MGH BACKUP CHILDCARE CENTER ~ 55 Fruit Street ~ Warren Lobby
REGISTRATION AND EMERGENCY CONSENT FORM ~ Revised 06-19-17
For The Safety Of Your Child(ren) It Is Imperative To Thoroughly Complete This Document

Employee ID #_____ Dept._____ Initial to confirm benefits eligibility at MGH or PHS (Partners Corporate) _____

Patient Blue Card #:_____ Dept._____ Please initial to attest registered MGH Patient _____

Child / Children's First and Last Names; Please list all children in attendance:

1. _____ DOB: _____-_____-_____ Gender: _____

2. _____ DOB: _____-_____-_____ Gender: _____

3. _____ DOB: _____-_____-_____ Gender: _____

Parent/Guardian: #1_____ Work Phone: _____

Beeper #_____ Cell Phone: _____ Work Email: _____

Home Address:_____ Apt. # _____ Home Phone # _____

City_____ State_____ Zip Code _____

Parent/Guardian: #2_____ Work Phone: _____

Beeper #_____ Cell Phone: _____ Work Email: _____

Home Address:_____ Apt. # _____ Home Phone # _____

City_____ State_____ Zip Code _____

CONTACT INDIVIDUAL

In the event that you leave your office or work area (i.e. lunch, meetings, etc.), who can we call to get in touch with you? Generally, this person is a co-worker, administrative assistant, etc.

Name:_____ **Work / Cell Phone #** _____

ALLERGIES

Please **list and verbally alert** us to any allergies your child may have to food, medication, etc**.** **

1. Child's Name: _____ **Allergies: ****_____ **Reactions:**_____ **NO KNOWN ALLERGIES** ____

2. Child's Name: _____ **Allergies: ****_____ **Reactions:**_____ **NO KNOWN ALLERGIES** ___

3. Child's Name: _____ **Allergies: ****_____ **Reactions:**_____ **NO KNOWN ALLERGIES** ____

**** Has your child's physician prescribed an Epi-pen for this allergy? If so, protocols must be discussed with Center staff before your child's first visit.**

MEDICAL AND/OR DEVELOPMENTAL CONDITIONS

Please **list and verbally alert us** to any medical or developmental condition that could require special care or attention. If your child receives **early intervention or special needs services**, either at or outside of school, it is necessary to discuss your child's needs with classroom staff, preferable before your child's first visit to the Center.

MEDICAL AND/OR DEVELOPMENTAL CONDITIONS

1. Child's Name: _____ Medical and/or Developmental Conditions _____

2. Child's Name: _____ Medical and/or Developmental Conditions _____

3. Child's Name: _____Medical and/or Developmental Conditions _____

ANY OTHER INFORMATION WE SHOULD KNOW ABOUT YOUR CHILD(REN) TO HELP US MAKE HIS/HER STAY MORE ENJOYABLE?

Comments:_____

MEDICATION

Is your child currently taking any medication(s)?_____ If yes, please complete below:

1. Child's Name: _____ Medication(s) _____ Reason_____

2. Child's Name: _____ Medication(s) _____ Reason_____

3. Child's Name: _____ Medication(s) _____ Reason_____

Please note: Staff can only administer prescription medication when it is in the original prescription container and accompanied by a completed ***AUTHORIZATION FOR MEDICATION***, which we provide for you. Please ask a staff member about our specific medication policies so we can best serve you and your child.

It is essential to allow time at drop-off to discuss your child's needs and routines with classroom staff. Please be sure to inform them of any unusual circumstances that might affect your child's day. Thank you!

PLEASE GIVE ALL MEDICATIONS TO A TEACHER - NEVER LEAVE MEDICATIONS IN YOUR CHILD'S BAG OR CUBBY.

EMERGENCY RELEASE INDIVIDUALS-OTHER THAN PARENT/GUARDIANS

I hereby authorize the MGH Backup Child Care Center to release my child to the following persons:

#1 Name:_____ **Relationship to child:**_____

*Address:*_____ *City:*_____ *State:* _____ *Zip:*_____

Day Phone:_____ ***Evening Phone:***_____ ***Cell Phone:*** _____

#2 Name:_____ **Relationship to child:**_____

*Address:*_____ *City:*_____ *State:* _____ *Zip:*_____

Day Phone:_____ ***Evening Phone:***_____ ***Cell Phone:*** _____

#3 Name:_____ **Relationship to child:**_____

*Address:*_____ *City:*_____ *State:* _____ *Zip:*_____

Day Phone:_____ ***Evening Phone:***_____ ***Cell Phone:*** _____

PARENT/GUARDIAN SIGNATURE:_____ **Print:** _____ **Date:** _____

MGH BACKUP CHILD CARE CENTER ~ EMERGENCY AUTHORIZATION AND CONSENT FORM

1. Child's Name: _____

2. Child's Name: _____

3. Child's Name: _____

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 MGH Backup Child Care Center to transport my child to *Massachusetts General Hospital Emergency Department* to secure for my child the necessary medical treatment, including anesthesia. I understand the teachers in the MGH Backup Child Care Center are trained in the basics of First Aid and I authorize them to provide First Aid to my child when appropriate.

Is/are your child/children allergic to any medications? If so please state:

1. Child's Name: _____ Medication Allergy: _____ Reaction: _____

2. Child's Name: _____ Medication Allergy: _____ Reaction: _____

3. Child's Name: _____ Medication Allergy: _____ Reaction: _____

PARENT/GUARDIAN SIGNATURE:_____ **Print:** _____ **Date:** _____

PHYSICAL DESCRIPTION AND/OR PHOTO FOR CHILD'S CENTER FILE

Below please provide a detailed physical description of your child(ren) including height, weight, hair color, eye color, skin color and any other identifying marks. Alternatively, you may choose to email your child's photo(s) to the Center Director at stowle1@partners.org. Photo must be current-day; photo must be clear, at least from the waist up and taken from no more that 5 feet away and no closer than 3 feet away.

Detailed physical description(s):

1. Child's Name: _____ HT _____ WT _____ Hair_____ Eyes _____ Skin _____ Other identifying marks _____

2. Child's Name: _____ HT _____ WT _____ Hair_____ Eyes _____ Skin _____ Other identifying marks _____

3. Child's Name: _____ HT _____ WT _____ Hair_____ Eyes _____ Skin _____ Other identifying marks _____

MEDICAL INSURANCE WITH:_____ POLICY NUMBER:_____

DOCTOR'S NAME:_____

DOCTOR'S ADDRESS:_____

DOCTOR'S PHONE:_____

1. Child's Name:_____ MGH Blue Card # (if applicable) _____

2. Child's Name:_____ MGH Blue Card # (if applicable) _____

3. Child's Name:_____ MGH Blue Card # (if applicable) _____

PARENT/GUARDIAN SIGNATURE:_____ **Print:** _____ **Date:** _____

PARTNERS CHILD CARE

PHOTO/VIDEO/AUDIO CONSENT FORM

In accordance with standards set forth by the Department of Early Education and Care ("EEC") and the National Association for the Education of Young Children ("NAEYC"), Partners Child Care may take photos, videos, and/or audio recordings for educational purposes to promote curriculum development and/or to support individual child assessment.

Photos may also be taken for the purpose of providing parents with an opportunity to view their children engaged in daily activities. These photos, videos and audio recordings will be displayed on site at the Partners Child Care Center where they are produced and/or are shared directly with the parents of the children depicted in the photos via email and Center Newsletters.

For the purposes described above, I hereby give permission to Partners Child Care to:

Take my child's photograph, video image and audio recording.

YES NO

Please clearly circle **YES** or **NO**

_____

I understand that the production of photos, videos, or audio recordings for any purpose ***other than*** the reasons described above will require separate written authorization from a parent or guardian.

Print name of Parent/Guardian _____

Signature of Parent/Guardian _____

Dated _____

CHILD CARE DEDUCTION AUTHORIZATION – ONE TIME MGH Backup Center (0100PH2206)

EMPLOYEE #	HOW PAID	DEPARTMENT	OFFICE TEL
	□Weekly □Monthly		
LAST NAME (print)	FIRST NAME MI		AMOUNT Based on use and applicable fees. *

I AUTHORIZE THE MASSACHUSETTS GENERAL HOSPITAL/PARTNERS HEALTHCARE SYSTEM, INC. to deduct from salary or wages payments for child care services, including applicable fees charged for late pick-up and reservation cancellation.

This deduction is to be at the child care rate established by the Partners HealthCare System, Inc. and may be adjusted from time to time. I understand that if I do not wish to continue this deduction authorization, I may cancel by notifying the child care center.

_____
Name of Authorized Person ~ (please print)

_____ _____
Signature of Authorized Person Date

*** Fee Descriptions**

- Child care: $8 per hour, per child (minimum reservation 2 hours).
- Family max. rate $20 per hour when 3 or more siblings attend at the same time.

All vacation club tuition is prepaid/nonrefundable. Rates as follows:

- Vacation Club five-day week: $375 per child 6 – 12 years old;
- Vacation Club four-day week: $300 per child 6 – 12 years old;
- Vacation Club single day(s): $80 per day, per child 6 – 12 years old;
- Reservations for children 2-5 years during Vacation Club weeks: $8 per hour/child.

- Cancellation fee: $40 per child.
- Late pick up after 5:45pm: $1 per minute, per child.