Required Child Documentation and Forms:

Child Enrollment Form

Transportation Plan, Pickup Information, and Custody Information

First Aid and Emergency Medical Care Consent Form

Individual Health Care Plan Form (IHCP)

Medication Consent Form

HBGC waiver

Health & Safety Protocols & Procedures
The Commonwealth of Massachusetts
Department of Early Education and Care

FORM

Subject: Child Enrollment Form for Emergency Child Care Program
Effective Date: March 19, 2020

Emergency Child Care

Child Enrollment Form for
Emergency Child Care Program

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: __________________________

Reason Eligible

DCF Involved: ☐ DTA/TAFDC Involved: ☐ Homeless: ☐ Critical worker: ☐

Explain: ____________________________________________

Parent/Guardian Information

Parent/Guardian #1:

Parent/Guardian Name: ____________________________________________

Relationship to Child: ____________________________________________

Home Address: ____________________________________________

Reachable Phone Number: ____________________________________________

Email Address: ____________________________________________

Occupation: ____________________________________________

Employer Name: ____________________________________________

Employer Address: ____________________________________________

Employer Phone Number: ____________________________________________
Hours at Work:__________________________________________________________

Parent/Guardian #2:
Parent/Guardian Name:____________________________________________________________________
Relationship to Child:____________________________________________________________________
Home Address:___________________________________________________________________________
Reachable Phone Number:_________________________________________________________________
Email Address:___________________________________________________________________________
Occupation:____________________________________________________________________________
Employer Name:________________________________________________________________________
Employer Address:_______________________________________________________________________
Employer Phone Number:_________________________________________________________________
Hours at Work:__________________________________________________________________________

Additional Information

Child’s Physician:_______________________________________________________________________
Address:_______________________________________________________________________________ Phone Number:______________________________
Special Diet?___________________________________________________________________________
Allergies: □ If yes, describe:________________________________________________________________
Epipen: □ If yes, describe _________________________________________________________________
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? _____________________________________________________________

I acknowledge that this care is being provided in a state of an emergency pursuant to Governor Baker's Executive Order. EEC's Emergency Child Care Program is not subject to EEC licensure and does not require that the program meet all requirements in EEC regulations. I recognize that this child care is being offered on a temporary basis.

__________________________________________  ______________________
Parent/Guardian Signature                        Date
TRANSPORTATION PLAN / AUTHORIZED PICK-UP

<table>
<thead>
<tr>
<th>My child will arrive to the program by:</th>
<th>My child will depart the program by:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Parent Drop-Off</em></td>
<td><em>Parent Pick Up</em></td>
</tr>
<tr>
<td><em>Supervised Walk</em></td>
<td><em>Supervised Walk</em></td>
</tr>
<tr>
<td><em>Unsupervised Walk</em></td>
<td><em>Unsupervised Walk</em></td>
</tr>
<tr>
<td><em>Public/Private Van</em></td>
<td><em>Public/Private Van</em></td>
</tr>
<tr>
<td><em>Bus</em></td>
<td><em>Program Bus/Van</em></td>
</tr>
<tr>
<td><em>Private Transportation Provided by Parent</em></td>
<td><em>Private Transportation Provided by Parent</em></td>
</tr>
</tbody>
</table>

In the space below, please note any important information regarding transportation of your child to and from the program (i.e.—indicate who will be supervising children during transport or prior to their arrival at the program, who supervises the walk from a bus stop, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I additionally authorize the following individual to take my child from the child care premises. (Please let me know at the beginning of the day when your child will be picked up by one of the authorized individuals.)

Name __________________________ Address ________________________________

Telephone ___________ Cell Phone __________________________

Name __________________________ Address ________________________________

Telephone ___________ Cell Phone __________________________

Anticipated Days/Time of Attendance

<table>
<thead>
<tr>
<th>Day</th>
<th>Arrival Time</th>
<th>Departure Time</th>
<th>Day</th>
<th>Arrival Time</th>
<th>Departure Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td>Friday</td>
<td></td>
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</tr>
<tr>
<td>Tuesday</td>
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<td>Saturday</td>
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<tr>
<td>Wednesday</td>
<td></td>
<td></td>
<td>Sunday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
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</tr>
</tbody>
</table>

If applicable: Name of School Child Attends: ________________________________

☐ Copies of any custody agreements, court orders, restraining orders (if applicable)

Notes:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Child's Name __________________________
Written Acknowledgement of Receipt of Parent Handbook

I acknowledge that I have received a copy of the provider’s parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook).

Parent/Guardian ________________________________ Date ____________

Parental Visit Notice

I understand that I may visit this child’s home unannounced at any time during the hours that my child is in care.

Parent/Guardian ________________________________ Date ____________

Child’s Physician or Health Care Professional

Name: ________________________________ Telephone: ________________________________

Address: ________________________________

Information on allergies, special diets, chronic health conditions, special limitations, concerns including medications child is taking at home/school and possible side effects:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Medical Insurance Information (OPTIONAL)

Subscriber’s Name: ________________________________ Policy #: ________________________________

Type of Insurance: ________________________________

[ ] Copy of Insurance Card

SCHOOL AGE ONLY

Current School: ________________________________ School Address: ________________________________

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: ________________________________

Child’s Name ________________________________

Page 3
Permission - (Transport to Medical Facility and Receive Emergency Medical Treatment)

Medical Emergency Treatment (Department of Early Education and Care recommends checking with your local hospital about the acceptability of this statement)

I, hereby give _______________________________ permission to administer basic first aid and/or (educator/assistant)

CPR to my 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

Topical Medication/Ointments (Please list only those medications/ointments which you will allow the educator(s) to administer to your child’s skin): Ex: sunscreen, insect repellent (bug spray), diapering ointment.

_________________________________________

Parent/Guardian Signature                            Date
Emergency Card Information

REMINDER: This emergency card information is for the educator's first aid kit. The educator(s) must take first aid materials when leaving the child care premises.

Child's Name: ___________________________ Date of Birth: ___________________________

Child's Home Address: ___________________________ Phone: ___________________________

Instructions to Reach Parent or Guardian
1. ___________________________ (Name, Address, Home and Cell Phone #)
2. ___________________________ (Name, Address, Home and Cell Phone #)

Contact Information for Physician or Health Care Professional
1. ___________________________ (Physician's Name, Address, Phone #)

Emergency Contact Person(s)
1. ___________________________ (Name, Address, Home and Cell Phone #)
2. ___________________________ (Name, Address, Home and Cell Phone #)

Emergency Medical Treatment
I hereby give ___________________________ permission to (Name of educator/assistant) administer basic first aid and/or CPR to my child ___________________________ (Name) and/or take my child ___________________________ (Name), to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

Parent/Guardian ___________________________ Date ___________________________

Medical Insurance Information (Optional)

Subscriber's Name: ___________________________
Type of Insurance: ___________________________
Policy Number: ___________________________
[ ] Copy of insurance card
Other pertinent medical information: ___________________________
__________________________________________________________________________
Dear Physician: ____________________________  (Child’s Name)

is enrolled in a [ ] home which is [ ] 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 (1) 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 ______

(*At least one (1) time between ages 0-12 months; Annually-Ages 2 & 3; at Age 4 if High Risk for Lead Poisoning)

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 educator? If so, please detail below:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Physician’s Signature: ____________________________  Date: ____________________________

Comments: ____________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please return this form and the child’s immunization record to:

______________________________________________________________________________
# Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

**Check all that apply...**

**Plan was created by:**
- Parent
- Doctor or Licensed Practitioner
- Program's Health Care Consultant
- Older school age child (9+ yrs. of age)
- Other: _______________________

**Plan is maintained by:**
- Director
- Assistant Director
- Child's Educator
- Other: _______________________

<table>
<thead>
<tr>
<th>Name of child:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Any change to the child's Health Care Plan?
- YES (indicate changes below)
- NO (updated physician/parental signatures required)

<table>
<thead>
<tr>
<th>Name of chronic health care condition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of chronic health care condition:</td>
</tr>
<tr>
<td>Symptoms:</td>
</tr>
<tr>
<td>Medical treatment necessary while at the program:</td>
</tr>
<tr>
<td>Potential side effects of treatment:</td>
</tr>
<tr>
<td>Potential consequences if treatment is not administered:</td>
</tr>
</tbody>
</table>

| Name of educators that received training addressing the medical condition: |
| Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant): |

Name of Licensed Health Care Practitioner (please print): _______________________

Licensed Health Care Practitioner authorization: _______________________

Parental/Guardian consent: _______________________

---

**For Older Children ONLY (9+ years of age)**

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

<table>
<thead>
<tr>
<th>Age of child:</th>
<th>Date of birth:</th>
<th>Back-up medication received?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Parent signature: _______________________

Administrator's signature: _______________________

Date: _______________________

Date: _______________________

Date: _______________________

Date: ______________________

Date: ______________________

Date: ______________________

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)
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) ___________________________
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 not 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)
# Emergency Child Care Program Application

## MEMBER INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Preferred Name</td>
<td></td>
</tr>
<tr>
<td>Birthdate</td>
<td>Age</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Racial / Ethnic Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>American Indian or Alaska Native</td>
</tr>
<tr>
<td>Female</td>
<td>Asian</td>
</tr>
<tr>
<td></td>
<td>Hispanic or Latino</td>
</tr>
<tr>
<td></td>
<td>Black or Latino</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

## WAIVERS & RELEASES

### Medical

- **Yes** □  **No** □  I give permission to **Boys & Girls Clubs of Greater Holyoke** to seek emergency medical treatment for my minor child if I cannot be reached. I will be responsible for any/all costs of medical attention and treatment.

### Technology

- **Yes** □  **No** □  As a member of the **Boys & Girls Clubs of Greater Holyoke**, your child may have access to the Internet. While the Boys & Girls Club has rules prohibiting such conduct and precautions are taken by the Club to prevent such access, it is possible your child may access inappropriate sites. The **Boys & Girls Clubs of Greater Holyoke** will not be responsible for such unauthorized access.

### Press / Media

- **Yes** □  **No** □  I give permission for my child's picture, video image, or any other graphic depiction or likeness, to be used by **Boys & Girls Clubs of Greater Holyoke**, Boys & Girls Clubs of America and its affiliates or donors and acknowledge neither my child nor I will receive payment for same.

### Miscellaneous

- **Yes** □  **No** □  I understand that **Boys & Girls Clubs of Greater Holyoke** is not responsible for lost or stolen items.

- **Yes** □  **No** □  I understand each Club has the right to make membership decisions based on the resources and capacity of their facility and staff. **Boys & Girls Clubs of Greater Holyoke** reserves the right to decline the application, rescind the enrollment of, or suspend any youth that cannot successfully associate with other club members.

## APPLICATION APPROVAL

I, the parent/guardian of the minor child listed on this application, on behalf of the minor child listed herein and for ourselves, our heirs, executors and administrators, hereby release, waive, acquit and forever discharge the **Boys & Girls Clubs of Greater Holyoke** and **Boys & Girls Clubs of America**, their representatives, successors, insurers, assigns or any other person or entity associated with any of the above organizations such as staff, directors or volunteers, from all liability, claims, demands, or causes of action for any and all loss, damage, injury or death and any claim of damages resulting from use of facilities owned or controlled by the above organizations, or participation in activities of said organizations either at or away from the Club.

Your signature below confirms that all information above is true and accurate.

| Parent/Guardian Signature | Date |
Health and Safety COVID-19 Protocols and Procedures

Created 3/20/20

The health and safety of Boys & Girls Club of Greater Holyoke (HBGC) staff, Club members, parents and/or guardians, and volunteers is of the utmost importance. The CDC has developed the suggested strategies and actions below for preventing the spread of illness in response to Coronavirus (COVID-19). HBGC will follow all CDC guidance as it relates to the state-approved Early Education and Care Exempt Emergency Childcare Program:

**Before Enrollment:**

- HBGC staff will meet with the Club member parent and/or guardian to discuss health and safety protocols as well as procedures for emergency events addressing various Coronavirus (COVID-19) scenarios.
- Anyone, including staff, youth, parents and/or guardians and volunteers who has traveled to, or through, any CDC Level-3 country (China, Italy, Iran, South Korea), in the last 14 days, can’t attend the daycare center program.
- Discourage anyone, including staff, Club member, parents and/or guardians and volunteers who are sick from attending the program and have anyone that begins to feel ill and/or display any Coronavirus (COVID-19) symptoms leave immediately.
- Identify and show each parent/guardian as well as Club member the Club quarantine zone for anyone who may fall ill.
- HBGC must collect contact information for all Club members, parents and/or guardians, and volunteers so that we can be in contact if we learn of anyone at the event who gets Coronavirus (COVID-19).
- All parents and/or guardians must agree to an automated platform that can be used to quickly disseminate updates to staff members and attendees via text message, email and more. HBGC will utilize the Remind App to communicate.
- Please note that the Club has ample supplies such as soap, hand sanitizers, tissues and disposable face masks that will be distributed on-site on an as need basis. If inventory runs low, HBGC will provide immediate notification to all parents and/or guardians.
- Outside of essential work functions and visits to grocery store, pharmacy, or addressing a medical need, HBGC encourages all parents and/or guardians to best practice protocols as it relates to 6 feet of social distancing method, shelter in place requirements, and/or any other federal, state, or local mandates. It is critical that you follow these guidelines for the health and safety of your essential work, personal health, the health of your child, our other Club members, and HBGC staff.

**During the Program:**

- Program staff and Club members are required to practice good personal health habits each day. Hand sanitizers will be available throughout program operations. Surfaces and objects that are frequently touched will be wiped down and disinfected on a frequent basis.
- Signs will be posted throughout the facility to remind Club members and HBGC staff of personal hygiene guidelines such as frequently washing hands, avoid touching your eyes, nose and mouth, and sneeze or cough into your elbow.
- HBGC staff will frequent updates with parents and/or guardians, parent and/or guardian employers, Club members, and more.
- HBGC will maintain a healthy stockpile of prevention supplies as there is existing inventory available.
Products with EPA-approved emerging viral pathogens claims external icon are expected to be effective against COVID-19 based on data for harder to kill viruses. Follow the manufacturer’s instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).

For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
- If the items can be laundered, launder items in accordance with the manufacturer’s instructions using the warmest appropriate water setting for the items and then dry items completely.
- Otherwise, use products with the EPA-approved emerging viral pathogens claims that are suitable for porous surfaces

**Linens, Clothing, and Other Items That Go in the Laundry**

Do not shake dirty laundry; this minimize the possibility of dispersing virus through the air. Wash items as appropriate in accordance with the manufacturer’s instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people’s items. Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

**Personal Protective Equipment (PPE) and Hand Hygiene:**

Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash.
Gloves and gowns should be compatible with the disinfectant products being used. Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk of splash.
Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area. Be sure to clean hands after removing gloves.
Gloves should be removed after cleaning a room or area occupied by ill persons. Clean hands immediately after gloves are removed.
Cleaning staff should immediately report breaches in PPE (e.g., tear in gloves) or any potential exposures to their supervisor.
Cleaning staff and others should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains 60%-95% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
Follow normal preventive actions while at work and home, including cleaning hands and avoiding touching eyes, nose, or mouth with unwashed hands. Additional key times to clean hands includes:
- After blowing one’s nose, coughing, or sneezing
- After using the restroom
- Before eating or preparing foods
- After contact with animals or pets
- Before and after providing routine care for another person who needs assistance (e.g., a child)
Please sign and acknowledge that you understand HBGC protocols and procedures during COVID-19:

Name of Child: __________________________________________________________________________

Parent and/or Guardian Signature ___________________________ Date __________

______________________________________________________________________________________

Print Name: __________________________________________________________________________