Bright Horizons
FAMILY SOLUTIONS®

FORM

# Child Information Form

Child's Name: _____ Primary Language: _____

Child's Address: _____
Street City/Town Zip Code

Place of Birth: _____ Date of Birth: ____/____/____

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: _____ Height: _____ Weight: _____ Race: _____ Gender ☐M ☐F

Identified Allergies: _____

Identifying Marks: _____

Health Insurance Provider: _____

**Physician/Dentist Information**

Name of Physician/Clinic: _____ Phone: _____

Physician Address: _____
Street City/Town Zip Code

Date of Child's Last Physical **(WA State Only)**: _____

Name of Dentist: _____ Phone: _____

Dentist Address: _____
Street City/Town Zip Code

Parent/Guardian Signature: _____ Date: _____

**FOR CENTER USE:** Center: _____ Date of Admission_____ Age of Admission: _____

Date Registration Fee Rec'd:_____ Director's Initials: _____

Form J-800-2935
Revised June 2017

# ADMISSION INFORMATION

**Purpose:** Use this form to collect all required information about a child enrolling in day care.

**Directions:** The day care provider gives this form to the child's parent or guardian. The parent or guardian completes the form in its entirety and returns it to the day care provider before the child's first day of enrollment. The day care provider keeps the form on file at the child care facility.

## GENERAL INFORMATION

| | | |
|---|---|---|
| Operation's Name: Bright Horizons | Director's Name: | |
| Child's Full Name: | Child's Date of Birth: | Child Lives With: ☐ Both parents ☐ Mom ☐ Dad ☐ Guardian |
| Child's Home Address: | | |
| Date of Admission: | Date of Withdrawal: | |
| Name of Parent or Guardian Completing Form: | Address of Parent or Guardian (if different from the child's): | |

List telephone numbers below where parents/guardian may be reached while child is in care.

| | | | |
|---|---|---|---|
| Parent 1 Telephone No. | Parent 2 Telephone No. | Guardian's Telephone No. | Custody Documents on File: ☐ Yes ☐ No |

| | |
|---|---|
| Give the name, address, and phone number of the responsible individual **to call** in case of an emergency if parents/guardian cannot be reached: | Relationship: |

I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after verification of ID.

| | | |
|---|---|---|
| Name and Phone Number: | Name and Phone Number: | Name and Phone Number: |

## CONSENT INFORMATION

**CHECK ALL THAT APPLY:**

**1.TRANSPORTATION**

I give consent for my child to be transported and supervised by the operation's employees:

☐ for emergency care ☐ on field trips ☐ to and from home ☐ to and from school

**2.FIELD TRIPS**

☐ I give consent for my child to participate in field trips.

☐ I **do not** give consent for my child to participate in field trips.

**Comments:**

**3.WATER ACTIVITIES**

I give consent for my child to participate in the following water activities:

☐ water table play ☐ sprinkler play ☐ splashing/wading pools ☐ swimming pools ☐ aquatic playgrounds

## CONSENT INFORMATION

**CHECK ALL THAT APPLY:**

**4.RECEIPT OF WRITTEN OPERATIONAL POLICIES**

I acknowledge receipt of the facility's operational policies, including those for:

| | |
|---|---|
| ☐ Discipline and guidance | ☐ Procedures for release of children |
| ☐ Suspension and expulsion | ☐ Illness and exclusion criteria |
| ☐ Emergency plans | ☐ Procedures for dispensing medications |
| ☐ Procedures for conducting health checks | ☐ Immunization requirements for children |
| ☐ Safe sleep | ☐ Meals and food service practices |
| ☐ Procedures for parents to discuss concerns with the director | ☐ Procedures to visit the center without securing prior approval |
| ☐ Procedures for parents to participate in operation activities | ☐ Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website |

**5. MEALS**

I understand that the following meals will be served to my child while in care:

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

**6. DAYS AND TIMES IN CARE**

My child is normally in care on the following days and times:

| Day of the Week | AM | PM |
|---|---|---|
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |
| Sunday | | |

## AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

| | | |
|---|---|---|
| Name of Physician: | Address: | Phone Number: |
| Name of Emergency Care Facility: | Address: | Phone Number: |

| | |
|---|---|
| I give consent for the facility to secure any and all necessary emergency medical care for my child. | Signature - Parent or Legal Guardian |

## CHILD'S ADDITIONAL INFORMATION SECTION

## CHILD'S ADDITIONAL INFORMATION SECTION

List any special needs that your child may have, such as environmental allergies, food intolerances, existing illness, previous serious illness, injuries and hospitalizations during the past 12 months, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

Does your child have diagnosed food allergies? Yes ☐ No ☐ Plan submitted on:

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

| Signature - Parent or Legal Guardian: | Date Signed: |
|---|---|
| | |

## SCHOOL AGE CHILDREN

My child attends the following school:

| Name of School: | School Phone Number: |
|---|---|
| | |

My child has permission to (check all that apply):

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his/her sibling under 18 years old

Authorized pick up/drop off locations other than the child's address:

## ADMISSION REQUIREMENT

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Please check only one option:

1. ☐ HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

| Health Care Professional's Signature: | Date Signed: |
|---|---|
| | |

2. ☐ A signed and dated copy of a health care professional's statement is attached.

3. ☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

4. ☐ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name and Address of Health Care Professional:

| Signature - Parent or Legal Guardian: | Date Signed: |
|---|---|
| | |

## REQUIREMENTS FOR EXCLUSION

☐ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

☐ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

## VISION EXAM RESULTS

| | | |
|---|---|---|
| R 20/ | L 20/ | ☐ Pass ☐ Fail |
| Signature: | Date Signed: | |

## HEARING EXAM RESULTS

| Ear | 1000 Hz | 2000 Hz | 4000 Hz | Pass or Fail |
|---|---|---|---|---|
| Right | | | | ☐ Pass ☐ Fail |
| Left | | | | ☐ Pass ☐ Fail |
| Signature: | | | Date Signed: | |

## VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

| Vaccine | Vaccine Schedule | Dates Child Received Vaccine |
|---|---|---|
| Hepatitis B | Birth (first dose)<br>1–2 months (second dose)<br>6–18 months (third dose) | |
| Rotavirus | 2 months (first dose)<br>4 months (second dose)<br>6 months (third dose) | |
| Diphtheria, Tetanus, Pertussis | 2 months (first dose)<br>4 months (second dose)<br>6 months (third dose)<br>15–18 months (fourth dose)<br>4–6 years (fifth dose) | |
| Haemophilus Influenza Type B | 2 months (first dose)<br>4 months (second dose)<br>6 months (third dose)<br>12–15 months (fourth dose) | |

## VACCINE INFORMATION

The following vaccines require multiple doses over time. Please provide the date your child received *each dose*.

| Vaccine | Vaccine Schedule | Dates Child Received Vaccine |
|---|---|---|
| Pneumococcal | 2 months (first dose)<br>4 months (second dose)<br>6 months (third dose)<br>12–15 months (fourth dose) | |
| Inactivated Poliovirus | 2 months (first dose)<br>4 months (second dose)<br>6–18 months (third dose)<br>4–6 years (fourth dose) | |
| Influenza | Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group. | |
| Measles, Mumps, Rubella | 12–15 months (first dose)<br>4–6 years (second dose) | |
| Varicella | 12–15 months (first dose)<br>4–6 years (second dose) | |
| Hepatitis A | 12–23 months (first dose)<br>The second dose should be given 6 to 18 months after the first dose. | |

## PHYSICIAN OR PUBLIC HEALTH PERSONNEL VERIFICATION

Signature or stamp of a physician or public health personnel verifying immunization information above:

| Signature : | Date Signed: |
|---|---|
| | |

## VARICELLA (CHICKENPOX)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine.

| Parent's Signature: | Date Signed: |
|---|---|
| | |

## ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/immunize/public.shtm.

| TB TEST (IF REQUIRED) | | |
|---|---|---|
| ☐ Positive | ☐ Negative | Date: |

| GANG FREE ZONE |
|---|
| Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties. |

| PRIVACY STATEMENT |
|---|
| DFPS values your privacy. For more information, read our Privacy and Security Policy online at http://www.dfps.state.tx.us/policies/privacy.asp. |

| SIGNATURES | |
|---|---|
| Child's Parent or Legal Guardian:<br>X | Date Signed: |
| Center Designee:<br>X | Date Signed: |

TEXAS
Health and Human Services

Form 2550
March 2018-E

# Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

**Directions:** Parents will review this policy upon enrolling their infant at _____ and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

## Safe Sleep Policy

All staff, substitute staff, and volunteers at _____ will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide an Infant Sleep Exception Form 2710 signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415 and §747.2315]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415 and §747.2315].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing _____ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415 and §747.2315].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2415 and §747.2315].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide an Infant Sleep Exception Form 2710 signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised "tummy time" several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide an Infant Sleep Exception Form 2710 signed by the infant's health care professional [§746.2428 and §747.2328].

## Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

## Signatures

| This policy is effective on (Date) | Child's name |
|---|---|
| | |

Signature — Director/Owner

Date Signed

Signature — Staff member

Date Signed

Signature — Parent

Date Signed

# OPERATIONAL DISCIPLINE AND GUIDANCE POLICY

**Purpose:** This form provides the required information per minimum standards §744.501(7), §746.501(a)(7), and §747.501(5).

**Directions:** Parents will review this policy upon enrolling their child. Employees, household members, and volunteers will review this policy at orientation. A copy of the policy is provided in the operational policies.

## DISCIPLINE AND GUIDANCE POLICY

**Discipline must be:**

1) Individualized and consistent for each child;
2) Appropriate to the child's level of understanding; and
3) Directed toward teaching the child acceptable behavior and self-control.

**A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control, and self-direction, which include at least the following:**

1) Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior;
2) Reminding a child of behavior expectations daily by using clear, positive statements;
3) Redirecting behavior using positive statements; and
4) Using brief supervised separation or time out from the group, when appropriate for the child's age and development, which is limited to no more than one minute per year of the child's age.

**There must be no harsh, cruel, or unusual treatment of any child. The following types of discipline and guidance are prohibited:**

1) Corporal punishment or threats of corporal punishment;
2) Punishment associated with food, naps, or toilet training;
3) Pinching, shaking, or biting a child;
4) Hitting a child with a hand or instrument;
5) Putting anything in or on a child's mouth;
6) Humiliating, ridiculing, rejecting, or yelling at a child;
7) Subjecting a child to harsh, abusive, or profane language;
8) Placing a child in a locked or dark room, bathroom, or closet with the door closed or open; and
9) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child's age.

## ADDITIONAL DISCIPLINE AND GUIDANCE MEASURES (ONLY APPLIES TO BAP/SAP PROGRAMS THAT OPERATE UNDER CHAPTER 744)

**A program must take the following steps if it uses disciplinary measures for teaching a skill, talent, ability, expertise, or proficiency:**

- Ensure that the measures are considered commonly accepted teaching or training techniques;
- Describe the training and disciplinary measures in writing to parents and employees and include the following information:
  - (A) The disciplinary measures that may be used, such as physical exercise or sparring used in martial arts programs;
  - (B) What behaviors would warrant the use of these measures; and
  - (C) The maximum amount of time the measures would be imposed;
- Inform parents that they have the right to ask for additional information; and
- Ensure that the disciplinary measures used are not considered abuse, neglect, or exploitation as specified in Texas Family Code §261.001 and Chapter 745, Subchapter K, Division 5, of this title (relating to Abuse and Neglect).

| SIGNATURE | |
|---|---|
| This policy is effective on the following date: | |
| Signed by:<br>X | Role:<br>☐ Parent ☐ Caregiver/Employee<br>☐ Household Member (Ch. 747 only) |

## MINIMUM STANDARDS RELATED TO DISCIPLINE

- Title 40, Chapter 746 Subchapter L:
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=746&sch=L&rl=Y
- Title 40, Chapter 747 Subchapter L
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=747&sch=L&rl=Y
- Title 40, Chapter 744 Subchapter G:
  http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=19&ch=744&sch=G&rl=Y

# BRIGHT HORIZONS

## PARENT/GUARDIAN INFORMATION FORM

There may be times phone numbers and addresses of families are requested by parents/ guardians so that children may have "play dates" outside of the center/school.

Please check the information that Bright Horizons **MAY** give to other parents/guardians enrolled in the center/school upon request.

Child's Name: _____

Parent/Guardian Name: _____

- ❒ Parent/Guardian Home Phone Number
- ❒ Parent/Guardian Work Phone Number
- ❒ Parent/Guardian Cell Phone Number
- ❒ Parent/Guardian Home Address
- ❒ Parent/Guardian E-mail Address

Parent/Guardian Name: _____

- ❒ Parent/Guardian Home Phone Number
- ❒ Parent/Guardian Work Phone Number
- ❒ Parent/Guardian Cell Phone Number
- ❒ Parent/Guardian Home Address
- ❒ Parent/Guardian E-mail Address

❒ **Please do not give out any of the information listed above.**

The information detailed above will be shared only with parents/guardians whose children are currently enrolled in the center/school.

_____ _____

(Parent/Guardian's Signature) (Date)

# Bright Horizons **Informed Consent**

Child's Name: _____

## Access

I will have access to the center without notice when my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

## Child Release

For a child's safety, Bright Horizons will release a child only to parent(s)/legal guardian(s) or to the third parties I authorized below. Parents/guardians are required to provide a current copy of any relevant Custody Order. Third party pick-up is subject to the following rules:

- At least two people other than the parents/guardians must be listed and designated as emergency contacts by checking the corresponding box below. Emergency contacts will be contacted if parents/guardians cannot be reached.
- If the person picking up is listed below, but does not pick up the child regularly, I will notify the center **verbally, in advance**. Verbal authorization is not permitted for any person not listed on this form.
- If the person picking up is **NOT** listed below, I must notify the center/school **in writing, in advance**. (Note: In RI, parents/guardians must also provide notice in person and in writing.)
- Photo identification will be required if the third party does not pick up the child regularly or is unknown to the staff member releasing the child.

### THE FOLLOWING PEOPLE (WHO ARE NOT PARENTS/GUARDIANS) ARE AUTHORIZED TO PICK UP MY CHILD.

NAME _____

ADDRESS _____

CITY/TOWN/STATE/ZIP CODE _____

RELATIONSHIP TO CHILD _____

DAYTIME PHONE _____ CELL PHONE _____

E-MAIL _____

CONTACT IN THE EVENT OF AN EMERGENCY? ☐ YES ☐ NO

NAME _____

ADDRESS _____

CITY/TOWN/STATE/ZIP CODE _____

RELATIONSHIP TO CHILD _____

DAYTIME PHONE _____ CELL PHONE _____

E-MAIL _____

CONTACT IN THE EVENT OF AN EMERGENCY? ☐ YES ☐ NO

Bright Horizons will not release a child to anyone who appears impaired. If an impaired person attempts to pick up your child, pick-up will be refused and we will attempt to contact the other parent/guardian or authorized persons. If alternative arrangements cannot be made, the local child protective services agency and/or the local police will be called, as required by state licensing.

## Walk Permission

Weather permitting, children may go on walks supervised by staff in the surrounding area. Infants and young toddlers are transported in a buggy or stroller. Children may be taken to the areas listed below, which are not part of our licensed premises.

_____

_____

☐ I give permission for my child to participate in walks.

Preschool and school-age children may take field trips. A separate **Field Trip Permission Slip**, describing the activity, will be sent home for signature.

## Photography & Video Permission

Bright Horizons takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner. Bright Horizons regularly takes photographs and videos of children enrolled. They may be shared with you and other families in a variety of ways: on the Bright Horizons website, via email, through *My Bright Day®*, on *Teaching Strategies®* Gold (TSG), on a posting in the center, or in a parent newsletter. They may also be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. Additionally, they may be used for other center, general business, and marketing purposes, including online. Bright Horizons retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment.

☐ I give permission for Bright Horizons to take photographs and videos of my child and use these materials as described above.

☐ I give permission for Bright Horizons to take photos and videos of my child and to only use those pictures for curriculum purposes, documenting my child's progress (TSG, My BrightDay) and communication with me and other families.|

## Child Illness

If my child becomes ill, I will be called. I may be required to to pick up my child as soon as possible (within 90 minutes at most). A child must remain out of the center until he/she is symptom free for 24 hours, unless a doctor's note is provided which states that the child is 1) not contagious; and 2) can participate in group care. The Family Guide contains Bright Horizons' full Child Illness Policy, including protocols for contagious illnesses.

## Children's Injuries

If my child sustains a minor injury during care, I will receive an Occurrence Report when I pick-up describing the incident. I will be contacted immediately if the injury produces any swelling, is on the face or head, or requires medical attention.

## Emergency Medical Care

If emergency medical attention is needed for my child, _____ , the center will attempt to contact me or the emergency contacts listed (if I cannot be reached). I authorize Bright Horizons to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility, or to _____ my preferred facility, if possible.

Staff is trained in pediatric first aid and CPR and I authorize staff to administer the same. My child's health information may be viewed by staff, on a need to know basis, and state licensors for compliance.

_____
CHILD'S HEALTH INSURANCE PROVIDER

_____
NAME OF INSURED

_____
POLICY NUMBER

## Family Guide Acknowledgement

By signing below, I acknowledge and agree that: 1) in addition to this Informed Consent, I received the Bright Horizons Family Guide or client equivalent, as well as any center-specific information and relevant state policies; 2) it is my responsibility to read and familiarize myself with all these materials and address any questions with center management; and 3) I will abide by these materials.

**I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.**

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Annual parent/guardian review and signature is required by Bright Horizons. If any changes are necessary, a new form will be completed.

_____ _____
PARENT/GUARDIAN SIGNATURE REVIEW DATE

_____ _____
PARENT/GUARDIAN SIGNATURE REVIEW DATE

_____ _____
PARENT/GUARDIAN SIGNATURE REVIEW DATE

Bright Horizons.
Early Education & Preschool

ORIGINAL: CHILD'S FILE 11/2018 DUPLICATE: PARENT/GUARDIAN COPY

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Bright Horizons
FAMILY SOLUTIONS

FORM

# Sunscreen and Insect Repellent - Permission

Sunscreen and insect repellent should be applied to a child at least once at home to test for any allergic reaction. Aerosol sprays are prohibited.

Sunscreen/sun block must provide UVB and UVA protection with an **SPF of 15 or higher**. Sunscreen **may not** be used on infants under **6 months** of age unless accompanied by a doctor's note.

Insect repellent may only be used if recommended by public health authorities or requested by a parent/guardian. The repellent must contain a concentration of **30% DEET or less.** Insect repellant **may not** be used on infants under **2 months** of age. Oil of lemon eucalyptus and para-methane products may not be used on children under the age of three.

All sunscreen/sun block and insect repellent provided by a parent/guardian must be:

- provided in the original container;
- clearly labeled with the child's full name;
- within the expiration date;
- appropriate for the age of the child; and
- free of nut ingredients.

I give Bright Horizons permission to apply (*name of sunscreen*) _____
and/or (*name of insect repellant*) _____
when outdoor conditions warrant and consistent with package instructions (subject to any special instructions below) to my child, _____>

From: _____/_____/_____ To: _____/_____/_____ (not to exceed one year)

## Special Instructions

Sunscreen/Sun Block: _____

_____

Insect Repellent: _____

_____

_____ _____

(Parent/Guardian Signature) (Date)

Bright Horizons FAMILY SOLUTIONS

FORM

# Allergy Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

| Allergen | Treatment/Substitution |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Type of allergy transmission:** ☐ Ingestion ☐ Contact ☐ Inhalation

**Note: Do Not Depend on Antihistamines or Inhalers to treat a severe reaction. USE EPINEPHRINE.**

**Extremely Reactive to the Following Foods** _____; **therefore:**

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**

☐ **If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.**

**For the following signs of a *mild* allergic reaction administer:** _____

_____

☐ **Skin:** Hives: Mild Itch

☐ **Nose:** Itchy, Runny, Sneezing

☐ **Stomach:** Mild Nausea/Discomfort

☐ **Mouth:** Itchy

☐ **Other:** _____

**For any of the following signs of a *severe* allergic reaction or a combination of symptoms from different body areas, give Epinephrine and call 911. If prescribed and directed, give other medications (antihistamine/inhaler). Lay person flat. *If breathing is difficult or vomiting, place on side, or sit up.***

☐ **Mouth:** Significant Swelling of Tongue and/or Lips

☐ **Heart:** Pale, blue, faint, weak pulse, dizzy

☐ **Throat:** Tight, hoarse, trouble breathing/swallowing

☐ **Lungs:** Short of Breath

☐ **Skin:** Many hives over body, widespread redness

☐ **Stomach:** Repetitive vomiting, severe diarrhea

☐ **Other:** Feeling something bad is about to happen; anxiety, confusion

**Other Medication Instructions:** _____

_____

**Prescribed Medications/Dosage:**

**Epinephrine** (brand and dose): _____

**Antihistamine** (brand and dose): _____

**Other** (e.g., inhaler-bronchodilator if asthmatic): _____

**Potential Side Effects of Medication:** _____

_____

**Potential Consequences to Child if Treatment is Not Administered:** _____

_____

**For MA and MN centers only:**

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____ _____

_____ _____

_____ _____

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Director/Principal Signature Date

**Parent/Guardian Acknowledgement Statement**

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed 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) ; or be exposed to the item(s); nor can we add an item(s) or change a medication without a signed 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 classrooms and kitchen.

_____ _____
Parent/Guardian Signature Date

*For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the *Medication Authorization* form.

***This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.***

Bright Horizons
FAMILY SOLUTIONS®

FORM

# Asthma Health Care Plan

Name of Child: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

The following information should be completed by the child's medical provider and parent/guardian.

**Severity:** ☐ Mild ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

**Check all triggers: (completed by child's medical provider)**

☐ Smoke (cigarette) ☐ Colds/flu ☐ Dust mites ☐ Exercise: _____
☐ Sudden temperature changes ☐ Ozone Alert ☐ Pet dander ☐ Strong
☐ Odors _____ ☐ Wood smoke ☐ Cut flowers, grass or pollen
☐ Mold ☐ Food: _____
☐ Cleaning Products: _____
☐ Others: _____

**Suggested classroom strategies to support this child's needs:** _____

**Specific Medical Information:**

Medication to be administered:* ☐ Yes ☐ No If yes, medication to be administered and potential side effects: _____

**For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization form.*

Potential consequences to child if treatment is not administered: _____

Special Staff Training Needs: _____

Additional Emergency Procedures/Instructions: _____

**GO (Green Zone)**

| The child is able to do all of these: | What to do: | Medication: |
|---|---|---|
| • Breathing is regular<br>• No cough or wheeze<br>• Can engage in active play | • Allow current activity | • "As needed medication" not needed at this time<br>• Regular medication should be given as ordered |

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FORM

**CAUTION (Yellow Zone)**

| The child has any of the following: | What to do: | Medication |
|---|---|---|
| • Early signs of a cold (runny nose, sneezing)<br>• Exposure to a known trigger<br>• Cough<br>• Mild Wheeze<br>• Chest tightness | • Cease current activity<br>• If the child is outdoors bring inside<br>• Observe breathing before and after the treatment (15 minutes) | • Administer the "As needed medication" (see the medication administration form and follow directions for use)<br>• Monitor breathing status if no improvement follow the steps for the DANGER (Red Zone) |

**DANGER (Red Zone)**

| The child's asthma is worse and any of the symptoms are seen: | What to do: | Medication: |
|---|---|---|
| • The medications are not helping within 15-20 minutes of being given.<br>• Breathing is becoming hard and fast<br>• Nose (nostrils) open wide<br>• Ribs are showing<br>• Lips, fingernails or mouth area are blue or blue gray in color<br>• Trouble walking or talking | • Activate EMS (emergency medical services)<br>• Stay with the child—Stay calm<br>• Ancillary staff notify the parent/guardian<br>• Accompany the child to ER<br>• Complete an incidence form within 24 hours | • Medication available has already been given with no relief<br>• Notify EMS staff regarding the type of medication and the time it was given. |

**For MA centers only:**

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____ _____

_____ _____

_____ _____

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Director/Principal Signature Date

**Parent/Guardian Acknowledgement Statement**

To ensure the safety of your child we cannot delete a health care diagnosis which has previously been documented unless we have a signed note from the child's physician stating that the condition no longer exists; nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's health. I also understand that for the safety of my child, my child's photograph and health information will be posted in the classrooms and kitchen.

Parent/Guardian Signature: _____ Date: _____

***This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.***

Bright Horizons
FAMILY SOLUTIONS®

FORM

# Permission
# Topical Ointment Administration

Child's Name: _____

I understand that **topical ointments**, such as **lotion, lip balm or diaper cream**, can be applied only as a preventive measure and cannot be used if the skin is broken or bleeding, unless I provide a Medication Authorization Form signed by me and my child's physician.

I understand that the topical ointment provided by me must:

- be appropriate for use on a child;
- be applied according to instructions on the label;
- be labeled with the child's full name; and
- be handed to a staff member and not left in a diaper bag or cubby.

I give my permission for the staff at Bright Horizons to apply

- _____
- _____
- _____

as needed from: _____/_____/_____ to: _____/_____/_____ (not to exceed one year).

_____ _____

(Parent/Guardian Signature) (Date)

# BRIGHT HORIZONS
# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

**MEDICATION TYPE:**

❒ **PRESCRIPTION** ❒ **NON-PRESCRIPTION** ❒ **TOPICAL OINTMENT**

I have read the *Policy on Administering Medications and Ointments* and I hereby authorize Bright Horizons agents to administer the following medication to my child:

Child's Name: _____

- **Prescription Medications:** must have a current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
- **Oral Non-prescription Medications:** require a written order from the child's medical provider and the parent/guardian specifying the product, dosage, time, start date and end date and reason for a period not to exceed ***one week***.
- **As Needed Children's Medications:** require a written order from the child's medical provider and the parent/guardian for a period not to exceed ***6 months***. Authorization must list the reason, dosage, start date and end date.
- **Non-prescription Topical Children's Ointments:** can be applied with authorization from the parent/guardian according to manufacturer's instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children.
- **Non-prescription Topical Children's Ointments:** require a written order from the child's medical provider and parent/guardian to be applied to ***open, oozing sores***. Authorization must list the reason, dosage, start date and end date.
- **Medications for Chronic Illnesses**: require a written order from the child's medical provider and parent/guardian. Authorization for prescription medications will not exceed the period indicated on the prescription label; however, will not exceed ***one year***. Non-prescription medications must have a written order from the medical provider and parent/guardian; list the reason, dosage, times of administration, start date and end date, for a period not to exceed ***one year***.
- **Diaper Cream, Sunscreen and Insect Repellant:** can be applied with authorization from the parent/guardian according to manufacturer's instructions for a period not to exceed ***one year***. Directions must be designated for use for children.

**Note:** Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider for a period not to exceed ***seven consecutive days***.

**Note:** All medications must be provided in the original container, labeled with the child's full name and any medication spoon/device to administer the medication must be provided. Non-prescription medications must be designated for use for children.

I further agree to indemnify and hold harmless Bright Horizons Children's Centers LLC, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Medication: _____

Administration Route: _____

Reason for Medication: _____

Medication Storage: _____

Side Effects _____

Dosage: _____

Times of Administration: _____ _____ _____ _____

Start Date: _____ End Date: _____

Physician's Name: _____ Physician's License Number: _____

Physician's Signature: _____

Parent/Guardian Signature: _____

**Six Rights of Medication**

1. **Verification that the *right* child receives**
2. **The *right* medication**
3. **In the *right* dose**
4. **At the *right* time**
5. **By the *right* method**
6. ***And the right* documentation is completed**

# Items to bring for your child:

## Infants:

Your child's bottles prepared for the day.

Please label all bottles and bottle caps with your child's name. We can assist with labeling here!

A large package of diapers

A container for diaper wipes

Any diapering products frequently used such as Desitin, A&D, etc. Products must be in their original containers. We will provide you with the proper forms needed to authorize these applications.

A supply of jar food (if applicable) and any cereals (boxed).

2 extra changes of seasonally appropriate clothing including socks and undershirts/onesies.

Sunscreen (if your infant is 6 months or older) Non-aerosol applicators only.

Sun hat for outdoor play

Pacifier (optional)

A few photos of your family, extended family, pets, etc

## Toddlers:

A large package of diapers

A container of diaper wipes

Any diapering products frequently used such as Desitin, A&D, etc. Products must be in their original containers. We will provide you with the proper forms needed to authorize these applications.

2 extra changes of seasonally appropriate clothing including socks and undershirts

Small blanket, pillow, and naptime item (optional)

Seasonal sunscreen and/or insect repellant. Forms will be provided to authorize these applications.

Seasonally appropriate winter attire: hat, coat, and boots

A few photos of your family, extended family, pets, etc

***Please check frequently to make sure that the supply is adequate. Please label EVERYTHING with your child's name***

## Young Preschool/Preschool:

Pull-ups as needed

Diaper wipes as needed

Any diapering products frequently used such as Desitin, A&D, etc. Products must be in their original containers. We will provide you with the proper forms needed to authorize these applications.

2 extra changes of seasonally appropriate clothing including socks and undergarments

An extra pair of shoes (optional)

Small blanket, pillow, and naptime item (optional)

Seasonal sunscreen and/or insect repellant. Forms will be provided to authorize these applications.

Seasonally appropriate winter attire: hat, coat, and boots

A few photos of your family, extended family, pets, etc

# INFANT PERSONAL CARE PLAN
# DEVELOPMENTAL HISTORY FORM



Today's Date: _____ Date of Enrollment/Transition: _____

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

Date of Last Physical (for WA State only): _____

What would you like us to call your child?: _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Name of Person Completing Form: _____

Primary Caregiver: _____

Classroom: _____

## FAMILY INFORMATION

In the columns below list the names of family members residing with the child. Please include siblings, extended relatives, and pets. For each person listed provide the name the child uses to address that individual and include ages of siblings.

| Name | How child addresses this individual? | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list the words used in your language corresponding to the words in English. Include additional words in the blank columns if needed.

| | |
|---|---|
| I'll take good care of you | |
| I see that you are crying | |
| Let's change your diaper | |
| I like your smile | |
| It's time for your bottle | |
| Time to eat | |
| Time for your nap | |
| Mommy will be back | |
| Daddy will be back | |
| | |
| | |

If parental custody is shared, describe the custody arrangements: _____

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

# INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

## DEVELOPMENTAL HISTORY

Age Child Began: Sitting: _____ Crawling: _____ Standing: _____ Walking with support: _____

Walking independently: _____ Cooing: _____ Babbling: _____

Saying audible words: _____ Saying 2 or 3 simple sentences: _____

Do you have developmental concerns about your child? _____

How does your child communicate his/her needs? _____

## CHILD'S HEALTH

List medications regularly taken and conditions requiring them: _____

Describe serious illnesses or hospitalizations: _____

Describe special physical conditions, disabilities, allergies, or concerns: _____

Does your child have a special need? _____

Explain special services and accommodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel): _____

***Note: For documented medical allergies an Allergy Health Care Plan completed by the child's medical provider is required.***

# INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

## NUTRITION PRACTICES AND ROUTINES

How is your child fed? Check all that apply: Breast: ☐ Bottle: ☐ Cup: ☐

In the corresponding row, provide your child's feeding details.

| | Brand | Amount | Preferred time of day given |
|---|---|---|---|
| Formula/Milk | | | |
| Breast Milk | | | |
| Juice | | | |

If your baby is exclusively breast fed, please outline your daily plan: _____

_____

_____

_____

If your baby is breast fed or receiving expressed breast milk, how can we support you?_____

_____

_____

_____

List special dietary requests, and restrictions: _____

_____

_____

_____

Have solid foods been introduced? Yes ☐ No ☐ If yes, please identify: _____

_____

_____

_____

Food likes and eating preferences: _____

_____

Child Eats With: Spoon: ☐ Fork: ☐ Fingers: ☐

Child is Fed in: Highchair: ☐ In Arms: ☐ Bouncy Seat: ☐ Other: _____

Preferred time of day to feed child: ☐ A.M. ☐ A.M. ☐ P.M. ☐ P.M.

Additional Information: _____

_____

_____

# INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

## SLEEPING ROUTINES

Pre-nap routines/rituals: _____

_____

_____

_____

Number of naps daily: ___ **From:** _____ **To:** _____ **From:** _____ **To:** _____ **From:** _____ **To:** _____

Preferred sleep position*: _____

At home child sleeps in (Check all that apply: Bassinet: ☐ Crib: ☐ Bed: ☐

Child's typical waking behavior/routine: _____

_____

_____

Special sleeping concerns: _____

_____

_____

***Note: Bright Horizons places infants to sleep on their backs in crib unless a waiver has been signed by the parents and the child's physician, stating that the child should be placed in a position other than on his/her back and if allowed by the state licensing agency. Following the recommendation of the American Academy of Pediatrics, soft items such as bumpers, stuffed animals (including pacifiers with a stuffed animal attached), blankets and quilts are not allowed in cribs. The use of sleep or swaddle sacks are recommended for naptime.***

## COMFORTING CHILD

Position child prefers to be held: _____

Security object (if any):_____ Name child uses for object/when needed: _____

_____

_____

Does your child use a pacifier? Yes ☐ No ☐ If yes, when: _____

Describe how adults can comfort your child? _____

_____

_____

## DIAPERING/TOILETING ROUTINES

Please check which type of diapers you will provide: disposable: ☐ cloth: ☐

Words used for urination: _____

Words used for bowel movement: _____

_____

_____

# INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM



CHILD'S NAME: _____

## SOCIAL RELATIONSHIPS

Has your child had any experience with group care? If yes, please describe: _____

How does your child react to new situations and new children and adults? _____

Has your child had previous child care experience? If yes, explain how it met, or did not meet, your expectations? _____

Child's favorite toys and activities: _____

Does your child have any fears? Explain: _____

## ADDITIONAL PERTINENT INFORMATION

To help us care for your child as an individual, please explain your parenting philosophy: _____

Is there additional information you feel is important for the staff to know about your child or family? _____

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

# Infant Personal Care Plan - Developmental History Form



CHILD'S NAME: _____

Sections of this Personal Care Plan will be updated every 3 months or sooner if requested by a parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

| | | | | | |
|---|---|---|---|---|---|
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |
| Date of Change: | | Parent Initials: | | Staff Initials: | |