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:_____

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 Bilingual Montessori School of Sharon

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: _____

* 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 Bilingual Montessori School of Sharon

SMALL AND LARGE GROUP TRANSPORTATION PLAN AND AUTHORIZATION

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT PICK UP

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

CHILD'S NAME:_____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT PICK UP

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION

The Bilingual Montessori School of Sharon

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

The Bilingual Montessori School of Sharon

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	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
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			3	
	2		**Other:**		
	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

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- 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: _____

The Bilingual Montessori School of Sharon

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	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	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.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

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:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ 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.

The Bilingual Montessori School of Sharon

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 **no**t 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 Bilingual Montessori School of Sharon

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)

The Bilingual Montessori School of Sharon

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

OVER

Door Access Card

I understand a $50 fee is required to each access card given to the parents. And I also understand that this fee will not be refunded at the end of the contract. Access keys will be replaced if lost.

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 6:00 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 8:00 to 4:00pm for students attending the 8 hour 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 $10 plus $1 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 4:00 pm, I agree to have my child automatically enrolled in Late Crown Club (LCC).
If I pick up after 6:00 I agree to pay a late fee of $10 plus $1 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