____
Home Address:_____ Place of Birth:_____
_____ Primary Language:_____
Telephone #:_____

Child's Identifying Information (required by Department of Ealry Education and Care))
Eye Color:_____ Hair Color:_____ Sex:_____
Height:_____ Weight:_____ Skin Color:_____
Identifying marks:_____
Allergies/ Special Diets:_____
Chronic Health Conditions:_____
Special Limitations or Concerns:_____

School age only: Current school:_____ Grade:_____
I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poison screening in accordance with public health requirements are on file at my child's school. **Parent/guardian initials** _____

PARENT/GUARDIAN INFORMATION:

Name:_____ Name:_____
Relationship to Child:_____ Relationship to Child:_____
Home Address:_____ Home Address:_____
_____ _____
Home Telephone#:_____ Home Telephone #:_____
Cell Phone#:_____ Cell Phone #:_____
Business Name:_____ Business Name:_____
Business Address:_____ Business Address:_____
Business Phone #:_____ BusinessPhone #:_____
Hours at work:from _____AM to _____PM Hours at work:from _____AM to _____ PM

If parents cannot be contacted, notify (include names on emergency card)

Name:_____ Name:_____
Address:_____ Address:_____
_____ _____
Relationship to Child:_____ Relationship to Child:_____
Daytime telephone #:_____ Daytime telephone #:_____

Child's Physician/Clinic _____ Telephone #:_____

_____ _____
Parent/Guardian signature **Date**

WHIZ KIDS LEARNING CENTER

APPLICATION FOR ENROLLMENT

Child's name:_____ Date of birth:_____

Address: _____
_____ Phone: _____

Parent Name:_____
Home phone #: _____ Work phone #: _____

Parent name: _____
Home phone #: _____ Work phone #:_____

ENROLLMENT INFORMATION

Please circle the days you would like your child to attend:

Monday Tuesday Wednesday Thursday Friday

Which program would you like to enroll your child in:

( )Toddler (full days, full week only)

( )Morning childcare (includes Preschool/Pre-K) (8:30 - 12:30)

( )Short daycare (includes Preschool/Pre-K) (8:30 - 3:30)

( )Long daycare (includes Preschool/Pre-K) (8:30 - 5:00)

( )Short Afternoon care (12:30 - 3:30)

( )Long Afternoon care (12:30 - 5:00)

( )After school care (3:00 - 5:00)*

( )Before school care (8:30 - 9:00)*

( )Before and After school care*

* which school does your child attend? _____grade____

( )Summer Camp (full days only)

When would you like your child's enrollment to begin? _____

How did you hear of Whiz Kids Learning Center? _____
Date of Application: _____

There is a one time (non-refundable) $25 registration fee per child, to be paid at time of registration.

Whiz Kids Learning Center
CONTRACT OF ENROLLMENT

Whiz Kids Learning Center agrees to provide educational and/or day care services to _____, during the calendar year starting on _____ (Date) and ending about _____ (Date), according to the following schedule: M T W TH F; _____AM to _____PM.

I agree to make tuition payments of $ _____ per week or $_____ per day. I understand that if my child comes under a voucher agreement, I agree to pay any copay involved and cover the self-pay costs should the voucher be terminated and the child remains in our care.

The following are additions to the payment policies as stated in the Parent handbook:

- Tuition is due in advance by Friday for the following week. Any account with a balance on Tuesday @ 12 noon, will be charged a $10 late payment fee.

- Tuition may be paid by check, money order, cash or credit card. There is a $25 charge for returned checks.

- Tuition is due for all time reserved for your child.

- If your tuition payment is behind for two weeks we will suspend your child from attending Whiz Kids Day Care until payment arrangements have been made in writing and/or we will have to request the services of our collection agency. You will be responsible for all collection and legal fees.

- Whiz Kids closes at 5:00 PM. There is a $1 per minute late-pick-up fee, to be paid to the teacher who has to stay with your child.

-If you need to withdraw your child from Whiz Kids, we require a two-week written notice

Additional Policies:

-Children are accepted into the program on a trial basis to make sure that it's a good fit. We want to ensure that children have an enjoyable learning experience with us.

-In some cases, we also accept children with possible medical or development issues also on a trial basis to make sure that we can accommodate the child and have that child be safe and happy in our care.

I have read and agree to abide by all of the above and the policies in the Whiz Kids Learning Center Parent Handbook.

_____ _____

Signature of parent or guardian Date

WHIZ KIDS LEARNING CENTER EMERGENCY CARD

_____ SCHOOL YEAR

CHILD'S NAME: _____ DOB: _____

ADDRESS: _____
number, street, town, zip code)

PARENT INFORMATION	PARENT INFORMATION
NAME: _____	_____
WORKPLACE: _____	_____
WORK PHONE: _____	_____
HOME PHONE: _____	_____
CELL PHONE: _____	_____

(IN WHICH ORDER SHOULD WE CALL IF WE NEED TO REACH YOU?)

IF PARENTS CANNOT BE REACHED, CONTACT:

NAME:	PHONE:	RELATIONSHIP TO CHILD:
_____	_____	_____
_____	_____	_____
_____	_____	_____

IN CASE OF AN EMERGENCY I AUTHORIZE WHIZ KIDS STAFF TO PROVIDE FIRST AID AND TRANSPORT MY CHILD TO CAPE COD (OR NEAREST) HOSPITAL. I UNDERSTAND THAT I WILL BE CONTACTED IMMEDIATELY.

CHILD'S PHYSICIAN
OR CLINIC: _____ PHONE: _____

CHILD'S ALLERGIES: _____

I AUTHORIZE THE FOLLOWING PERSON(S) TO PICK UP MY CHILD FROM WHIZ KIDS:

NAME:	RELATIONSHIP TO CHILD:
_____	_____
_____	_____
_____	_____

I WILL CALL AHEAD TO LET WHIZ KIDS KNOW, WHEN A PERSON OTHER THAN THE PARENT(S) IS PICKING UP MY CHILD. IF A PERSON NOT ON THE LIST IS PICKING UP I WILL PROVIDE A NOTE TO WHIZ KIDS.

_____ _____
(SIGNATURE) (DATE)

TRANSPORTATION PLAN
AND
ALTERNATIVE TRANSPORTATION PLAN

CHILD'S NAME: _____

MY CHILD ATTENDS _____ SCHOOL AND IS IN GRADE ____

IN THE AM MY CHILD WILL ARRIVE AT THE CENTER BY:
_____ parent drop off
_____ unsupervised walk
_____ supervised walk (who _____)
_____ other (describe _____)

IN THE AM MY CHILD WILL DEPART FROM THE CENTER BY:
_____ unsupervised walk
_____ supervised walk (who _____)
_____ program bus
_____ public school bus
_____ other (describe _____)

IN THE PM MY CHILD WILL ARRIVE AT THE CENTER BY:
_____ unsupervised walk
_____ supervised walk (who_____)
_____ program bus
_____ public school bus
_____ other (describe_____)

IN THE PM MY CHILD WILL DEPART FROM THE CENTER BY:
_____ unsupervised walk
_____ supervised walk (who_____)
_____ parent pick up
_____ other (describe_____)

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 my permission to the following people te receive my child at the end of the day. (If no one is authorized, please indicate below by writing "NO ONE").

1. Name _____ Relationship _____
   Address_____ Phone _____
2. Name _____ Relationship _____
   Address_____ Phone _____
3. 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 program year from the date of the signature.

Parent/Guardian signature _____ Date _____

MEDICAL AUTHORIZATION AND CONSENT

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. If, however, I cannot be reached, I hereby authorize Whiz Kids Learning Center to arrange transport for my child to the Cape Cod (or nearest) Hospital and secure for my child the necessary medical treatment. I understand that the teachers at Whiz Kids are trained in the basics of First Aid and CPR and I authorize them to give my child first aid when appropriate. I hereby release Whiz Kids Inc., and its staff, from all claims, demands, actions, and damages whatsoever arising out of or resulting from said medical care.

HEALTH INSURANCE INFORMATION

Name of Insurance Plan: _____ Subscriber #: _____

Date: _____ Parent/Guardian signature: _____

PHOTOGRAPH CONSENT

I hereby grant permission for my child to be photographed by the staff of Whiz Kids Learning Center for purposes of school activities and publications. I understand that no photographs of my child will be released to the media without my written consent.

Date: _____ Parent/Guardian signature: _____

FIELD TRIP CONSENT

I hereby grant permission for my child to attend class field trips and/or weekly summer trips. I grant Whiz Kids permission to transport my child via Whiz Kids school bus to the trip location and back to the center. By signing this section, I give permission for Whiz Kids to take my child on class field trips and outings during the school year and during the summer program. Only the children in Pre-School thru School Age go on these trips (2.9 years to 13 years)

Date:_____ Parent/Guardian signature: _____

SWIMMING/PLAYGROUND TRIPS

Our summer program schedule includes 1/2 day trips to local beaches for swimming and water play, or, if it is not warm enough, we go to local playgrounds during the time allotted for swimming.
I hereby grant permission for my child to be transported to local beaches and/or playgrounds during swimming times indicated on the summer camp schedule, and to participate in water activities.

Date: _____ Parent/Guardian signature: _____

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)

AUTHORIZATION FOR NON-PRESCRIPTION DRUGS

The Massachusetts Department of Early Education and Care requires us to have this form (signed and dated by the physician) on file in order to be able to give your child a non-prescription medication that you will provide when needed. This form will be valid for one year from the date the physician signs it. The parent/guardian will fill out a form for the specific medication, indicating the dates and times we are to administer it, at the time that you bring in such medication.

Name of Child: _____

Name of Parent: _____

I authorize Whiz Kids Learning Center to administer the non-prescription medication indicated below to the above named child at the request of the child's parent. I understand that Whiz Kids will never exceed the recommended dosage on the drug package.

dosage	
_____	Children's fever medication
_____	Children's cold medication
_____	Children's cough medicine
_____	Children's allergy medicine
_____	_____

Date: _____ Physician's Signature: _____

Please return to:

Whiz Kids Learning Center
593 Flint Street
Marstons Mills, Ma. 02648

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)**_____

My child has previously taken this medication_____

My child has **not** 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_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____**, (parent or guardian) gives permission**
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

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

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)