ENROLLMENT CONTRACT AND FEE SCHEDULE

________________________________ will be attending Crayon Campus Inc. beginning
Child's Name
_______________________ for a weekly fee of $ ________.

Days of the week scheduled: ______________________________________

Due upon enrollment First Week Tuition: $_______ Registration Fee: $______

I understand that if I wish to withdraw my child at two week notice will be required. I also understand that I am responsible for my payment during those two weeks as well as any pervious balances owed.

I am personally responsible for payment on the first day of my child's week.

_________________________________ ________________
Parent/Guardian Signature **Date**

PERMISSION SLIPS

My child has permission to participate in all functions and activities of Crayon Campus Inc. I understand that this includes field tri[s arranged by the Center and supervised by its staff. I give permission for my child to be transported to and from the Center with the Center's transportation.

I give permission for my child to be photographed for use in various activities or functions of the center.

I give permission for my child to be observed by students or people interested in the field of Early Childhood Education.

____ ____________________
Parent/Guardian Signature **Date**

TERMINATION and SUSPENSION of CHILDREN

Suspension

A child will be suspended if he/she knowingly causes injury to another student or teacher. A child may also be suspended for the use of profanity in the Center. The Center will document the incident. A copy of which will be given to the parent/guardian and a copy will be placed in the child's file.

Termination

Termination may occur when there have been three or more documented suspension. Reasons for termination will be detailed in a written report that will be provided to the parents or guardians. For example, behavioral issues, safety concerns and endangerment to him/herself and other in the center.

- Termination may also occur after three weeks of non-payment without notification to the parents or guardians since parents or guardians are notified of this policy.

______________________________ ______________________

Parent / Guardian Signature **Date**

BEHAVIORAL MANAGEMENT PLAN

Keeping in mind the needs and development of the individual child, and to ensure the health and safety of all of the children the school rules and restrictions should be consistent and easy to understand.

If a child exhibits unacceptable behavior, staff will first redirect the child to another activity or remove the child from that situation. If the behavior is still inappropriate, we will separate the child from the group and redirected to another activity. The teacher then talks to the child about the behavior and why it was not acceptable. The teacher will then allow the child to rejoin the group.

The child needs to know that he/she is loved and accepted even though the behavior is not acceptable for the moment. If the unacceptable behavior is extreme, the child may be brought to the Director and the Director may call the parent/guardian if unable to remedy the behavior problem. In the event of unacceptable behavior the following is understood:

There will be no physical abuse, no verbal abuse or denial of food as a punishment.

Biting Policy

We are aware that biting does occur. Crayon Campus Staff will be alerted and will be made aware of situations where children may bite.

Staff and management will be available to work with children and their parents to ensure the safety of their child and others students.

We recommend that parents/guardians discourage biting under any circumstance.

Staff and management will be available to work with the parents/guardians if behavioral problems become apparent.

____ ___________________________

Parent/Guardian Signature **Date**

The Commonwealth of Massachusetts
Department of Early Education and Care

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? ____
____

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**

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)**

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) Any medical concerns may be released to the following people.

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)**

For the safety and well-being of my child, Crayon Campus Inc will post allergies and or special medical concerns discreetly within the classroom and food preparation areas. If there are any issues regarding this I will address them to the Director.

Parent/Guardian Signature **Date**

AUTHORIZED PICK-UPS

Permission is given for my child to be released from the program as stated below and/or I give permission for the following individuals, including parents/guardians to receive my child at the end of the day.
I authorize the following people to be informed of any medical concerns regarding my child.
If NOT authorized please indicate.

Name: Relationship:
Address: Phone #:
Name: Relationship:
Address: Phone #:
Name: Relationship:
Address: Phone #:
Name: Relationship:
Address: Phone #:
Name: Relationship:
Address: Phone #:
Name: Relationship:
Address: Phone #:

My child will attend Crayon Campus the following days: (check appropriate AM /PM days)
Monday ☐AM ☐PM Tuesday ☐AM ☐PM Wednesday ☐AM ☐PM Thursday ☐AM ☐PM Friday ☐AM ☐ PM

My child will arrive at the program by:
Choose one and check whether AM or PM – notify Site Coordinator in writing of any special instances or changes.
☐ Walking from Classroom to Program Meeting Spot (☐ Unsupervised Walk ☐ Supervise Walk)
☐ AM ☐ PM ☐ AM ☐ PM ☐ AM ☐ PM
☐ Parent Drop Off ☐ School bus Drop Off Bus # ______ ☐ Other ______________________

My child will depart from the program by:
Choose one – notify Site Coordinator in writing of any special instances.
☐Parent Pick Up ☐ School Bus Pick Up ☐Supervised Walk (who___________________)
☐ AM ☐ PM ☐ AM ☐ PM ☐ AM ☐ PM
☐ Other ____☐ AM ☐ PM
☐ Unsupervised Walk (I give permission for my child to de dismissed from Crayon Campus at the end of the program day without an authorized adult picking him/her up. It is understood that my child is responsible for finding his/her own way home and that I assume all responsibility for my child getting home. I also release Crayon Campus from any responsibility or liability during this time.)

Parent / Guardian Signature: ________________________________ Date: ____________________

Dear Teacher,

In order to assist my child in being successful in school, I have enrolled in the Crayon Campus Program. I am excited about the opportunities for increased personal and academic growth for my child that can result from a partnership among home, school, and Crayon Campus. To support that partnership, I give permission for you to release information regarding my child' school performance to Crayon Campus. Please contact my f you have any questions regarding this request.

Thank you for your cooperation in this important matter.

Sincerely,
Parent/Guardian Signature: ___________________________Student Name: ________________________
Name of Teacher: ______________________________ School ________________ Date: ____________

Dear Physician: ____

(Child's Name)

is enrolled in an early childhood program licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: Date of Birth:

Address: Phone #

Name of Parents:

Address:

Date of Examination of Child:

What is your opinion concerning the child's general health and appearance:

Has this child been screened for lead poisoning? Yes No

If Yes, date screened:

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:

____

____

____

Physician's Signature:

Date: Comments:

Please return to Program: ____

____

____