

BRIGHT HORIZONS FAMILY SOLUTIONS

CHILD'S INFORMATION

Child's Name: _____ Date of Birth: ____/____/____

Place of Birth: _____ Primary Language: _____

Child's Schedule: MON _____ TUE _____ WED _____ THU _____ FRI _____

Parent/Guardian Information

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Home E-mail Address: _____ Home E-mail Address: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Home Phone: _____

Others in Family Relationship: _____

Parent/Guardian Business Information

Company Name: _____ Company Name: _____

Address: _____ Address: _____

Business Phone: _____ Business Phone: _____

E-mail Address: _____ E-mail Address: _____

Medical Information

Eye Color: _____ Hair Color: _____ Sex: _____

Height: _____ Weight: _____ Race: _____

Identifying Marks: _____

Identified Allergies: _____

Health Insurance Provider: _____

Physician Information

Name of Physician/Clinic: _____ Phone: _____

(Parent/Guardian Signature) (Date)

FOR CENTER USE

Center: _____ Date of Admission: _____ Age of Admission: _____

Emergency Information

A copy of this form is kept with your child's teacher at all times to ensure immediate access to emergency contacts.

Child's Name: _____ **Date of Birth:** _____

Child's Address: _____

Home Phone: (____) _____ **Cell Phone:** _____

Parent/Guardian's Name: _____

Address (if different): _____

Workplace: _____ Phone: (____) _____ ext _____

Parent/Guardian's Name: _____

Address (if different): _____

Workplace: _____ Phone: (____) _____ ext _____

Pediatrician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

ALLERGIES: _____

EMERGENCY CONTACT(S) *other than parents* :

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

AUTHORIZATION AND CONSENT: 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 GORSE CHILDREN'S CENTER to transport my child to the nearest hospital (or one recommended by the emergency medical team) and to secure for my child the necessary medical treatment. I understand the teachers in the child care center are trained in the basics of First Aid and CPR and I authorize them to give my child First Aid when appropriate.

Parent/Guardian's Signature

Date

BRIGHT HORIZONS AUTHORIZATION AND CONSENT / CHILD RELEASE

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child, _____. If I cannot be reached, I understand that the emergency contacts listed below will be called. However, I hereby authorize Bright Horizons to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. I understand the staff in the child care Center/School is trained in the basics of first aid and CPR and I authorize them to give my child first aid. In the best interests of my child, I realize any member of the teaching staff assigned responsibility for the care and education of my child may view my child's health information, as well as state licensors to ensure compliance.

Child's Health Insurance Provider: _____
 Name of Insured: _____ Policy Number: _____

To ensure children's safety, Bright Horizons will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below as undersigned by the parent/guardian.

By signing this form, I understand that Bright Horizons will not release my child to any other person unless I notify the Center/School in advance, following the guidelines listed below:

- If the person (spouse, relative, friend) picking up my child is listed on this form, I must notify the Center/School verbally.
- If the person picking up my child is **NOT** listed on this form, I must notify the Center/School in writing.
- Photo 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 #: _____
 Cell Phone #: _____

2. Name: _____ Relationship: _____
 Address: _____ Day Phone #: _____
 City/Town & Zip: _____ Evening Phone #: _____
 Cell Phone #: _____

3. Name: _____ Relationship: _____
 Address: _____ Day Phone #: _____
 City/Town & Zip: _____ Evening Phone #: _____
 Cell Phone #: _____

4. Name: _____ Relationship: _____
 Address: _____ Day Phone #: _____
 City/Town & Zip: _____ Evening Phone #: _____
 Cell Phone #: _____

 (Parent/Guardian's Signature)

 (Date)

 (Parent/Guardian's Signature)

 (Date)



Bright Horizons

FAMILY SOLUTIONS®

The Gorse Children's Center
27 Morgan Street, South Hadley, MA 01075
P (413)533-9819 F (413) 539-5850

Please have your physician fill out the following forms:

ANNUAL PHYSICAL EXAM FORM (including annual lead test)
CERTIFICATE OF IMMUNIZATION

All children enrolled in child care programs in Massachusetts must have the following:

1. An annual physical exam. The initial form is due within one month after enrollment. A new form must be submitted to The Gorse Children's Center after each annual physical exam. WE ARE REQUIRED TO HAVE RECORD OF A PHYSICAL EXAM WITHIN THE PAST YEAR.
2. Up-to-date immunizations. The initial form is due PRIOR TO ENROLLMENT and a new form must be submitted to The Gorse Children's Center after each annual physical exam or immunization update.
3. Blood tests for lead poisoning are required beginning at 9 to 12 months and repeated annually through 48 months. This is recorded on the annual physical exam form.

If these practices conflict with the family's **religious** beliefs, written documentation of such beliefs must be submitted to The Gorse Children's Center.

If these practices are contraindicated for medical reasons, the physician must submit written supportive documentation to The Gorse Children's Center each year.

Thank you.

200 Talcott Avenue South, Watertown, Massachusetts 02472 p 617.673.8000 f 617.673.8001

www.brighthorizons.com

BOSTON CHICAGO DALLAS DUBLIN LONDON LOS ANGELES NASHVILLE NEW YORK SEATTLE

One of Fortune Magazine's "100 Best Companies to Work for in America"

Back to School Pup Says

By Two Years

3 doses of Hep B

4 doses of DTaP/DTP

3 doses of Polio

4 doses of Hib

1 dose of MMR

1 dose of Varicella

By Kindergarten

3 doses of Hep B

5 doses of DTaP/DTP

4 doses of Polio

2 doses of MMR

1 dose of Varicella

By 7th Grade

3 doses of Hep B

1 booster dose of Td

3 doses of Polio

2 doses of MMR

1 dose of Varicella*

(*2 doses if 13 years of age or older)



VACCINATE ALL YOUR CHILDREN

For more information, contact your health care provider
or the regional immunization office in your area:

Central Region: (508) 792-7880
Northeast Region: (978) 851-7261
Western Region: (413) 545-6600

Metro/Boston* Region: (617) 983-6860
Southeast Region: (508) 947-1231
* For BOSTON providers/schools only, you may call
the Boston Health Commission: (617) 534-5611

Massachusetts Immunization Program
Main Number (617) 983-6800 or Toll-Free 888-658-2850

**Gorse Children's Center
PHYSICAL EXAM FORM**

Dear Physician: _____
(Child's Name)

is enrolled in an early childhood program licensed 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 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/Guardians: _____

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 _____

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 provider? If so, please detail below:

Physician's Signature: _____

Date: _____

Comments: _____

Please return to Program:

Gorse Children's Center
27 Morgan Street
South Hadley, MA 01075
Phone: (413) 533-9819
Fax: (413) 539-5850

Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: female male

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)	1		Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
		4			
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		Measles, Mumps, Rubella (MMR)	1	
	2			2	
	3		Varicella (Var)	1	
	4			2	
	5				
	6		Hepatitis A (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		Pneumococcal Polysaccharide (PPV23)	1	
	2			2	
	3		Influenza Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1		Other:	3	
	2				
	3				
	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	
<input type="checkbox"/>	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: _____

Bright Horizons Family Solutions

Child's Allergy Information

All allergies requiring medication and/or special meal requirements must be documented by the child's physician.

Name of Child _____ Date of Birth _____

Allergen:	Symptom:	Treatment*/Substitution:*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*If treatments require medication administration, it will be necessary to have medication authorization paperwork completed and the physician's signature must be in place as required.

Further Emergency Response

Procedures: _____

Additional

Information/Instructions _____

Referred for Allergy Testing: Yes No Allergy Testing completed: Yes No

I know of no known food allergy at this time, no dietary adjustments indicated

Physician's Signature

Date

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a note from the child's physician stating that the child is no longer allergic to that item(s) (and may now have that specific food(s)), nor can we add an item(s) or change a medication without a note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the homebases and kitchen on the Allergy Awareness Chart.

Parent/Guardian Signature

Date

HEALTH ALERT

The Gorse Children's Center is a PEANUT- & NUT-FREE ZONE

Peanut-Free Zone:

We have infants, toddlers, and preschool children at the Gorse Children's Center who have severe allergies to peanuts, peanut butter, peanut oil and any products that have peanuts in them. These allergies can be fast acting and **lethal**. Even touching surfaces that have peanut residue on them can cause life-threatening reactions in some of these children. Therefore, our whole Center is peanut-free.

Nut-Free Zone:

Currently, and in the past, there have been children and teachers with tree-nut allergies. These allergies are just as severe and potentially lethal as the peanut allergies that affect the children we have in our care. It is for this reason that our Center has adopted the policy to be completely nut-free.

In order to protect the teachers and children with allergies (in addition to younger children who may have allergies that have not yet been discovered) we ask that no peanut- or nut-containing foods are brought into the building and that children have their hands washed before entering the Center if they have eaten these types of foods prior to arriving. Please check your children's lunch-food ingredients and remember:

- No peanut butter sandwiches
- No peanut butter or other cookies with peanuts or tree nuts
- No candy bars
- No peanut or nut products of any kind
- No muffins or breads with nuts (walnuts are common in baked goods)
- No products that include peanut oil (check all crackers, breakfast bars, etc.)

ALSO, PLEASE DO NOT BRING SNACKS TO THE CLASSES UNLESS YOU KNOW ALL THE INGREDIENTS (e.g., is there peanut oil in the product?)

A safe alternative to peanut butter is soy butter or sunflower seed butter. It is safe to send sandwiches made with these butters. On the back of this notice is a list of suggestions for various types of lunches and snacks that are peanut and nut-free.

If you have any questions or concerns, please see Sharon Maryea or Jaime Scala in the office. You can also email Sharon directly at: gorse@brighthorizons.com. Thank you for your cooperation.

BRIGHT HORIZONS

INFANT/TODDLER DEVELOPMENTAL HISTORY

Child's Name: _____ Date of Birth: ____/____/____

What would you like us to call your child? _____

DEVELOPMENTAL HISTORY

Type of birth: _____ Complications: _____

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

Does child: pull up crawl walk with support

Times child is fussy: _____

How do you handle these fussy times? _____

FAMILY INFORMATION

With whom does child reside? _____

Who else lives in the home (siblings, extended family, pets)? _____

What does child call family members? _____

Language spoken at home: _____

Are books read in languages other than English? _____

Are there words in your home language that we should know? _____

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful: _____

HEALTH/ DEVELOPMENT

Serious illnesses or hospitalizations (describe)? _____

Any history of colic? _____

Special physical conditions, disabilities, or allergies (describe)? _____

Is your child presently or ever been diagnosed with a special need? _____

If so, is he/she receiving any special services? _____

Regular medications? _____

EATING HABITS

Special characteristics or difficulties? _____

Special diet: _____ Formula: _____ Breast Milk: _____

Any food allergies? _____

Have solid foods been introduced? yes no If yes, please identify: _____

Favorite foods: _____ Foods refused: _____

Child eats: on lap in high chair other

Child eats with: spoon fork hands other

TOILETING/DIAPERING HABITS

Is there frequent diaper rash? yes no

Do you use: oil powder lotion other

Does child wear: disposable diapers cloth diapers

Are bowel movements: regular how often: _____

Is there a problem with: diarrhea constipation

Is your child toilet trained: yes no If yes, when did you begin? _____

urination bowels or both

What is used at home: potty-chair special seat regular seat

Word used for urination: _____ bowel movement: _____

Does your child have accidents? yes no If yes, how often/when? _____

SLEEPING HABITS

Does child sleep in: crib bed with parents

Does child sleep on: back side stomach

Times child take naps? Times: a.m. _____ / _____ p.m. _____ / _____

What does child take to bed? _____ mood on awakening: _____

What time does child go to bed at night: _____ awake in morning: _____

Are there any sleep/wake time rituals? If so, please describe. _____

SOCIAL RELATIONSHIPS

Has child had any experience playing with children? If so, please describe. _____

Is child: friendly aggressive shy withdrawn

Reaction to strangers? _____

Have you had any previous child care experience? yes no If yes, did it meet your needs and expectations? Explain: _____

Prefers to play: alone in small groups

Favorite toys and activities? _____

Is child frightened by: animals rough children loud noises dark other

Explain: _____

How do you comfort your child? _____

How does your child prefer to be held? _____

What is your style of disciplining? _____

DAILY SCHEDULE

Please describe by approximate time your child's current daily activities (e.g., awakening, eating, time out of crib, napping, toilet habits, fussy time, bedtime):

MORNING

AFTERNOON

PARENTING PHILOSOPHY

Do you have ideas about parenting that would help us to better care for your child as an individual? _____

What do you, as a family, hope to get out of this child care experience? _____

(Parent/Guardian's Signature)

(Date)

BRIGHT HORIZONS
PRESCHOOL/KINDERGARTEN DEVELOPMENTAL HISTORY

Child's Name: _____ Date of Birth: ____/____/____

What would you like us to call your child? _____

DEVELOPMENTAL HISTORY

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

Any speech difficulties? _____

FAMILY INFORMATION

With whom does the child reside? _____

Who else lives in the home (siblings, extended family members, pets)? _____

What does child call family members? _____

Language spoken at home: _____

Are books read in languages other than English? yes no If yes, what language(s)? _____

Are there words in your home language that we should know? _____

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful: _____

HEALTH/DEVELOPMENT

Serious illnesses or hospitalizations (describe): _____

Any physical/chronic conditions, disabilities, including allergies? Describe: _____

Regular medications: _____

Is your child presently or ever been diagnosed with a special need? yes no If so, is he/she receiving any special services? Explain. _____

EATING HABITS

Any food allergies? _____

Special diet: _____

Special characteristics or difficulties? _____

Favorite foods: _____ Foods refused: _____

Child eats with: spoon fork hands other

TOILETING HABITS

How does child indicate bathroom needs (include special words)? _____

Is child reluctant to use the bathroom? yes no If yes, how do you handle? _____

Does child have accidents? yes no If yes, how often and when? _____

SLEEPING HABITS

Does child become tired or nap during the day (include when and how long)? _____

What time does child go to bed at night: _____ awake in morning: _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking): _____

Are there any sleep/wake time routines? _____

SOCIAL RELATIONSHIPS

How would you describe your child? _____

Describe any previous experience with children: _____

Has there been any previous child care experience? yes no If so, did it meet your needs and expectations? _____

Reaction to strangers: _____

Prefers to play alone or in groups? _____

Favorite toys and activities: _____

Fears (e.g., the dark, animals): _____

How do you comfort your child? _____

How do you discipline your child? _____

DAILY SCHEDULE

Describe your child's schedule on a typical day:

What would you like your child to gain from the child care experience?

Anything else you would like us to know about your child?

(Parent/Guardian's Signature)

(Date)

The Gorse Children's Center

Full Day Program Child Study Program (September-May)

PERMISSION FOR CHILD STUDY ACTIVITIES

I understand that as a child enrolled in The Gorse Children's Center,
_____ will have contact with students in Psychology,
Education, and other disciplines.

As part of their training in Early Childhood and related fields, students from Mount Holyoke College will be observing the children and also engaging them individually, and in small and large group activities.

For course work purposes, it will be necessary to share your child's birth date with students. Occasionally, this work may also include the children being photographed, audiotaped, or videotaped.

I agree to allow my child, _____, to
participate in observation and activities conducted by students at Mount Holyoke
College.

Signature

Date

PLEASE NOTE: Students and faculty who are conducting research projects will request separate permission.

Child Guidance (Discipline) Policy

During the early childhood years, children are learning to be in charge of their own behavior. We believe in establishing consistent, easy-to-understand limits and in having teachers who respond to inappropriate behavior with insight, sensitivity, and skill. When clear, consistent and age-appropriate limits are present; children increasingly become responsible for themselves. When out-of-bounds behaviors do occur, we believe it is important for children to understand why the behavior is inappropriate and how to modify it.

We work to prevent behavior problems by arranging each classroom so that children work in small groups and have a choice of activities. The range of activities will give your child the freedom and ability to experience success and become self-directed. Teachers are also trained to skillfully direct behavior along appropriate channels. Children are encouraged to verbalize their feelings to learn to positively work through strong emotions. Teachers act as role models and encourage children's appropriate behaviors. **Under no circumstances is corporal punishment permitted. Discipline will not be associated with food, rest or toileting.**

We believe that it is our responsibility to provide children with positive guidance and in our experience, most children will respond well to our approach. In the event that a child does not respond, we will notify the parents and work closely with them to develop a plan to help the child gain self-control and a positive attitude toward their peers and teachers. Should the child's continued negative behavior put themselves, their peers or their teachers at risk for physical harm or, if the child damages Center property, we reserve the right to ask the parent to withdraw the child from the Center. While we understand the developmental tendencies of children to experiment with inappropriate language to shock others, withdrawal may also be requested for those children who are verbally abusive, including the repeated use of inappropriate language with other families consider offensive.

I have read and understand the above Child Guidance (Discipline) Policy.

Signature of Parent/Guardian

Date