



The
Bilingual Montessori School
of Sharon

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: _____

CHILD'S ENROLLMENT FORM

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? _____

School Age Only

Current School: _____

School Address: _____ School Phone Number: _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school. **Parent/Guardian initials:**

Parent/Guardian Signature

Date



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DEVELOPMENTAL HISTORY AND BACKGROUND

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: _____

DEVELOPMENTAL HISTORY AND BACKGROUND

- * 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) _____

DEVELOPMENTAL HISTORY AND BACKGROUND

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)



SMALL 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



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OFF SITE ACTIVITIES PERMISSION FORM

Section 1 - Program completes prior to parental consent

Program: _____

Name of Educator(s) responsible for child: _____

Name of off-site location and address: _____

Date of off-site activity: _____ Time Leaving Program: _____ Time Returning to Program: _____

Method of Transportation: _____ Fee associated with activity (if any): _____

****NOTE**** Each child must carry on his/her person the name, address, and telephone number of staff or child care program whenever she/he is off the premises in care of the program.

Section 2 – Parent/Guardian completes prior to off-site activity

I give permission for my child to attend the above identified off-site activity

Child's Name: _____ Child's Date of Birth: _____

Parent's/Guardian's Name: _____ Phone Number: _____

I authorize child care program staff to secure necessary emergency medical treatment

Name of child's Physician, Address, phone number: _____

Child's allergies, health conditions, or Individual Health Plan: _____

Health Insurance Plan and Policy #: _____

Emergency Contact Name: _____ Contact #: _____

(Parent/Guardian Signature) (Date)

This form must accompany each child on the off-site activity



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CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: female male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
		4			
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5		Hepatitis A (HepA)	1	
	6			2	
7					
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1	
	2			2	
	3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1		Other:	3	
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on:
<ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____

Date: / /

Signature: _____

Facility name: _____



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MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History _____

Pertinent Family History _____

Current Health Issues

- | | | |
|--------------------------|--------------------------|---|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma: Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (Please specify) _____ |

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination

Date of Examination: _____

Hgt: _____ (____%) Wgt: _____ (____%) BMI: _____ (____%) BP: _____

(Check = Normal / If abnormal, please describe.)

- | | | |
|--|--|--|
| <input type="checkbox"/> General _____ | <input type="checkbox"/> Lungs _____ | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Neurologic _____ |
| <input type="checkbox"/> HEENT _____ | <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental/Oral _____ | <input type="checkbox"/> Genitalia _____ | |

Screening:

- | | | | | | |
|-------------------|---|--------------------|---|-------------------------------|---|
| | (Pass) (Fail) | | (Pass) (Fail) | | (Pass) (Fail) |
| Vision: Right Eye | <input type="checkbox"/> <input type="checkbox"/> | Hearing: Right Ear | <input type="checkbox"/> <input type="checkbox"/> | Postural Screening: | <input type="checkbox"/> <input type="checkbox"/> |
| Left Eye | <input type="checkbox"/> <input type="checkbox"/> | Left Ear | <input type="checkbox"/> <input type="checkbox"/> | (Scoliosis/Kyphosis/Lordosis) | |
| Stereopsis | <input type="checkbox"/> <input type="checkbox"/> | | | | |

Laboratory Results: Lead _____ Date _____ Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: ____; Results: ____mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

- | | | | |
|---|-----------------------------------|--|---|
| <input type="checkbox"/> Vision | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> Fine/Gross Motor Deficit |
| <input type="checkbox"/> Emotional/Social | <input type="checkbox"/> Behavior | <input type="checkbox"/> Other | |

Comments/Recommendations: _____

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

Y N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date _____

Please print name of Examiner.

Group Practice _____ Telephone _____

Address _____ City _____ State _____ Zip Code _____

Please attach additional information as needed for the health and safety of the student.



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MEDICATION CONSENT FORM

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**)



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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) _____



AUTHORIZATIONS, POLICIES AND PROCEDURES

Picture Taking Permission Slip

I give BMSS permission to take pictures/videos of my child. Photographs and videos are only used for center purposes including website and promotion of all of our schools

SIGNATURE _____

DATE _____

Walking Excursions

I give BMSS permission to take my child on walking excursions from the Center. I understand that a specific permission slip will be issued if my child will be transported for any field trip.

SIGNATURE _____

DATE _____

Hospital Transportation/Medical Treatment

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 authorize BMSS's staff to accompany my child via ambulance to the closest hospital in Boston, MA. I authorize BMSS's staff to secure necessary medical treatment by the doctor/pediatrician on call.

SIGNATURE _____

DATE _____

First Aid/CPR

I authorize the trained staff at BMSS to perform First Aid and CPR to my child if needed.

SIGNATURE _____

DATE _____

POLICIES AND PROCEDURES

Parent Handbook

I have received, read and understand the Parent Handbook.

SIGNATURE _____

DATE _____

Application and Tuition

I understand and agree to the following conditions of this contract:

1. Once a child's application has been accepted, a non-refundable \$3,500 deposit is due with the parent's signed contract to secure a space for the child. This deposit is not refundable under any circumstance, even in the event of the child's withdrawal from the school regardless of the reason, or in the event of a schedule change schedule initiated by the parent to reduce the number of days of attendance for their child/children. The deposit is applied towards the school year tuition.
2. I understand that my contract is signed for the entire school year and once enrolled once enrolled parents and or guardians are responsible for the full school year tuition regardless of the student's withdrawal, non-attendance, or termination
3. Once enrolled I agree that a school supply account as listed in our parent handbook will be given to my child, and if the account is used I will receive a detail invoice that is paid upon receipt.

SIGNATURE _____

DATE _____

Illness/Medication

I have read understand, and agree to abide by BMSS's health policies regarding illness and administration of medication during Center hours.

SIGNATURE _____

DATE _____

Late Pickup after 5:30 pm

I understand that the school day begins at 8:00 am and ends at 11:45 am for students participating in our half day program and 8:00am to 3:00pm for students attending the full day.

I understand that I must pick up my child according to my contract and hours chosen and if I should run late the following fees will be added to my child's account and I agree to pay the listed fees of:

I agree to pay a late fee of \$25 plus \$5.00 per minute to compensate for my late arrival.

If I drop before 8:00 am, I agree to have my child automatically enrolled in Early Crown Club (ECC).

If I pick up after 3:00 pm, I agree to have my child automatically enrolled in Late Crown Club (LCC).

If I pick up after 5:30 I agree to pay a late fee of \$25.00 plus \$5.00 per minute for my tardiness.

SIGNATURE _____

DATE _____

Parent Parking

I understand parking is allowed only within designated parking spaces and I will not leave my car running and unattended. I also understand that children are not allowed to be left alone in a car.

SIGNATURE _____

DATE _____

Child Release

I authorize the following persons to pick up my child from BMSS. I also understand that these persons will also be called if the Center staff is unable to reach either parent in case of accident or illness. Please include both parents if applicable.

NAME _____

RELATIONSHIP _____

PHONE _____

SIGNATURE _____

DATE _____

NAME _____

RELATIONSHIP _____

PHONE _____

SIGNATURE _____

DATE _____

NAME _____

RELATIONSHIP _____

PHONE _____

SIGNATURE _____

DATE _____

NAME _____

RELATIONSHIP _____

PHONE _____

SIGNATURE _____

DATE _____

NAME _____

RELATIONSHIP _____

PHONE _____

SIGNATURE _____

DATE _____