



CHAPS Inc.

145 Main St. Unit C
Hudson, MA 01749
978-568-9664
978-568-0274

www.hudsonchaps.com

<u>Office Use Only</u> Admit _____ Date: _____
--

(CPEL)Community Programs for Early Learning 978-568-9668 (Part Day: Ages 2-5 yrs old)
(PACCS) Preschool Age Services 978-567-6180 (Full Day: Mixed Group; Ages 2-5 yrs old)
Early Childhood Center 978-568-8884 (Full Day: Toddler, Preschool, and Kindergarten)

Please attach a recent photo of your child.

Admission Date _____
Age at Admission _____

Child Information

Child's Name _____ Male/Female _____ DOB _____

Address _____ Town/City _____ Zip _____

Home Phone _____ Primary Language _____

Parent/Guardian Information

Parent/ Guardian Name _____ Primary Language _____

Home Address _____ Home Phone _____

Name/Address of Business: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

Parent/Guardian Name _____ Primary Language _____

Home Address _____ Home Phone _____

Name/Address of Business _____

Work Phone _____ Cell Phone _____

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 Health Conditions _____

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

Allergies _____

Special limitations or concerns _____

Regular medications given at home or school and their possible side effects _____



CHAPS Inc.

145 Main St. Unit C
Hudson, MA 01749
978-568-9664
978-568-0274

www.hudsonchaps.com

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 skin lotions, sunscreen, bug spray, Chap Stick 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 Permission

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.

YES NO

Parent/Guardian Signature: _____

Date: _____



CHAPS Inc.

145 Main St. Unit C
Hudson, MA 01749
978-568-9664
978-568-0274

www.hudsonchaps.com

Permission Form Cont

Email Use

Email is an important communication tool that CHAPS, Inc. uses for notices, reminders, monthly calendars/ newsletters, closing emergencies, school cancellations and special events. Please provide email addresses that you are able to check on a daily basis.

1. _____
(Parent/ Guardian) (Email Address)

2. _____
(Parent/ Guardian) (Email Address)

Media Release

I give permission for my child to be photographed and or videotaped for:

- Classroom purposes- YES NO
- The CHAPS website- www.hudsonchaps.com- YES NO

I understand that these pictures will be on the Internet and my child's name **will not** be mentioned alongside these pictures.

Parent/Guardian Signature: _____ Date: _____

Photos

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

Parent/Guardian Signature: _____ Date: _____



CHAPS Inc.
 145 Main St. Unit C
 Hudson, MA 01749
 978-568-9664
 978-568-0274
www.hudsonchaps.com

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 or 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: _____



CHAPS Inc.

145 Main St. Unit C
Hudson, MA 01749
978-568-9664
978-568-0274

www.hudsonchaps.com

Developmental History

Age Began Sitting _____ Crawling _____ Walking _____ Talking _____

Speech Difficulties (please explain) _____

Eating Habits

Special Diet _____

Food Preferences _____

Normal Eating Schedule _____

Toilet Learning

Is your child toilet trained? _____

If no, please explain your child's current progress _____

Sleeping Habits

Does your child become tired or nap during the day? (Please include when and how long) _____

What time does your child go to bed at night? _____

Does your child have accidents? _____

Describe any special characteristics or needs (stuffed animals, story, mood upon waking) _____

Play Habits

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

Is your child able to play alone? _____

Favorite toys _____

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



CHAPS Inc.

145 Main St. Unit C
Hudson, MA 01749
978-568-9664
978-568-0274

www.hudsonchaps.com

Tuition Agreement

Child's Name _____

- Please make checks payable to CHAPS
- Please note your child's name and on the check
- **Tuition is due on the first day of each week if weekly or 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 month regardless of personal vacations, school vacations and non-attendance for illness.

I agree to these conditions. I have attached a check/money order for the \$50.00 (CPEL) part day programs/\$75.00 full day programs for the 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, Inc. 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 _____



CHAPS Inc.

145 Main St. Unit C
Hudson, MA 01749
978-568-9664
978-568-0274

www.hudsonchaps.com

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 Emergency Treatment

I hereby give CHAPS, Inc. permission to administer basic first aid and/or CPR to my child
_____ and/or take my child _____, to the nearest
(Name) (Name)
hospital for treatment when I cannot be reached or when delay would be dangerous to my child's health.

(Parent Signature) (Date)

Allergies _____
Chronic Health Condition _____
Special Limitations or Concerns _____