Please attach/email a recent photo of your child.

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www.hudsonchaps.com

Office Use Only
Admit Date:

Infant/Toddler Enrollment Form

Child Information

Child's Name_____ Male/Female_____ DOB_____ Age_____

Home Address_____ Town/City/Zip_____

Home Phone_____ Primary Language_____

Parent/Guardian Information

Parent/Guardian Name_____ Primary Language_____

Home Address_____ Town/City/Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Name/Address of Business_____

Email Address_____

Parent/Guardian Name_____ Primary Language_____

Home Address_____ Town/City/Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Name/Address of Business_____

Email Address_____

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

Medical Information

Name of Physician/Clinic_____ Phone #_____

Address_____

Health Insurance Co._____ Policy #_____

Chronic Medical Conditions_____

Allergies_____

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

Special limitations or concerns_____

Regular medications given at home or school, reason for medication and their possible side effects_____

_____

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Emergency Contact / Release and Consent Form

Child's Name_____

Emergency Contacts

These individuals are authorized for CHAPS to release your child into their care and of make decisions regarding your child's care in an emergency when you cannot be reached.

1. Name_____ Relationship to child_____

Address_____ Phone #_____

2. Name_____ Relationship to child_____

Address_____ Phone #_____

3. Name_____ Relationship to child_____

Address_____ Phone #_____

Release Consent

Your child can be released from the program to the following individuals.
Please list if different from the above emergency contacts.

1. _____ 2. _____

3. _____ 4. _____

Arrival / Departure from Program

Check all that apply

My child will arrive to CHAPS by:
_____ Parent
_____ Other (school bus, etc.) _____

My child will depart from CHAPS by:
_____ Parent
_____ Authorized Pick-ups
_____ Other (school bus, etc.) _____

Parent/Guardian Signature_____ Date_____

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Permission Form

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_____

Topical Consent

I give the CHAPS staff permission to apply the following topical and non-prescription medications to my child. Topical creams are defined as hand sanitizer, skin lotions, sunscreen, bug spray, lip balm and diaper rash cream. I understand that I will need to provide and label these items for my child.

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.

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_____

Hudson Public Schools Consent

I give the staff at the CHAPS program permission to share information concerning my child with Hudson Public Schools Pupil Services and all other health and service providers concerning children.

I understand this information will only be used to develop an environment which is best suited to meet the needs of my child.

Parent/Guardian Signature_____ Date_____

Email Use

Email is an important communication tool that CHAPS uses for notices, reminders, monthly calendars and newsletters, closing emergencies, school cancellations and special events. Please make sure the email addresses you provided under Parent Information are checked daily.

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Permission Form (cont)

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, slideshows)

Parent/Guardian Signature_____ Date_____

I understand that other parents may wish to take pictures of their child at the CHAPS programs. CHAPS employees will discourage those individuals to respect the privacy of others but cannot guarantee that no photographs will be taken of my child.

Parent/Guardian Signature_____ Date_____

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Tuition Agreement/Program Policy Compliance

Child's Name_____

Tuition Agreement

- Please make checks payable to CHAPS
- Please note your child's name on the check
- Tuition is due on the first day of each week if weekly and on the first day of each month if monthly.
- A late fee of 5% will be added to the late payments.
  Payments made after the fifth day are considered late
- If payment continues to be delinquent, you will not be allowed to drop off your child without tuition.
- Failure to pay tuition may result in suspension, which may lead to termination.
- Tuition is paid each week/month regardless of holidays, personal vacations, school vacations and non-attendance for illness.

I agree to these conditions. I have attached a check/cash/money order for the $100.00 registration fee. I understand that the registration fee is non-refundable.

Parent/Guardian Signature_____ Date_____

Program Policy Compliance

I have read and understand the policies and procedures included in the Children's After School Programs, Inc. Parent Handbook located on the CHAPS website. I understand that these are the policies and procedures that are followed by the CHAPS staff and I understand and agree to comply with these program policies and procedures.

Parent/Guardian #1 Signature_____ Date_____

Parent/Guardian #2 Signature_____ Date_____

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Child's Name_____

Developmental History

Age Began Sitting_____ Crawling_____ Walking_____ Talking_____

Does your child pull up? _____ Crawl?_____ Walk with support? _____

Speech Difficulties (please explain)_____

Special Words to describe needs_____

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 Information

Serious illnesses or hospitalizations (please describe)_____

_____

Describe any physical/chronic conditions, disabilities, including medically diagnosed allergies, if applicable.

_____

Is your child presently or ever been diagnosed with a special need? (If yes, please explain)_____

_____

Does your child receive any special services?_____

_____

Eating Habits

Special characteristics or difficulties?_____

Special Diet: _____ Formula: _____ Breast Milk: _____

Have solid foods been introduced?_____Please Identify _____

_____

What is your child's typical eating schedule?_____

Please describe breast milk, formula and/or food preparation in detail_____

_____

Is your child fed held in lap? _____ High Chair? _____ Other?_____

Does your child eat with a spoon? _____ Fork? _____ Hands? _____

Toilet Learning

Is your child toilet trained? _____

What does your child use at home? (i.e.: potty chair, special seat)_____

If no, has it been attempted? (please explain your child's current progress)_____

_____

Does your child have accidents? _____

Are disposable diapers used? _____ Is there 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? _____

What special words are used for urination and bowel movements?_____

Sleeping Habits

Does your child sleep in a crib? _____ Bed? _____

What position does your child sleep? _____

Is your child swaddled or using a sleep sack to sleep? (Please specify)_____

Please specify your child's nap times. _____

_____

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 of your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

What time does your child go to bed at night? _____ and get up in the morning? _____

What does your child take to bed?_____ mood upon awakening _____

Are there any sleep/wake time rituals? If so, please describe. _____

_____

Play Habits

Does your child enjoy engaging in play with other children? _____

Is your child able to play alone? _____

Favorite toys _____

Fears (the dark, animals, loud noises etc.) _____

Reaction to strangers?_____

How do you comfort and/or reassure your child when necessary? _____

How does your child prefer to be held?_____

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

_____

_____

_____

Parent/Guardian Signature_____ Date_____

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Classroom Emergency Card Information

Child's Name_____ Date of Birth_____

Child's Home Address_____ Phone #_____

Instructions to reach Parent/Guardian

1. _____ _____
   (Name) (Address)

   _____ _____
   (Home Phone, Work Phone, Cell Phone) (Email)

2. _____ _____
   (Name) (Address)

   _____ _____
   (Home Phone, Work Phone, Cell Phone) (Email)

Physician/Clinic

_____ _____
(Physician Name) (Phone)

_____ _____
(Address) (Insurance Co.)

Emergency Contacts

1. _____
   (Name, Address, Phone)

2. _____
   (Name, Address, Phone)

Release Consent Your child can be released from the program to the following individuals.
Please list if different from the above emergency contacts.

1. _____ 2. _____

3. _____ 4. _____

Medical Care Consent

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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_____

Allergies_____
Chronic Health Conditions_____
Special Limitations or Concerns_____