Nationally Accredited by NAEYC's
National Academy of Early Childhood Programs
Program #478417

REQUIRED FORMS FOR ENROLLMENT

Health Form
Emergency Card
Permission Form
Permission to Administer Non-Prescription Medication
Medical Care Plan

EMERGENCY CARD
School Year: 2025/2026

Name of Child _____Birth date_____

Child's address_____Main phone _____

Date child entered program (mm/dd/yy)_____Cell/work phone _____

Child's home language: _____Translation needed? Y/N _____

Email: _____CC Email: _____

1. Family's Name & Home Address (if different)_____Main phone_____

2. Family's Name & Home Address (if different)_____Main phone_____

1. Family's Employer (include street address & zip code)_____

_____BUS. phone_____

2. Family's Employer (include street address & zip code)_____

_____BUS. phone_____

ALTERNATE: Persons, other than family members, who live nearby to be called to in case of emergency and authorized to pick up and transport your child.

1 Name:_____Phone: _____

2 Name:`_____Phone _____

Physician Name & Address _____Phone_____

Allergies: _____

Medication: _____Immunizations up to date? Y/N _____

Hospital preferred _____Insurance Policy Number_____

OTHER SIGNIFICANT MEDICAL INFORMATION _____

Child's dentist name & address_____Phone_____

I give permission to Five Mile River Nursery School to make whatever emergency, (e.g., first aid, disaster evacuation) measures as judged necessary for the care and protection of my child (name) _____ while under the supervision of the School/Center.

In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource, (police, rescue squad) deems it necessary. The child will be transported at the expense of _____(Family)

It is understood that in some medical situations, the staff will need to contact the local emergency resource before the family, child's physician, and/or other adult acting on the family's behalf.

Signed _____**Date**_____

PERMISSION AGREEMENT
School and Camp Year 2025/2026

A. I/we grant permission for my child to use all of the play equipment and participate in all of the activities of the school, unless exceptions are noted here. _____.

B. I/we grant permission for my child to leave the school premises under supervision of a staff member for neighborhood walks or for field trips in an authorized vehicle.

C. I/we grant permission for my child to be included in evaluations, pictures, and publicity connected with the center's programs. Publicity photos may include unidentified photos used on the school website, Facebook Fan Page, or community website. Please provide your preferred email address:

D. I/we grant permission for the program to post information about my child's allergy(ies) in food preparation areas and all other areas in the program facility the child uses to be used as a visual reminder to all those who interact with my child during the program day.

E. I hereby grant permission for the staff to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to, the following:

- Administer first aid
- Attempt to contact the family or guardian.
- Attempt to contact the child's physician.
- Attempt to contact the family through any of the people listed on the emergency information card completed for the Center. (Note: It is the family's responsibility to keep this card up to date.)
- If we cannot contact the family or the child's physician, we will call 911 for further guidance.
- Any expenses incurred will be borne by the child's family.

F. The school will not be responsible for anything that may happen as a result of false or incorrect information given at the time of enrollment.

G. The school will not assume responsibility for a child who has not been signed in when he/she arrives for the day.

H. I/we acknowledge that the behavior management/discipline plan has been discussed at the Family Meeting, supplied to me in the Family Handbook, and reviewed prior to enrollment.

I. After review of my child's developmental assessment (CT DOTS and ASQ), I/we grant permission for my child's teachers to communicate confidentially with any receiving school about the information contained in the report, for the purposes of educational planning for the needs of my child.

J. For children aged 32-36 months old: I agree to allow my child to participate in the FMRNS Camp and/or Preschool Program where my child will interact with children ages 3 to 5 years with child to teacher ratios not to exceed 10 to 1. I understand that the policies and procedures that are applied to children that are three years old will be applied to this child, including but not limited to the ratio of staff to children and group size.

Signed: _____**Date:** _____
(Family or Legal Guardian)

Signed: _____**Date:** _____
(Director)

ALTERNATE PICK-UP PERMISSION FORM
School and Camp Year 2025/2026

OPTIONAL ALTERNATE PICK-UP PERMISSION FOR_____

(Child's Name)

I/WE GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO PICK UP MY CHILD AT ANY TIME:

Name Telephone # Relationship

1._____

2._____

3._____

4._____

5._____

FAMILIES PLEASE NOTE:

1. A picture ID is required for anyone picking up your child. Please upload a photo of yourself, your child, and any approved persons picking up your child to BrightWheel.
2. If any of the approved persons come in to pick up your child, we will release your child to them, provided they have proper identification, as they have already been approved by your signature below. However, we would prefer prior notification as an extra precaution.
3. If there is any change in this pick-up agreement, it is the family's responsibility to notify the school of the change.
4. Families should add all approved pickups and upload their photo to the BrightWheel App and make sure each person has downloaded the app.

I have read and agree to the requirements to allow the above person(s) to pick up my child at any time.

Signed: _____**Date:**_____

(Family or Legal Guardian)

No one will be allowed to pick up your child without prior written permission

ADMINISTRATION OF NON-PRESCRIPTION TOPICAL MEDICATIONS
School Year 2025/2026

To Childcare nurse, director or teacher:

I hereby request that the following non-prescription topical medication be administered by my child under the supervision of a staff member of the childcare facility. I understand that I must supply the childcare center or group home with the non-prescription topical medication in the original container labeled with my child's name, the name of the medication and the directions for the medication administration.

This authorization is limited to the following topical medications: Separate form required for each medication

1. Non-prescription skin lotion.
2. Non-prescription insect repellants.
3. Non-prescription sunscreen protectants that are free of amino benzoic acid (PABA) or its derivatives.

Name of child _____ DOB_____

Address_____

Medication:

Name, method of administration, area of application_____

Schedule of administration_____

Medication shall be administered: From: _____To_____
(Date) Date)

Reason for which medication is being administered_____

I have administered at least one application of the above medication to my child without adverse side effects.

Signed:_____ **Date:**_____
(parent/legal guardian)

Printed Name of Family/Guardian: _____ **Relationship:** _____

Please contact the school for appropriate permission forms if you require any prescribed medications to be administered by school staff. No prescription medication will be administered without fully completed, signed and staff-reviewed forms on file at the school.
Note that your child may not attend school without his/her necessary medications and permissions to administer.

FOR STAFF TO COMPLETE:

Family authorization form and medications received by

Signature of staff _____

Medication started_____
Date and time

Medication completed_____
Date and time

Medical Care Plan
2025/26

(To be filled out by the parent and reviewed by the classroom teacher and program administrator for any medical assessment need indicated on health form)

Child's Name		
Date of Birth		
Medical Condition		
Signs and Symptoms		Plan of Action:
1.		
2.		
3.		
4.		
5.		
6.		
Monitoring		
Signature of Parent		Date:
Please print name		
Parent Contact Information	Phone:	Alternate Phone:
Other Emergency Contact	Name/Relationship:	Main Phone:
Other Emergency Contact	Name/Relationship:	Main Phone:
Signature of Teacher		Date:
Print name and classroom		
Signature Administrator		Date:
Please print name and title		