FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MASSACHUSETTS
Department of
Early Education and Care

YMCA Cape Cod

Exempt Emergency Child Care Program (EECCP)

Provider Packet

March 20, 2020

The Commonwealth of Massachusetts
Department of Early Education and Care

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

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?_____ Medications? YES or NO

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**

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)

USE THIS FORM ONLY IF YOU ANSWERED YES TO AN IHP ON PAGE 2

Child's Photo

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: _____

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
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:_____ Date:_____

Parental/Guardian consent: _____ Date:_____

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.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: _____ Date: _____

USE THIS FORM ONLY IF YOU LISTED MED NEEDS ON P.2

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)**

TRANSPORTATION PLAN / AUTHORIZED PICK- UP

My child will arrive to the program by:	My child will depart the program by:
__Parent Drop-Off __Supervised Walk __Unsupervised Walk __Public/Private Van __Bus __Private Transportation Provided by Parent	__Parent Pick Up __Supervised Walk __Unsupervised Walk __Public/Private Van __Program Bus/Van __Private Transportation Provided by Parent

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

Day	Arrival Time	Departure Time	Day	Arrival Time	Departure Time
Monday	_____	_____	Friday	_____	_____
Tuesday	_____	_____	Saturday	_____	_____
Wednesday	_____	_____	Sunday	_____	_____
Thursday	_____	_____			

If applicable: Name of School Child Attends: _____

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

Notes:

_____

_____

_____

Child's Name _____

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 _____, to a hospital for medical treatment
(Name)

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:_____
_____
_____