

MARKMAN

EI / IEP

Children's Programs, Inc.

505 North Main Street • Attleboro, MA 02703 • 508-226-0282
95 Pine Street Attleboro, MA 02703 508-226-5718

Start Date: _____ Program: _____ End Date: _____

CHILD INFORMATION

Name: _____ M / F DOB: _____

Home Address: _____ City: _____

Home Phone: _____ Zip Code: _____

Ethnicity: _____ Primary language: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to child: _____

Home Address: _____ City: _____

Home Phone: _____ Cell Phone: _____

Email address: _____ DOB: _____

Place of Employment: _____ City: _____

Work hours: _____ Work phone: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to child: _____

Home Address: _____ City: _____

Home Phone: _____ Cell Phone: _____

Email address: _____ DOB: _____

Place of Employment: _____ City: _____

Work hours: _____ Work phone: _____

Can pick up child without notification? YES NO

If divorced or separated, please explain custody/visitation arrangements or court orders:

Other family members/people living in the household:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Schedule: (Indicate days and times your child will be in care)

Monday: _____ to _____ Tuesday: _____ to _____ Wednesday: _____ to _____

Thursday: _____ to _____ Friday: _____ to _____

Parent / Guardian Signature

Date

PERMISSIONS

I give MARKMAN CHILDREN'S PROGRAMS permission to apply the following products on my child, _____, I understand that products will be used as stated on the label and my child will be tested for allergies to these products prior to use.

- | | | |
|--|-----|----|
| • Bug spray
(Avon-Skin So Soft) | YES | NO |
| • Sun Block SPF 30+
(No-Ad,Equate,CVS,Coppertone) | YES | NO |
| • Triple antibiotic ointment
(Neosporin,Equate,CVS) | YES | NO |
| • Diaper rash cream
(Equate,CVS,Desitin,A&D) | YES | NO |
| • Calamine lotion
(Humco,CVS, Walgreens) | YES | NO |
| • Fluoride toothpaste
(Plak Smacker,Colgate,Aqua Fresh) | YES | NO |

I give MARKMAN CHILDREN'S PROGRAMS permission to take and display my child's photo for the following.

- | | | |
|----------------------------------|-----|----|
| • Classroom and center display | YES | NO |
| • Agency Newsletter | YES | NO |
| • Local Newspaper / publications | YES | NO |
| • Agency website | YES | NO |

I give MARKMAN CHILDREN'S PROGRAMS permission to take my child on walking trips in the neighborhood near or around the center. I understand that my child will be supervised by staff at all times.

YES NO

I give MARKMAN CHILDREN'S PROGRAMS permission to transport my child by Markman van or bus in the event of an emergency.

YES NO

Parent / Guardian Signature

Date

HEALTH INFORMATION

Child's Name: _____ DOB: _____

Hair Color: _____ Eye Color: _____

Height: _____ Weight: _____

Identifying Marks (birth mark, scars): _____

Does your child have Allergies? YES NO To what? _____

Does your child have Asthma? YES NO Triggers? _____

Does your child have any health concerns (seizures, nosebleeds, earaches)? YES NO
What? _____ How often? _____

Does your child take any medication on a regular basis? YES NO
If yes, what medication? _____
What are the side affects to this medication? _____

Child's Doctor: _____ Phone: _____

Child's Dentist: _____ Phone: _____

I give MARKMAN CHILDREN'S PROGRAMS permission to contact my child's doctor or dentist with medical concerns or questions. YES NO

I give MARKMAN CHILDREN'S PROGRAMS permission to give my child first aid when necessary. I understand my child will be transported to the hospital by ambulance if medically necessary. I hereby authorize MARKMAN CHILDREN'S PROGRAMS to secure necessary medical treatment for my child until I arrive at the hospital. YES NO

Health Insurance: _____ Policy #: _____

Parent / Guardian Signature

Date

SCHOOL AGE ONLY

Child's School: _____

I certify that documentation of my child's physical examination, immunizations and lead screening in accordance with public school health requirements are on file at my child's school. YES NO

PERSONAL HISTORY

Child's Name: _____ DOB: _____

HEALTH

Any complications at birth? YES NO
If yes, explain? _____

Illness and/or hospitalization? YES NO
If yes, explain. _____

Special physical conditions, disabilities? YES NO
If yes, explain. _____

DEVELOPMENT

Age child began sitting? _____ crawling? _____ walking? _____ talking? _____

Any speech difficulties? YES NO
If yes, explain. _____

Any developmental delays or concerns? YES NO
If yes, explain. _____

Is child receiving any services (speech, OT/PT)? YES NO
If yes, what service? _____ How often? _____

EATING HABITS

Favorite foods: _____

Foods refused: _____

Can child use a spoon ? _____ fork? _____ knife? _____

Any concerns or difficulties? YES NO
If yes, explain. _____

TOILETING

Is child fully toilet trained? YES NO

If no, have you begun training at home? YES NO

What is used at home? Potty chair _____ child toilet seat _____ regular seat _____

Does child have accidents? YES NO How often? _____

Words/gestures used when needing to use bathroom? _____

SLEEPING HABITS

Does child sleep in a crib? _____ Bed? _____

Time child goes to bed at night? _____ wakes up in the morning? _____

Does child nap during the day? YES NO
If yes, how long? _____

Does child use anything special to sleep (blanket, stuffed toy)? _____

Does child have nightmares? YES NO
If yes, how often? _____

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Children's Programs Inc. _____

ACKNOWLEDGMENT AND AGREEMENT

I have received a copy of the Markman Children's Programs Parents Handbook and I have read and understand its contents. I agree to all procedures and conditions set forth therein,

I have received a copy of Community Resources which includes information about:

- ✓ Assistance in obtaining food, clothing and housing
- ✓ Legal and financial aid
- ✓ Parenting support services

For parents of infants under 12 months of age

I acknowledge that I have received information on sudden Infant Death Syndrome (SIDS). I understand my infant will be placed on his/her back to sleep unless my doctor signs a letter stating, for medical reasons, that my child should sleep on his/her stomach.

Signature of Parent/Guardian

Date

Signature of Program Representative

Date

Markman

Children's Programs Inc.

LATE PICK UP POLICY AND AGREEMENT

- I have read and understand the **LATE PICK UP POLICY** under Section VII, page 3, of the Markman Children's Programs Parent Handbook, which states that any Parent whose child is picked up after closing hours will be charged as stated in this policy. In signing this form I am agreeing to this policy and commit to the said pick up time. I also understand that failure to comply with this policy may result in termination of services.

TUITION PAYMENT AGREEMENT

- I have read and understand the **FEE POLICY AND LATE FEE POLICY** under Section VII, page 22, of the Markman Children's Programs Parent Handbook, which states that weekly fees are due on Friday for the following week. In signing this form I am agreeing to this policy and commit to making tuition payments accordingly. I also understand that failure to comply with this policy may result in termination of services.

In addition, I understand that a two week written notice is required when withdrawing from Markman Children's Programs, as also stated under the **FEE POLICY**.

Parent Name (Please Print): _____

Parent Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____