PLOWSHARES CHILD CARE PROGRAM

At Franklin
125 Derby Street W. Newton 02465
617-244-9330

457 Walnut Street(NNHS)
Newtonville, Massachusetts 02460
Phone: (617) 527-3755 Fax (617): 244-0227

At Lincoln Eliot
191 Pearl Street, Newton 02458
617-965-6082

ENROLLMENT APPLICATION*

(* Please enclose the $25.00 Application Fee with this form.)

Application Fee_______________
Deposit Paid _________________
Check# _____________________
Date Paid _____________________

Age of child at admission: _________ Entering Grade _______

I hereby attest that all e-signatures throughout this application serve as authorized signatures.

Site Requested: Franklin_____ Lincoln Eliot_____ Newton North_____

Student Data:

Child's Name: ____
Last First Middle

Home Address: ____

____
City State Zip Code

Child's Social Security #: ________________________ Birth date: ____________________

Home Phone:____

Guardian 1 Data

Name ________________________ Relation ____________________

Address ________________________ Soc Sec # ____________________

________________________ Work Hours____________________
City State Zip Code

Employer: ________________________ Occupation ____________________

Address ________________________ Email Address____________________

Home Phone________________**Work Phone**________________**Cell Phone**________________

Guardian 2 Data

Name ________________________ Relation ____________________

Address ________________________ Soc Sec #____________________

________________________ Work Hours____________________
City State

Employer: ________________________ Occupation____________________

Address ________________________ Email Address____________________

Home Phone:________________**Work Phone**________________**Cell Phone**________________

Enrollment Information: (Please Circle Appropriate Program Information)

Summer Camp / School Year / Full Year Toddler / Preschool / Kindergarten / After-School

Schedule of Attendance: M T W TH F

Hours (From - To) ________ ________ ________ ________ ________

Dates of Enrollment: From: _____/______/______ To: _____/______/______

List all Known Allergies/Medical Conditions:______________________________

____

We/I will be solely responsible for our/my child's daily transportation to and from Plowshares Childcare Program. For alternate pickups please see authorized escorts below. _______________ _______________
(Parent(s)/Guardians please initial)

AUTHORIZED RELEASE OF CHILD
(Other than Parents)

Escort 1 Name ____ Relation ___________________________

Address ____ Phone ___________________________

Escort 2 Name ____ Relation ___________________________

Address ____ Phone ___________________________

Any person(s) to whom child should NOT be released:

Name ____ Relation ___________________________

Name ____ Relation ___________________________

EMERGENCY CONTACTS (*Other than Parents*)

1. Name, address, phone #'s (Home,work,cell) ____

____

2. Name, address, phone #'s (Home,work,cell) ____

____

Emergency Information

Doctor's Name ____ Phone ___________________________

____
Address City State Zip Code

Hospital Name ____ Phone # ___________________________

Insurance Company ____ **Policy #** ___________________________

Identification Data (Required by state regulations)

Height ____________________ Weight ____________________ Sex _______________ Race ____________________

Hair Color _________________ Eye Color ________________ Distinguishing Marks ________________________

*** Wallet size photo required (please attach)**

BACKGROUND INFORMATION ON CHILD AND FAMILY

The following information will help us to know your child better and to offer the type of care and attention which best meets your child's needs.

Household Composition
Names and Ages of Siblings: ____

____

Names and Relationships of others living in the home: ____

____

Languages Spoken at Home: ____

Has your child received any of the following screenings or evaluations? **{If yes, please submit a copy of report(s)}**

_______Vision ______Hearing _______Speech _______Psych _______IEP _______Other (Specify)

Findings/Disabilities: ____

Recommendations: ____

Food Restrictions
Food Allergies? ____

Any Eating problems/disorders? ____

Favorite Foods ____Food Refused ___________________

Health:
Any serious illness or hospitalization? ____

Any Physical disabilities or allergies (Asthma, hay fever, insect bites, medications)

____

Any Medications given regularly? ____

Other Information
Does your child have any fears (e.g. noises, animals etc.) ?

____

Social Relationships:
Has your child been in another preschool/playgroup?____

By nature is your child: Outgoing ________? Active ________? Shy________? Withdrawn_________?

How does child relate to strangers? ____

Does child play well alone? ___________________________________ Favorite Toys _____________________

Is your child frightened by _______animals; _______rough play; ______loud noises; ______dark; _____storms

Other (Please indicate)____

In general, how does your child react to a stressful situation? (cry, withdraw, tantrum etc.) ________________________

____

How do you respond/lend support at home? ____
How do you comfort your child? ____

____

When needed, how do you discipline your child? ____

____

Who does most of the disciplining? ____
What is the best way of handling your child? ____

____

What goals would you most like us to help your child with? ________________________________

____

Please provide a brief account and date of important events related to the child and family (e.g. recent moves, death in the family, adoption, divorce or separation, long absences, serious illness, birth complications

____

____

____Share insights into your child's personality, uniqueness, behavior or anything else you would like.

____

____

____

What are your child's strengths and special characteristics? ________________________________

____

AFTER-SCHOOL: As per EEC regulations, I verify that my child's health records are on file at the
[ ] Lincoln Eliot; [ ] Franklin; [ ] Other (Please name)__________________________school office.

Parent Signatures ____ Date_________________________

____ Date_________________________

Toddlers and Preschoolers Only
Any complications at birth? ____

Age child Sat_______________Crawled________________Walked__________________Talked________________

Any difficulties speaking?______________________________Other languages spoken_______________________

Special words to describe needs____

Does child indicate toileting needs?____

Is child frightened of bathroom/toilets? ____

Is child self-sufficient in toileting skills?______________________Does child have accidents?________________

Does child take naps? ________________From when _____________________ to _________________________

What time does child go to bed in P.M.? ______________________ Awake in A.M.? _______________________

Mood upon awakening? __________________________What does child take to bed? ______________________

Plowshares strives to protect the privacy and rights of all our children and families and will not release photos, media or private information without consent, unless so required by law or deemed to be in the best safety interest of the children in our care.
Please note: Children's applications/files are subject to confidential review by staff and student teachers.

Plowshares Education Development Center,
Inc. 457 Walnut Street, Ma 02160
Ph.(617)527-3755 Fax.(617)244-0227

EMERGENCY CARD INFORMATION

Child's Name:____ Date of Birth:_________________

Child's Home Address:____

____Phone:______________________

INSTRUCTIONS TO REACH PARENT/GUARDIAN (Name, Address, Phone #'s **Work, Cell, Home**)

1.____

____

2.____

____

PEDIATRICIAN OR SOURCE OF HEALTH CARE (Doctor's Name, Address, Phone #'s)

1.____

EMERGENCY CONTACT & RELEASE PERSON(S) (***other than parents***) (Name, Address, Phone #'s **Work, Cell, Home**)

1.____

____

2.____

____

Name/Address/#'s for Authorized Release Persons (if different) ____

____

MEDICAL EMERGENCY TREATMENT

I hereby give Plowshares Educational Development Center permission to administer basic first aid and/or CPR to my child and/or take my child ____________________________ to Newton Wellesley (or nearest) Hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

____ ______________________
(Parent/Guardian Signature) (Date)

ALLERGIES/MEDICAL CONDITIONS____

____

Current Height: ___________Weight:______________ **Wallet size photo required (please attach)**

INSURANCE INFORMATION (OPTIONAL)

Company Name:_____________________________________ Policy #______________________

Participating Hospital:____

Special Instructions:____

I hereby attest that all e-signatures throughout this application serve as authorized signatures.

(OVER)

(revised 06/09)

PERMISSION TO TAKE CHILD OFF THE PREMISES

I hereby attest that all e-signatures throughout this application serve as authorized signatures.

I hereby give permission for staff members and all parent or guest supervisors of **PLOWSHARES CHILDCARE PROGRAM, INC.,** to take my child, ___________________________________, on excursions from the center which will include the following types of activities:

1. Walks to neighborhood parks, stores and other educational attractions.

2. Special Events.

If a parent chooses not to send a child on a field trip he/she is responsible for making alternative childcare arrangements. If enough children are not participating on the trip, Plowshares may make arrangements for them, <u>if</u> <u>staffing permits.</u>

____

Signature of Parent or Guardian

Date:_______________________________

Parents, please list any special information we might need to know about your child concerning field trips. Thank you.

- OVER -

PLOWSHARES EDUCATION DEVELOPMENT CENTER, INC.

AFTER-SCHOOL PROGRAMS

ATLERNATIVE TRANSPORTATION RELEASE FORM

CHILD'S NAME: ____

MY CHILD WILL ARRIVE AT THE PROGRAM BY:

__________ Unsupervised Walk __________ Supervised Walk (Who __________________________________)

__________ School Bus Drop Off __________ Parent Drop Off

__________ Other (Describe _____________________________________)

MY CHILD WILL DEPART FROM THE PROGRAM BY:

__________ Parent Pick Up _________Unsupervised Walk ________All Year/_______________List Specific Dates

__________ Supervised Walk (Who ____________________________________)

__________ Other (Describe____) **

** (Time_______________ Date(s)______________Mode of Transportation___________________)

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 to 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 signature.

I understand that the program is responsible for my child only upon their arrival at the program and ceases upon their departure from the program as authorized above. I accept responsibility for my child at all other times. On behalf of myself, my child, and all family members, I hold the program, its officers, directors, employees, and the City of Newton, harmless from any liability except in the case of intentional misconduct.

I understand this policy and have had the opportunity to ask questions for clarification.

Parent/Guardian ____

Date ____________________________________ (A.S. Regs. 11.05(9) (b)

Form 12/09

I hereby attest that all e-signatures throughout this application serve as authorized signatures.

457 Walnut Street
Newtonville, Ma. 02460
(617) 527-3755/ Fax (617) 244-0227

Plowshares Education Development Center, Inc.

Lincoln Eliot
191 Pearl Street
Newton, MA. 02458
Ph 617-965-6082
Fax 617-965-1395

Franklin
125 Derby Street
W.Newton, MA. 02465
Ph 617-244-9330
Fax 617-244-8194

IN-HOUSE MEDIA RELEASE

(Plowshares strives to protect the privacy and rights of all our families and will not release photos, media or private information without consent, unless so required by law or deemed in the best safety interest of the children in our care.)

I DO [ ]

I DO NOT [ ]

GIVE PERMISSION FOR MY CHILD, ____

TO HAVE HIS/HER PHOTO/VIDEO TAKEN WHILE AT PLOWSHARES.

I UNDERSTAND THAT THESE IMAGES WILL BE USED FOR IN-HOUSE PURPOSES ONLY SUCH AS, BUT NOT LIMITED TO, THE FOLLOWING:

* **PLACEMENT IN MY CHILD'S FILE OR PORTFOLIO**
* **DISPLAY ON PLOWSHARES BULLETIN BOARDS**
* **USE DURING PLOWSHARES YEAR-END VIDEO PRODUCTION (WHICH IS OFTEN DISTRIBUTED TO OTHER PLOWSHARES FAMILIES)**
* **PICTURES OF PROGRAM ACTIVITIES/EVENTS FOR ANY CHILD TO TAKE HOME**
* **PLACED ON PLOWSHARES COMPUTER SCREEN-SAVER**

FURTHER,

I DO [ ]

I DO NOT [ ]

GIVE PERMISSION FOR MY CHILD'S PHOTO TO BE USED ON PLOWSHARES BROCHURES AND/OR WEBSITES ACCESSIBLE BY THE GENERAL PUBLIC.

I hereby attest that all e-signatures throughout this application serve as authorized signatures.

SIGNATURE: ____

DATE: ____

Plowshares Education Development Center, Inc.

NON-ANTISPETIC TOPICAL OINTMENT APPLICATION PERMISSION

I hereby authorize Plowshares to administer the following non-antiseptic topical ointment (e.g. sunscreen, Desitin, Calamine Lotion, etc.) for my child:

____
Name of Child

SUNSCREEN: **(specify brand and type)** ______________________________

____

When to be Given: ____

Direction for Usage: ____

____

Parent Signature: ________________________________Date: ____________

NOTE: Should my child run out of sunscreen, I give permission for the staff to use Plowshares sunscreen, **Coppertone Water Babies SPF 45** on my child.
Please Initial ______________________

Special Indications: (e.g. **DO NOT USE ANY OTHER BRAND**, etc.) ________________
____
____

I hereby attest that all e-signatures throughout this application serve as authorized signatures.

Please return to: **PLOWSHARES EDUCATION DEVELOPMENT CENTER, INC.** Tel: (617) 527-3755
Newton North High School Fax: (617) 244-0227
CONFIDENTIAL **457 Walnut St**
Newtonville, Ma. 02460

Date ____________________________

Pupil's Name____
(Last Name) (First Name) (Initial)

D.O.B. ______________________________ Age ___________________ Sex____________________

Parent or
Guardian____ Phone#:______________________________
Address:

____

MEDICAL INFORMATION

History: (Illness, Injuries, Childhood Diseases)-

____

____

Medical Conditions :____
Medications :____
Medication Allergies :____

____

Immunizations: Dates

	1	**2**	**3**	**4**	**5**	**6**
DPT/Td	_________	_________	_________	_________	_________	_________
TOPV	_________	_________	_________	_________	_________	_________
HIB	_________	_________	_________	_________	_________	_________
HEP B	_________	_________	_________	_________	_________	_________
MMR	_________	_________	_________	_________	_________	_________
LEAD	_________	_________	_________	_________	_________	_________
T.B. SKIN TEST	_________	_________	_________	_________	_________	_________
VARICELLA (Chicken Pox)	_________	_________	_________	_________	_________	_________

Statistics: Height ___________ Weight___________ Blood Pressure___________ Pulse___________

Nutrition____
(Good, Poor, Obese, Underweight)

I have examined____________________________________on ________________________________ and found her/him to
(Child's Name) **(Date)**

be in excellent health. She/He may participate in all activities without restrictions ________________________________.

Physician Name:____________________________________ Physician Signature:_________________________________

Address:____ Phone #: ____________________________________

____

Form: 06/09

ACTION PLAN FOR MEDICAL CONDITIONS

Child's Full Name____ Date of Birth______________

Home Address____ Zip Code________________

Medical Conditions____

____

(i.e. Food-ingestion and/or exposure, Bee stings, Asthma etc.)

Symptoms of an allergic reaction may include: (check all that apply)

_____Trouble breathing _____Wheezing/Cough _____Dizziness _____Vomiting _____Skin Rash/Redness

_____Throat tightening _____Swelling _____Fainting _____Eye Puffiness _____Nausea

_____Diarrhea _____Abdominal Pain _____Hives _____Itchiness _____Sneezing

Symptoms/Asthma reactions:

_____Wheezing _____Coughing _____Tight Chest _____Breathing hard and fast _____Nostrils flaring _____Trouble Talking

OTHER:____

____

EMERGENCY ACTION (if necessary):____

____

TREATMENT: **(Please be specific and detailed)**

Name of Medicine(s)_____________________________________Dosage_______________________

____Dosage_______________________

When to Administer____

____

****Side Effects of Treatment**____

****Consequences of Non-Treatment**____

I give _______________________ my permission to instruct the staff of Plowshares Child Care in the specifics
(PARENT/GUARDIAN(S) NAME)
regarding his/her child's____________________ medical/health condition treatment and the side effects of that treatment.
(CHILD'S NAME)

Physician Name (**print**)______________________________________ Tel#________________________

Signature ____ Date________________________

Allergist Name (**print**)______________________________________ Tel#________________________

Signature ____ Date________________________

Additional Information / Instructions:

____

____

Call Parent(s) / Guardian(s) with any questions or concerns.

Parent/Guardian____ **Relation** ____________________

HOME TEL#__________________________ **WORK #**__________________________ **CELL#**______________________

Parent/Guardian____ **Relation**____________________

HOME TEL#__________________________ **WORK #**__________________________ **CELL#**______________________

Signature ____ **Date**__________________________

Parent/Guardian

Signature ____ **Date**__________________________

Parent/Guardian

Plowshares Child Medication Sheet and Parental Authorization for Administration of Medication and Liability Release

***Please note*:**

The Department of Early Education and Care prohibits us from administrating the first dose of any new medication.

I authorize Plowshares to administer the following medication____
to my child____and release and indemnify
Plowshares and any affiliated staff, members, officers,volunteers or other associates from any liability which might arise due to any act or omission related to the administration of the following medication:

****Medication:____ Dosage:___________________________________**

*****If the medication is an Epi pen be sure the child's name is on the syringe as well as the outer packaging***

Time to be Administered: ____________________ Duration of Administration__________________________

Special Instructions or Information:____

If this is a medication prohibited under DEA Schedule II-V, do we have medical authorization to administer? ______YES_____NO

If NO, Plowshares cannot administer this medication today.

Is this the very 1st time your child has taken this medication? __________YES_________NO

If YES, Plowshares cannot administer this medication today. Date of 1st dose_________ 2nd dose_________?

Does this medication require refridgeration ? ___________Yes ___________NO

Please list ALL medications your child is currently taking: ____

(Note: If medications are from different pharmacies, we must have the pharmacy interaction sheet to be sure there are no adverse reactions)

Parent or Guardian's Signature____Date:___________________

Receipt of Medication (Staff Signature)____Date:_______________

****

FOR STAFF USE:

If you are *not* trained per EEC regs in this child's Individual Health Plan (IHP), medical condition, symptoms, medication, treatment, side effects and consequences of non-administration of meds: *DO NOT PROCEED*

NOTIFY DIRECTOR/SUPERVISOR IMMEDIATELY

I have been trained by ____

Have the " 5 Rights " been addressed? _______

1. Is the name of the child given above on the container?______

2. Is the date on the prescription current (within the month for antibiotics and within the expiration date for medications which are so labeled) within the year otherwise?_________

3. Is the dose, name of drugs, frequency of administration given on the label consistent with parental instructions? __________

4. Is the medication in a safety cap container?________

5. Is the original prescription label on the medication container?______

Medication can be administered ONLY if the answers to all the staff questions above are "YES"

**** If an Epi pen is administered did you call 911 ?**

Edition 2014

CHILD'S NAME ____ MEDICATION ________________________________

DID YOU CHECK THE LABEL 3 TIMES ? ____________

DATE	NAME OF MEDICATION	DOSAGE	ROUTE GIVEN	TIME	MISDOSE/ ERRORS	CHILD REFUSAL	Staff Initials A

IF CHILD REFUSED MEDICATION, EXPLAIN WHY:

Parental Notification: ______________DATE ______________TIME _______________ STAFF INITIALS

If a medication error occurs, explain:

Parental Notification: ______________DATE ______________TIME _______________ STAFF INITIALS

After administering the medication/treatment:

A). I have filled out and signed the medication log completely. __________

B). I have properly returned the medication to safe storage under lock and key.__________

C). If medication is low, I have notified Director/Supervisor of need to inform parent for refill/additional medication.__________