STORYHEIGHTS

MONTESSORI

Registration Forms

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Registration Forms

Child's Information

Name: _____ Date of Birth: _____ Sex: _____
Age (at admission): _____ Date of Admission: _____

Address: _____ City: _____ Zip: _____
_____

Identifying Marks: _____ Height: _____ Eye color: _____
_____ Weight: _____ Hair Color: _____
_____ Language: _____ Skin Color: _____

Parent/Guardian Information

Name: _____ Relationship to Child: _____

Address (Home): _____ City: _____ Zip: _____
_____ Email: _____
Phone: _____

Address (Work): _____ City: _____ Zip: _____
_____ Email: _____
Hours at Work: _____ Phone: _____

Name: _____ Relationship to Child: _____

Address (Home): _____ City: _____ Zip: _____
_____ Email: _____
Phone: _____

Address (Work): _____ City: _____ Zip: _____
_____ Email: _____
Hours at Work: _____ Phone: _____

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Registration Forms

Additional Information

Child's Physician: _____ Phone: _____

Address: _____ City: _____ Zip: _____

_____

Allergies/Dietary Restrictions: _____

_____

_____

_____

Does your child have an EpiPen?

Does your child have an Individual Health Care Plan for a chronic health condition? YES NO
If yes, please attach.

Is there a custody agreement, court order or restraining order pertaining to the child? YES NO
If yes, please attach.

Any special limitations or concerns? _____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

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First Aid & Emergency Medical Care Consent Form

Child's Name: _____ Date of Birth: _____

I authorize staff in StoryHeights Montessori & Early Education Center who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate. _____ Initials

I understand that every effort will be made to contact me in the event of an emergency requiring medical treatment 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. _____ Initials

Child's Physician: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Insurance Plan: _____ Policy Number: _____

Allergies & Reactions: _____ Anaphylactic?: YES NO

Medical Alert Bracelet/Necklace?: YES NO

IF YOUR CHILD HAS AN ANAPHYLACTIC ALLERGY SHE/HE MUST HAVE A MEDICAL ALERT BRACELET/NECKLACE.

Chronic health conditions? YES NO
If yes, you must fill out an Individual Health Plan that is signed by your child's physician.
Please Describe: _____

Has your child ever had a seizure? YES NO
Please Describe: _____

Does your child have any physical limitations? YES NO
Please Describe: _____

Any other concerns?: _____

Parent/Guardian Signature: _____ Date: _____

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Emergency Contacts

Child's Name: _____ Date of Birth: _____

Please provide emergency contacts that we can call if we are unable to reach the child's parent/guardians. Please let your contacts know that they may be called.

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____
_____ Best Phone: _____
Alternate Phone: _____

Do you give permission for your child to be released to this person? YES NO

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____
_____ Best Phone: _____
Alternate Phone: _____

Do you give permission for your child to be released to this person? YES NO

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____
_____ Best Phone: _____
Alternate Phone: _____

Do you give permission for your child to be released to this person? YES NO

Parent/Guardian Signature: _____ Date: _____

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Consent Form

Child's Name: _____ Date of Birth: _____

Transportation
I agree to allow my child to participate in the off-site activities and to be transported as part of StoryHeights Montessori and will not hold the school or any of its personnel responsible.
Individual permission slips will be sent home when a field trip is scheduled.

_____ Initials

Car Seat
I authorize the StoryHeights Montessori staff to assist my child getting into his/her car seat.

_____ Initials

Visiting StoryHeights Montessori
I understand that I may visit the school at any time with or without notice.

_____ Initials

Sunscreen
I authorize the StoryHeights Montessori staff to assist my child in the reapplication of his/her sunscreen.

_____ Initials

First Aid & Medical Care
I authorize the StoryHeights Montessori staff that is trained in the basics of first aid and CPR to give my child first aid and/or CPR when appropriate.

_____ Initials

Photos and Videos
I permit the taking of photos and videos of my child and his/her family during school activities for use in the daily emails sent to enrolled families. Please note there is a separate consent for for social media.

_____ Initials

Toothbrush
I authorize the StoryHeights Montessori staff to assist my child in brushing his/her teeth after snacks and meals daily.

_____ Initials

I/we, the undersigned, for myself and/or as parent(s) or legal guardian(s) of _____, a minor, hereby acknowledge my wish to participate in, and/or my consent to said minor's participation in, the foregoing StoryHeights Montessori & Childcare Center, Inc. In signing this consent and release, I/we do forever RELEASE, acquit, discharge and covenant to hold harmless StoryHeights Montessori & Childcare Center, Inc., and its successors, departments, officials, officers, employees, servants and volunteers, from any and all actions, causes of action, claims, demands, damages, costs, loss of services, expenses and compensation in account of, or in any way arising from, directly or indirectly, all known and unknown personal injuries or property damages which I/we may now or hereafter have for myself and/or as the parent(s) or legal guardian(s) of said minor, and also all claims and rights of action or damages which said minor may have or hereafter may acquire as a result of his/her participation in the StoryHeights Montessori & Childcare Center Program. FURTHERMORE, I/we hereby agree to indemnify StoryHeights Church and its successors, departments, officials, officers, employees, servants and volunteers from and against any and all claims for damages, compensation, attorney's fees or otherwise arising out of or resulting from my and/or said minor's participation in the StoryHeights Montessori & Childcare Center, Inc.

Parent/Guardian Signature: _____ Date: _____

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Social Media Consent

Child's Name: _____ Date of Birth: _____

Social Media
Our school utilizes social media so that we can help grow our school and reach other amazing families like yours. Occasionally, we use pictures of our activities in the classroom to post on our school blog and social media postings to show people what we do in our school. All children remain anonymous in our posts. No names, ages, or other personal information will ever be used.

Is your child allowed to be in these images:

- ☐ No, do not use my child in any social media or blog post that is on the internet.
- ☐ Partially, do not show my child's face but body is okay.
- ☐ Yes, my child can be used in all blog and/or social media content posted by SHM.

Parent/Guardian Signature: _____ Date: _____

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Pick-Up Authorization

Child's Name: _____ Date of Birth: _____

StoryHeights Montessori will release a child to parents/guardians listed on the registration form unless provided with court-ordered documentation stating otherwise.

I give permission to the following people to pick up my child from StoryHeights Montessori & Childcare Center, Inc. You must have at least 1 person listed other than parent/guardian.

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____
_____ Best Phone: _____
Alternate Phone: _____

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____
_____ Best Phone: _____
Alternate Phone: _____

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____
_____ Best Phone: _____
Alternate Phone: _____

All other permission to pick-up requests must be submitted in writing and maintained in the child's file. This permission is valid for one program year from the date of signature.

Parent/Guardian Signature: _____ Date: _____

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Transportation Plan

Child's Name: _____ Date of Birth: _____

My child will arrive at the program:

_____ Parent drop-off
_____ Supervised walk
_____ Unsupervised walk
_____ Public/private van
_____ Private transportation arranged by parent
_____ Other (describe) _____
_____
_____

My child will depart from the program:

_____ Parent drop-off
_____ Supervised walk
_____ Unsupervised walk
_____ Public/private van
_____ Private transportation arranged by parent
_____ Other (describe) _____
_____
_____

Parent/Guardian Signature: _____ Date: _____

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Developmental History & Background

Child's Name: _____ Date of Birth: _____

Please provide information for Infants and Toddlers (marked*) as appropriate to the age of your child. Regulations for licensed childcare facilities require this information to be on file to address the needs of children while in care.

Developmental History

Age began Sitting?: _____ Crawling?: _____ Walking?: _____ Talking?: _____
*Does your child pull up?: _____ *Crawl?: _____ *Walk with support?: _____

Speech difficulties?: _____
Special words to describe needs?: _____

Language(s) spoken at home?: _____

*Any history of colic?: _____ *Details/Additional Information?: _____
*Does your child use a pacifier or suck his/her thumb?: _____ *When?: _____
*Does your child have a fussy time?: _____ *When?: _____
*How do you deal with this time?: _____

Health

Any known complications at birth?: _____
Serious illnesses and/or hospitalizations?: _____
Special conditions or disabilities?: _____
Allergies (i.e. asthma, hay fever, insect bites, medicine, food reactions)?:
Details: _____
Medications taken on a regular basis?: _____

Eating Habits

Special characteristics or difficulties?: _____
Favorite foods?: _____
Foods refused?: _____
*If infant is on a special formula, describe its preparation in detail: _____

_____

*Is your child held in lap?: YES NO *High chair?: YES NO *Does your child eat with a spoon?: YES NO
*Fork?: YES NO
*Hands?: YES NO

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Developmental History & Background

Toilet Habits

*Are cloth or disposable diapers used?: _____
*Is there a frequent occurance of diaper rash?: _____
Do you use oil?: _____ Powder?: _____ Lotion?: _____ Other?: _____

*Regular bowel movements?: YES NO *How many/day?: ___ *Diarrhea?: YES NO *Constipation?: YES NO
*Has toilet training been attempted?: YES NO
*Please describe any particular procedure to be used for your child at the center: _____

*What is used at home? *Potty Chair?: YES NO *Special Child Seat?: YES NO *Regular Seat?: YES NO
*How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom?: _____

Sleeping Habits

*Does your child sleep in a crib?: YES NO *Bed?: YES NO
Does your child become tired or nap during the day (include when and how long)?: _____

When does your child go to bed at night?: _____ Wake up in the morning?: _____
Describe any special routines or needs (stuffed animal, story, mood on waking, etc.): _____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back 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 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.

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Developmental History & Background

Social Relationships

How would you describe your child?: _____

Previous experience with other children/daycare?: _____

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 his/her experience at StoryHeights Montessori?: _____

Social Relationships

Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of bed/crib, napping, toilet habits, fussy time, night bedtime, etc.): _____

Is there anything else we should know about your child?: _____

Parent/Guardian Signature: _____ Date: _____

CERTIFICATE OF IMMUNIZATION

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

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			**Measles, Mumps, Rubella** (e.g., MMR, MMRV)	1		
	2				2		
	3			**Varicella** (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			**Meningococcal Quadrivalent** MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			**Meningococcal Serogroup B (Men B)** MenB-FHbp MenB-4C	1		
	4				2		
	5				3		
	6			**Seasonal Influenza** Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, ccIIV3-IM Live Attenuated LAIV, LAIV4 (quadrivalent)	1		
	7				2		
	8				3		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				4		
	2				5		
	3				6		
	4				7		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			**2009 H1N1 Influenza** Inactivated or Live	1		
	2				2		
	3			**Pneumococcal Polysaccharide** (PPSV23)	1		
	4				2		
	5			**Hepatitis A** (HepA, HepA-HepB)	1		
Pneumococcal Conjugate (PCV13, PCV7)	1				2		
	2			**Human Papillomavirus** (9vHPV, 4vHPV, 2vHPV)	1		
	3				2		
	4				3		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			**Zoster** (shingles)	1		
	2			**Other:**	1		
	3				2		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

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:

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____
_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi -Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____
(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date:_____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____ _____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*