Empowering immigrants and refugees to Succeed!

School Age Child Care
Emergency Contact & Release Information

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/ Guardian Name: _____ Relationship to Child: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

EmployerName: _____

Employer Address: _____

Employer Phone Number: _____ Hours of Work: _____

EMRGENCY CONTACTS (In order to be contacted)

Name: _____ Relationship to Child: _____

Address: _____

Home Phone Number: _____

Do you give permission for your child to be released to this person? (circle one) Yes No

Name: _____

Relationship to child: _____

Address: _____

Home Phone Number: _____

Do you give permission for your child to be released to this person? (circle one) Yes No

Name: _____ Relationship to Child: _____

Address: _____

Home Phone Number: _____

Do you give permission for your child to be released to this person? (circle one) Yes No

Parent /Guardian Signature: _____ Date: _____

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114 Main Street, Worcester, MA 01608

Angels-Net Foundation Inc, After-School
Early Education & Care 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:_____

ADDITIONAL INFORMATION

Child's Physician:_____

Address: _____ Phone Number:_____

Allergies/Special diets? _____

Individual Health Plan for child with a chronic health condition? If yes, please attached.

Copies of any legal/custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach. /comment

Parent/Guardian_____Signature Date"_____

Early Education & Care
First Aid and Emergency Medical Care Consent
102 CMR 7.09(3)

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:_____

Health Insurance Coverage_____ Policy _____

Parent/Guardian Signature:_____Date (Valid for one year):_____

Early Education & Child Care
Parent Volunteer Opportunities

Child's Name _____ Date of Birth _____

The ANF ASP Early Education & Care staff encourages parents /guardians to be an integral part of their child's/children growth and development. Please indicate any activities that are of interest to you.

- ✓ Assisting with homework help in my child/children's classroom.
- ✓ Chaperone a fieldtrip once a year
- ✓ Interpreter during program and other activities at the program
- ✓ Participate in Center open house and fundraising activities
- ✓ Participate in planning/executing family events
- ✓ Participate in planning/executing teacher appreciation events
- ✓ Other: _____

To Whom It May Concern:

_____ is enrolled in the Angels-Net Foundation Inc Early Education & Care program. We have been informed that he is allergic to _____. On the enclosed form, please provide us with any special instruction that maybe relevant to this child's allergy reaction and care.

Thank you for your response and assistance.

Sincerely,

Angels-Net Foundation Inc, Early Education & Care Staff.

Parental Consent:

I give my child's health care provider permission to release the information requested above to the Angels-Net Foundation Inc, ASProgram.

Parent/Guardian Signature_____ Date:_____

Early Education & Child Care Severe Allergy Plan

Child's Name _____ Date of Birth_____

Severe Allergy To: _____

MILD REACTION

Mild symptoms consist of: hives; itchy skin; swelling

Treatment Procedure

a. Contact parent or persons listed on the Emergency Card.

b. Stay with child until parent arrives.

c. Watch child for more serious symptoms.

Special Instruction (To be completed by health care provider)

SEVERE REACTION

Severe symptoms consist of: hives all over the body; swelling of the face/neck/tongue; tingling of the tongue; wheezing, difficulty swallowing/breathing; vomiting; signs of shock; loss of consciousness.

Treatment Procedure

Use premeasured EpiPen/EpiPen Jr.

Call 911. Anytime the EpiPen is given to a child, 911 will be contacted.

Contact parent or persons listed on the Emergency Card. Staff will accompany child if parent is unavailable.

Special Instruction (To be completed by health care provider)

_____

_____

_____

Parent/Guardian Signature:_____ Date:_____

Early Education & Care
Contact Information / Authorized to Release

Child's Name:_____ Date of Birth: _____

PARENT / GUARDIAN CONTACT INFORMATION

Parent/Guardian Name:_____Relationship to Child: _____
Home Address: _____
Reachable Phone Number:_____
Email Address: _____
Work Name: _____
Work Address: _____
Work Phone Number: _____ Hours at Work:_____
Parent/Guardian Name:_____Relationship to Child: _____
Home Address: _____
Reachable Phone Number: _____
Email Address:_____
Work Name:_____
Work Address:_____
Work Phone Number: _____Hours at Work:_____

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_____

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Parent/Guardian Signature:_____ Date:_____

Early Education & Child Care Emergency Card

Child's Name _____ Date of Birth_____

Home Address _____ Phone_____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. Name _____ Relationship_____
Phone Number _____ Address _____
2. Name_____ Relationship _____
Phone Number _____ Address_____

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. Name _____ Relationship _____
Phone Number_____ Address _____

EMERGENCY CONTACT PERSON(S)

1. Name _____ Relationship _____

Phone Number _____ Address _____

Do you give permission for child to be released to this person? Yes No

2. Name _____ Relationship _____

Phone Number_____ Address_____

Do you give permission for child to be released to this person? Yes No

INSURANCE INFORMATION (Optional)

Company Name_____ Policy #_____
Participating Hospital: _____
Special Instructions: _____

MEDICAL EMERGENCY TREATMENT

I hereby give Angels-Net Foundation Inc, ASP permission to administer basic first aid and/or CPR to me Child_____ and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

Parent/Guardian Signature:_____Date: _____

Early Education & Child Care Consent Form

Child's Name _____ Date of Birth _____

PHOTOGRAPHS

I give permission for photograph to be taken of my child/children for use by the ANF in program brochures, annual report, website, and other promotional materials and for release to local newspapers.

Parent Signature:_____

SUNSCREEN

I understand that I will apply sunscreen to my child prior to arriving to the center during summer time. I will provide to the center sunscreen with SPF 15 or higher and is labeled with my child's name for outdoors activities. I give the ANF staff permission to apply sunscreen on my child/children. _____ Initial

ACTIVITIES, PLAY & OBSERVATION

I give permission for my child to:

- Use play equipment at ANF after school program.
- Participate in ALL activities
- Leave the center for walks under the supervision of an authorized staff
- Be observed by students
- Participate in (summer swim lessons) a program in partnership with the YWCA

Parent/Guardian Signature:_____Date:_____

Date:

Dear Physician:

_____ is enrolled in an after-school age 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 to this 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:_____

Country of origin:_____ Date of entry:_____

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:

Comments:

_____

_____

_____

_____

Physician's Signature:_____ Date: _____

Please return to Program: _Angels-Net Foundation Inc

360 West Boylston Street, Suite 216

Worcester, MA 01583

Early Education & Care
Transportation Plan and Daily Schedule

Indicate how your child will arrive and depart from the ASP program on a daily basis.

Arrival & Departure

Arrival	**Departure**
___Supervised Walk ___Unsupervised Walk	___Supervised Walk ___Unsupervised Walk
___ Parent Drop-off ___ Parent Pick-up	___ Parent Drop-off ___ Parent Pick-up
___Public/Private/Van	___Public/Private/Van
___ANF Program Van	___ANF Program Van
___Contract/Van	___Contract/Van
___Other:	___Other:

Arrival	Monday	Tuesday	Wednesday	Thursday	Friday
Departure	Monday	Tuesday	Wednesday	Thursday	Friday

Late Pick-up

Children picked-up 7minitues later than regular pick up time will be charged a late fee of $5.00. The fee will be collected on the same day, or the following day upon the child's arrival to the program.

Parent/Guardian Signature: _____Date:_____

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Angels-Net Foundation Inc, Early Education & Care Transportation.
Parental Consent:

_____

Name of School:

Pick up start date:_____

_____ is enrolled in the Angels-Net Foundation Inc Early Education
Child/children's name

& Care program after school program. I, _____
Parent/Guardian

give permission to:_____
School name

To release my child/children to the Angels-Net Foundation Inc, ASP van at the end of each school day

M T W TH F (Please circle)

Thank you for your response and assistance. If you have any questions, please don to hesitate to connect

_____

Parent/Guardian (Print name)

Parent/Guardian Signature:_____ Date: _____