Dear New Parents,

Thank you for enrolling your child at Open Arms Child Care Center. I'd like to take a minute to guide you through some of this paperwork.

PHYSICAL & IMMUNIZATIONS

Physicals and Immunizations must be received with your child's enrollment paperwork or within 30 days of enrollment. If a physical is not received within this time, your child will not be eligible to remain at Open Arms. Your medical paperwork must include a physical (updated annually), a Lead Test (repeated annually until 48 months), a varicella immunization at 12 months, and required immunizations listed on the attached sheets.

ENROLLMENT PAPERWORK

This paperwork must be fully completed and returned at least one week prior to your child starting at Open Arms. It is important for the teachers to have this information to prepare for your child.

PARENT HANDBOOK

Please read this handbook completely. It contains information on all Open Arms Policies including our Health Care Policy, Tuition Policy, and Withdrawal Policy. You will be asked to sign an acknowledgment form, included in your enrollment paperwork, stating that you are aware of Open Arms Policies.

WELCOME PACKET

This packet includes information specific to the program your child will be entering.

TUITION

Your regular weekly tuition amount will be given to you upon enrollment. Tuition is payable through Tuition Express® on Tuesday the week **prior** to services. If you begin your enrollment part way through the week, we will give you a prorated amount for that week. Tuition must be paid prior to your child starting at Open Arms.
We require a written four week notification of withdrawal for any reason.

Please feel free to call our office at 413-569-5151, ext. 16, if you have any questions.

Thank You,

Kathie Couture
Director

ACKNOWLEDGEMENT FORM

Child's Name ____________________________________

I, ____ (Parent's/Guardian's Name) have read and agree to the policies outlined by Open Arms Child Care Center regarding the following:

- ◊ Child Guidance Policy
- ◊ Procedures for Emergency and Illness
- ◊ Plan for Ill Children
- ◊ Plan for Administration of Medication
- ◊ Toileting and Diapering Policy
- ◊ Toddler Biting Policy
- ◊ Referral Services and Termination Policy
- ◊ Field Trip Policy
- ◊ I give permission for _______________________________________
  (Child's name)
  to take walks on Open Arms/Christ Lutheran Church property.
- ◊ Tuition and Withdrawal Policies

____ (Parent's/Guardian's Signature)

_______________ (Date)

Valid for one year from date of signature.

Open Arms Child Care Center
Allergy Form

Let us know if your child has any allergies or special medical conditions which we need to be aware of. In case of emergencies it is important for our teachers to have this information.

Write any important information on this sheet and return it with your enrollment paperwork. Please let us know if any of this information is confidential.

Child's Name: ____

Allergies: ____

Medical Condition: ____

Special Instructions: ____

OPEN ARMS CHILD CARE CENTER
CHILD RELEASE POLICY

To ensure children's safety, Open Arms will release a child only to the people listed below. By signing this form, I understand that Open Arms will not release my child to any other person unless I notify the center in advance, following the guidelines:

- If the person (spouse, relative, friend) picking up my child is listed on this form, I must notify the center verbally.
- If the person picking up my child is NOT listed on this form, I must notify the center in writing.
- Photograph identification will be required of any person picking up my child.

Child's Name: ______________________________ **Date of Birth:** ___________________

1. Name: __________________________________ Relationship: ____________________

   Address: ________________________________ Day Phone: ______________________

   City/Town & Zip: ________________________ Evening Phone: ___________________

2. Name: __________________________________ Relationship: ____________________

   Address: ________________________________ Day Phone: ______________________

   City/Town & Zip: ________________________ Evening Phone: ___________________

3. Name: __________________________________ Relationship: ____________________

   Address: ________________________________ Day Phone: ______________________

   City/Town & Zip: ________________________ Evening Phone: ___________________

4. Name: __________________________________ Relationship: ____________________

   Address: ________________________________ Day Phone: ______________________

   City/Town & Zip: ________________________ Evening Phone: ___________________

Parent/Guardian's Signature: ________________________ Date: _____________________

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

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** ____________

*Note: 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 the 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 walking 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: _______________________

OPEN ARMS
CHILD'S FACE SHEET/ENROLLMENT FORM

Program____________________________ Group Day Care________ School Age Care_____________________

Child's Name_______________________ Eye Color_____________ Skin Color__________________________

Home Address______________________ Hair Color____________ Height______________________________

Telephone_________________________ Sex__________________ Weight_____________________________

Date of Admission__________________ Age at Admission____

Date of Birth______________________ Primary Language____

Identifying Marks____

Allergies/ Special Diets____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name___________________________ Parent/Guardian Name________________________

Relationship to Child____________________________ Relationship to Child_________________________

Home Address__________________________________ Home Address______________________________

Home Telephone #______________________________ Home Telephone #__________________________

Business Name_________________________________ Business Name_____________________________

Business Address______________________________ Business Address___________________________

Business #_____________________________________ Business #__________________________________

Hours at Work__________________________________ Hours at Work______________________________

ADDITIONAL INFORMATION:

Child's Physician/Clinic____
name address phone

Chronic Health Conditions____

Special Limitations or Concerns____

____ ___________________________
Parent/Guardian Signature Date

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: _______

OPEN ARMS
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 to give my child first aid 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 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:____________________ Phone #:____________________________

Do you give permission for child to be released to this person? Yes_____ No_____

Name:_______________________________ Address:____________________________

Relationship to Child:____________________ Phone #:____________________________

Do you give permission for child to be released to this person? Yes_____ No_____

Name:_______________________________ Address:____________________________

Relationship to Child:____________________ Phone #:____________________________

Do you give permission for child to be released to this person? Yes_____ No_____

Health Insurance Coverage:___________________________ Policy#__________________

Parent(s) Name_____________________________________ Phone(work)_______________
Phone(home)_______________

Parent(s) Name_____________________________________ Phone(work)_______________
Phone(home)_______________

____ ___________________
Parent/Guardian Signature **Date**

Medication Consent Form
102 CMR 7.05(2)(c)

Name of child: ____

Name of medication: ____

Prescription: _____________ Non-Prescription:__________

Dosage: ____

Date(s) medication to be given: _________________________________

Time(s) medication to be given: ________________________________

Reasons for medication: ______________________________________

Possible side effects:____

Name and phone number of prescribing physician:

____

Directions for storage:____

I, _________________________________, (parent or guardian) give permission to authorized staff member(s) to administer medication to my child as indicated above.

______________________________ __________________
Parent/Guardian Signature Date

Doctor's Signature: ____________________________________
(for non-prescription medication)

Registration Form
Open Arms Child Care Center
PO Box 1107
568 College Highway
Southwick, MA 01077
413-569-5151
Hours of Operation 7:00-6:00

Welcome to Open Arms Child Care Center. You have chosen a state of the art facility, which will provide the highest quality early care and education, as well as an introduction to God and Christian values.

To register your child, please return this completed form to Open Arms with a non-refundable registration fee of $50.00 for one child, $15.00 for each additional child. When your registration form and fee are received, the Center Director/Center Administrator will contact you regarding the enrollment process.

We look forward to providing a unique learning experience for your child and developing a partnership between home and school.

Child's Name:______________________________ Date of Birth:____________________

Parent/Guardian:
Name:____
Relationship:____
Address: ____
Home Phone: ____

Parent/Guardian location during childcare:

Name:____________________________	Name:____________________________
Name of Employer: __________________	Name of Employer: __________________
Address: _________________________	Address: _________________________
Telephone: _______________________	Telephone: _______________________
Instructions: _____________________	Instructions: _____________________

Schedules (Please check one):

Mon-Fri (8-9 hours)_____	Mon-Wed-Fri (8-9 hours)_____	Tue-Thu (8-9 hours)_____
Mon-Fri (4 hours) _____	Mon-Wed-Fri (4 hours) _____	Tue-Thu (4 hours)_____
Before School only _____	Before & After School _____	After School Only _____

Arrival/Departure times: ____
What date would you like enrollment to begin?_______________________________
How did you hear about Open Arms Child Care Center? _______________________

Parent/Guardian Signature: _______________________________ Date: ______________

Open Arms Child Care Center
Permission for Topical Creams and Ointments

I give permission for the staff of Open Arms Child Care to apply non-prescription creams

and ointments to ___________________________. I understand that these creams can't
(child's name)

be applied to a rash which is open or bleeding without a note from my child's

pediatrician.

____ ______________
Parent's Signature Date

*This form will expire one year from date signed.

All creams and ointments must be supplied by the parent and labeled with the child's

name.

Ointments and creams may include:
Desitin, Balmex, other diaper creams, hydrocortisone cream, petroleum jelly, other over the counter creams.

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

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, HepA-HepB)	1		**Rotavirus** (e.g., RV5: 3-dose series, RV1: 2-dose series)	1	
	2			2	
	3			3	
	4		**Measles, Mumps, Rubella** (MMR, MMRV)	1	
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap)	1			2	
	2		**Varicella** (Var, MMRV)	1	
	3			2	
	4		**Meningococcal** Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	5			2	
	6		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	7			2	
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1			3	
	2			4	
	3			5	
	4			6	
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Hepatitis A** (HepA, HepA-HepB)	1	
	4			2	
	5		**Human Papillomavirus** (HPV)	1	
Pneumococcal Conjugate (PCV7)	1			2	
	2			3	
	3		**Other:**		
	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:

OPEN ARMS CHILD CARE CENTER
PARENT CONTRACT

Please check the days your child will attend:

Monday _____ From _____ To _____

Tuesday _____ From _____ To _____

Wednesday _____ From _____ To _____

Thursday _____ From _____ To _____

Friday _____ From _____ To _____

Child's Name: ________________

Effective date: ________________

Reason for change: ____________

____

A tuition fee of $ _________ is due on the Tuesday of each week prior to services through the Tuition Express Program® with no reduction for any absences, holidays, or snow days. Once enrolled in the Tuition Express Program® there is a ten day written notice required to make any adjustments.

Tuition not paid in full by the last working day of the week will be assessed a $5.00 per day charge for the first 5 business days. Suspension/Termination may result after that time period if a payment plan is not agreed upon and adhered to.

I, ______________________________ (Parent/Guardian Sponsor Name) and/or _________________________________ (Parent/Guardian Co-Sponsor Name) agree to the contracted hours and tuition amount. If these hours change in any way, I will notify Open Arms immediately so that they may arrange for proper staffing. If we go beyond our normal contract hours, we understand that the appropriate fees will be charged to my account. Tuition rates will be adjusted accordingly for changes in contract. Tuition may be adjusted annually with a 30 day notice.

Neither credit nor make-up days are extended for absences, holidays, or illness.

We understand that if it becomes necessary for us to withdraw our child from the Center, a one month notice must be submitted in writing to the Director, and we are responsible for paying tuition for the one month notice.

Signature of both parents is required.

____ _______________

Parent/Guardian Sponsor Signature Date

____ _______________

Parent/Guardian Co-Sponsor Signature Date

Revised 7/25/2019

Open Arms Child Care Center
Address and Telephone Release

I give permission for Open Arms Child Care to release my address and/or telephone number to parents within the program for the purpose of birthday parties or special events. I understand that this information will not be released for any other purpose or to any other parties.

_____ Permission to release address

_____ Permission to release telephone number

____
Child's Name

____
Parent's Signature

____
Date

OPEN ARMS CHILD CARE CENTER
CONSENT FORM

While your child is enrolled at Open Arms he/she will be involved in a number of special activities for which we need your permission. Please read the following information carefully. You are encouraged to ask questions about anything which is unclear to you.

Please circle your choice:

- **I DO / DO NOT** give my permission for my child to go for supervised walks on Open Arms property.
- **I DO / DO NOT** give permission for sunscreen to be applied to my child. (Parents must provide sunscreen and we will not apply sunscreen to children under six months of age.)
- **I DO / DO NOT** give permission for my child to be screened for specific educational needs. All recommendations will be kept confidential and shared only with parents.
- **I DO / DO NOT** give permission for my child to be observed during general classroom observations or by student teachers. (All names will be kept confidential.)
- **I DO / DO NOT** give permission for my child to be photographed for Center use. (Including Open Arms publicity and classroom use.)
- **I DO / DO NOT** give permission for my child to be involved in fundraising events at Open Arms Child Care Center (i.e. Easter Seals Hop-a-thon). I understand that all fundraising events are optional.

____
Child's Name

____ ________________
Parent's Signature Date

This form expires one year from date signed

Open Arms Child Care Center
E-Mail Message Service

______ No, I do not want to participate in the e-mail message service.

______ Yes, I would like to participate in the e-mail message service.

Parent's/Guardian's Name: ____________________________

Child's Name: ____

Child's Classroom: ___________________________________

E-Mail Address: ______________________________________

______________________________ ________________

Parent's Signature Date

Open Arms Child Care Center
Family Background

Dear Parents,

It is our goal to encourage a sense of belongingness, promote an appreciation of others and enrich children's experiences by integrating into our curriculum, activities and information that reflect our individual children's background. One way we can do this is by learning about each child's family background, and celebrated holidays and traditions. Please take a few minutes to share with us your special family days or activities and how they are carried out in your home.

1) Is there any information about your family's background and culture you would like to share with us?

2) What are the holidays or special days your family celebrates?

3) Are there any activities from your family's culture or tradition that you would like to share with your child's classroom and other classrooms?

4) Any other comments you might have?

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) Open Arms Child Care Center to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name ______ Phone # ______

Cardholder Address ______ City ______ State ______ Zip ______

Account Number ______ Expiration Date ______

Cardholder Signature ______ Date ______

SECTION B (Bank Account)

Your Name ______ Phone # ______

Address ______ City ______ State ______ Zip ______

Bank or Credit Union Name ______ Bank or Credit Union Address ______ City ______ State ______ Zip ______

Routing Transit Number (see sample below) ______ Account Number (see sample below) ______ ☐ Checking ☐ Savings

Authorized Signature ______ Date ______

For Official Use Only

Date Received ______

Employee Signature ______

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