EXPANDING HORIZONS CHILDREN'S CENTER
"Where Quality Meets Service"

46 Pleasant Street
Norton, MA 02766
Phone 508-222-3865
Fax 508-222-8010

DATE OF ADMISSION: _____
AGE AT ADMISSION: _____

CHILD'S NAME _____
DATE OF BIRTH _____ PLACE OF BIRTH _____
GENDER: _____ ETHNICITY: _____
EYE COLOR: _____ HAIR COLOR: _____
HEIGHT: _____ WEIGHT: _____
PRIMARY LANGUAGE: _____ IDENTIFYING MARKS: _____

PARENT CHILD LIVES WITH: _____
OTHERS IN FAMILY/RELATIONSHIP:
_____/_____ _____/_____
_____/_____ _____/_____

PARENTS' / GUARDIANS' NAMES:

MOTHER: _____
HOME ADDRESS: _____
_____
HOME TELEPHONE: _____
OTHER TELEPHONE: _____
EMAIL ADDRESS: _____
MOTHER'S PLACE OF WORK: _____
ADDRESS: _____
WORK TELEPHONE & EXT. _____
HOURS AT WORK _____

FATHER: _____
HOME ADDRESS: _____
_____
HOME TELEPHONE: _____
OTHER TELEPHONE: _____
EMAIL ADDRESS: _____
FATHER'S PLACE OF WORK: _____
ADDRESS: _____
WORK TELEPHONE & EXT. _____
HOURS AT WORK _____

HOURS YOUR CHILD WILL BE ATTENDING EXPANDING HORIZONS CHILDREN'S CENTER

Morning drop off time: _____ Afternoon pick up time: _____

If there are any custody agreements, court orders, and restraining orders pertaining to the child, that Expanding Horizons should be aware of, please provide copies.

_____ _____

Parent/Guardian Signature ***Date***

Home Transportation Plan and Authorization

CHILD'S NAME _____

MY CHILD WILL ARRIVE AT THE PROGRAM:
__ EXPANDING HORIZONS VAN***
__ PARENT DROP OFF
__ OTHER _____

MY CHILD WILL DEPART FROM THE PROGRAM:
__ EXPANDING HORIZONS VAN***
__ PARENT PICK UP
__ OTHER _____

Main pickup/drop off location for children transported by Expanding Horizons bus.

NAME: _____
ADDRESS: _____
PHONE: _____

Alternative emergency pick up/drop off location for for children transported by Expanding Horizons bus.

NAME: _____
ADDRESS: _____
PHONE: _____

Public School Transportation Plan and Authorization

MY CHILD WILL DEPART FROM THE PROGRAM:
__ EXPANDING HORIZONS BUS/ VAN (ATTLEBORO)
__ PUBLIC SCHOOL BUS (NORTON)
__ OTHER _____

MY CHILD WILL ARRIVE AT THE PROGRAM:
__ EXPANDING HORIZONS BUS/ VAN (ATTLEBORO)
__ PUBLIC SCHOOL BUS (NORTON)
__ OTHER _____

I give permission for my child to be released from Expanding Horizons at the end of the program day as stated above and / or I give permission to the following people to receive my child at the end of the day. (If no one is authorized other than the parent/legal guardian, please indicate below "NO ONE".)

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
_____ PHONE NUMBER:_____

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
_____ PHONE NUMBER:_____

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
_____ PHONE NUMBER:_____

_____

Parent/Guardian Signature ***Date***

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize the staff at Expanding Horizons Children's Center who has been 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 Expanding Horizons Children's Center 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: _____ Phone Number: _____

Address: _____

Child's Allergies: _____

Chronic Health Condition (MUST PROVIDE COMPLETED INDIVIDUAL HEALTH CARE PLAN):_____

Medications Taken Daily: _____

Emergency Contacts

INSTRUCTIONS TO REACH PARENTS/ GUARDIAN:

Mother: _____ Phone numbers: _____

Father: _____ Phone numbers: _____

If parents can not be contacted, notify the following people: (In order to be contacted)

Name: _____ Relationship to child: _____

Address: _____

Phone Numbers: _____

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

Name: _____ Relationship to child: _____

Address: _____

Phone Numbers: _____

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

Name: _____ Relationship to child: _____

Address: _____

Phone Numbers: _____

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

Health Insurance Coverage _____ Policy # _____

_____ _____

Parent/Guardian Signature ***Date***

ALLERGY INFORMATION

CHILD'S NAME: _____

Individual Health Plan for child with chronic health condition? Yes _____ No _____

(If yes, please see office for Individual Health Care Plan)

ALLERGY	REACTION	TREATMENT REQUIRED (written instructions) (If none- write none)
1.		
2.		
3.		

DAILY MEDICATION INFORMATION

Medication:_____ Reason for medication:_____
Possible side effects:_____
Missed dose may result in:_____

Medication:_____ Reason for medication:_____
Possible side effects:_____
Missed dose may result in:_____

Special diets? _____

Special limitations and concerns? _____

Any Special needs or learning disabilities?_____

Tooth Brushing is a part of Expanding Horizons Children's Center daily program. If for any reason you **DO NOT** want your child to participate in brushing their teeth, please see the office for an opt-out form.

_____ _____

Parent/Guardian Signature ***Date***

School Age Children

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***: _____

EXPANDING HORIZONS CHILDREN'S CENTER

SCHOOL AGE PROGRAM

Dear Parents/Guardians,

Here at Expanding Horizons Children's Center we often enjoy taking pictures of children; for display, on field trips, special events etc…

_____ **YES**, My child _____ may be photographed at Expanding Horizons Children's Center.

_____ **NO,** I do not want my child _____ to be photographed at Expanding Horizons Children's Center.

_____ _____

Parent/Guardian Signature ***Date***

I give permission for my child _____ to leave Expanding Horizons Children's Center to attend walking excursions, or in the event of an emergency as decided by the director.

_____ _____

Parent/Guardian Signature ***Date***

Occasionally, the children get the opportunity to watch G or PG movies as part of a special week or treat. Teacher discretion will always be used when choosing a movie.

_____ **YES**, My child _____ may watch G or PG movies at Expanding Horizons Children's Center.

_____ **NO,** I do not want my child _____ to watch movies at Expanding Horizons Children's Center.

_____ _____

Parent/Guardian Signature ***Date***

BUS/ TRANSPORTATION RULES

In order to provide safe transportation for your children we ask that you review these rules with your child.

1. Parent/ Guardian must call as soon as possible to report an absence.
2. All Children must remain seated while the bus is moving. Use of a seat belt is mandatory.
3. There is no eating or drinking on the bus.
4. Respect of one another is a must.
5. Throwing anything out of the bus windows is forbidden.
6. Lunch boxes and book bags should not be opened nor should toys be taken out on the bus.
7. The bus driver's instructions are given to assure your safety. Please listen to and follow directions carefully.
8. Remember your inside voices and use them to talk to your friends. Yelling is not allowed.

I have read the bus rules and have reviewed them with my children. I understand that failure to follow these rules will result in suspension and or termination of transportation privileges.

Signature: _____

Date: _____

Expanding Horizons Children's Center
Receipt of Parent Handbook/Health Care Policy

I have read and understand the policies and procedures of Expanding Horizons Children's Center regarding:

___ Drop off and pick up policies

___ Attendance / Transportation policies

___ Tuition Policies

___ Termination / Suspension of childcare policy

___ Nutrition Requirements

___ Fever / Illness Policy

___ Personal Property Policy

___ Statement of Limited Liability

_____ _____

Parent's / Guardian's Signature Date