The Professional Center for Child Development

Early Intervention Toddler Playgroup Packet

Child's Name _____ DOB _____ Home Phone _____

DPH # _____ Community ☐ Group Placement _____

The information in these forms is required by the Department of Public Health. They must be completed and kept on file to maintain compliance with licensing authorities and for the safety of your child.

Please remember to complete full packet and provide current health form with results of ***physical exam within one year, lead test, and up to date immunizations, signed by Health Care Provider.***

If we do not receive theses forms on time, we may need to arrange an alternate start date for your child.

32 Osgood Street, Andover, Massachusetts 01810 -(978) 475-3806 • fax (978) 475-6288
439 So. Union Street, Suite 110, Lawrence, Massachusetts 01843 -(978) 688-5070 • fax (978) 688-0712
www.theprofessionalcenter.org

The Professional Center for Child Development

Child's Name _____ DOB _____ Home Phone _____

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First Aid and Emergency Medical Consent Form

Parent/Guardian:

Address:

Home Phone:

Mobile Phone:

Email:

Parent/Guardian:

Address:

Home Phone:

Mobile Phone:

Email:

Child's Allergies:

Chronic Health Conditions: ☐ No ☐ Yes

Child's Physician: Telephone:

Medical Care Plan: ☐ No ☐ Yes

If your child has a chronic medical condition or allergies that require medication or treatment at school, or if you will be bringing medication of any kind to school (prescription or over-the-counter), make sure you have noted this on the applicable forms and that you and your child's health care provider have completed the required forms.

Emergency Contacts:

Please list two people who live locally who you authorize to pick up your child. We will contact these people if we are unable to reach you in case of emergency, or if your child needs to be picked up and you are unable to do so.

1. Name: Address:
   Relationship to Child: Phone #:
2. Name: Address:
   Relationship to Child: Phone #:

I , authorize the PCCD staff, who are trained in the basics of first aid, to administer first aid to my child when appropriate. In case of a medical emergency, I authorize PCCD staff to administer CPR to my child and/or transport my child to the nearest medical facility for medical treatment, including but not limited to an epinephrine auto-injection for suspected exposure to a life-threatening allergen, when I cannot be reached or when delay would be dangerous to my child's health. In addition, I give the school permission to contact my child's physician/medical office when necessary.

Parent/Guardian Signature: **Date:**

Print Name:

The Professional Center for Child Development

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Medical Care Plan

The Professional Center for Child Development requires any child with a chronic medical condition and may require special health care services to have a Medical Care Plan on file. This form must be completed by the child's physician/health care provider. The child's health care provider and parent/guardian must authorize this plan by signing this form. This form is valid for one year from the date noted. The plan must be updated if the child's condition changes.

Child's Name: Date of Birth:

Diagnosis:

EACH SECTION MUST BE COMPLETED BY HEALTH CARE PROVIDER.	
	Symptoms of condition including any possible triggers:
	Medication (include specific dosage & time)/Medical Treatment Plan while in program:
	Potential side effects of treatment:
	Potential consequences to child's health if treatment not administered:

Signature of Licensed Health Care Practitioner: Date:

Signature of Child's Parent/Guardian: Date:

NOTE: Any medication administration (excluding epinephrine auto-injectors and asthma rescue medications) or treatment indicated on this plan will be carried out by a registered nurse (RN). In addition, the child's classroom staff will receive training/education relative to the child's Medical Care Plan by the designated RN.

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Photo Release Form

Photography, Website & Application Consent Form

I authorize PCCD to have, use, publish and reproduce images, slides, or videotape of my child for its records and for displays of our classroom activities inside the classrooms and in our school.

☐ I do authorize such use. ☐ I do not authorize such use.

I authorize PCCD to use images of my child for our public relations efforts, including brochures, marketing materials, slideshows, videos, and on our website (children will not be identified).

☐ I do authorize such use. ☐ I do not authorize such use.

I authorize PCCD to post images of my child on a classroom web site or application, with access granted only to parents of children in that classroom, teachers, and PCCD administrators.

☐ I do authorize such use. ☐ I do not authorize such use.

Parent/Guardian Signature: **Date:**

Print Name:

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E-mail Communication Consent Form

Please use this form to indicate any changes in your email preferences. Email address(es) provided on this form will supersede those currently in our databases.

Please send invoices to:

1st Email Address:

2nd Email Address:

IMPORTANT: Please note that invoices will come from the email address quickbooks@notification.intuit.com. We recommend that you add this email address to your "safe senders list" to ensure that monthly invoices from PCCD do not end up in your spam folder.

Parent Signature: Date:

Child's Name _____ DOB _____ Home Phone _____

DPH # _____ Community ☐ Group Placement _____

Transportation Plan and Release Authorization

My child will arrive at PCCD and depart from PCCD by parent, or another authorized person listed below, unless otherwise noted here:

I give permission for my child to be released to the following people. (If no one is authorized other than the parent/legal guardian please indicate below "NO ONE".) Please instruct everyone you authorize us to release your child to that they will need to bring a photo identification each time they pick your child up. ***If child is protected by a restraining order, please submit order to PCCD.***

Release Authorizations

I authorize PCCD to release my child to the following people:

☐ No One

Name: Relationship:

Address: Telephone #:

Alternate Telephone #: Alternate Telephone #:

Name: Relationship:

Address: Telephone #:

Alternate Telephone #: Alternate Telephone #:

If your child will be transported by DPH Approved Van, please provide the following:

Mass Health: Yes ☐ No ☐ Provider Name/Daycare:

Mass Health #: Street Address:

Child's Weight: City, Zip Code:

Parent/Caregiver Name: Contact Person:

Parent/Caregiver Name: Telephone:

Parent/Guardian Signature: Date:

Print Name:

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Parent/Guardian Consent Form

Consent to Apply Sunscreen

☐ I give consent for PCCD staff to apply sunscreen that I will provide.

Please list the brand here:

☐ I do not give consent.

Consent to Apply Diaper Cream

☐ I give consent for PCCD staff to apply diaper cream that I will provide.

Please list the brand here:

☐ Diaper cream is not needed for my child.

Consent to Use Hand Sanitizer Wipes

☐ I give consent for my child to use hand sanitizer wipe products supplied by PCCD

☐ I do not give consent to hand sanitizer only use soap and water

Consent for Classroom Observations

As part of our program, we often have consultants, specialists, therapists and college or graduate students observe in our classrooms, either to further their understanding of early childhood, or to provide feedback to us about our work with young children. This is one of the ways we learn about and implement best practices in early childhood education at PCCD.

☐ I give permission for my child to be observed during his/her group by students/teachers of affiliating schools which includes physical therapy, occupational therapy, speech and language therapy, education, nursing and social work. Strict confidentiality will be maintained at all times.

☐ I don't give permission for my child to be observed.

Parent/Guardian Signature: **Date:**

Print Name:

Child's Name _____ DOB _____ Home Phone _____

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Eating Habits

Special characteristics or difficulties:

Favorite foods:

Foods Refused:

Child eats with: ☐ Hands ☐ Spoon ☐ Fork ☐ Other

Which does the child drink from? ☐ Open cup ☐ Sippy cup

Toilet/Diapering Habits

Is your child toilet trained? Yes ☐ No ☐

Word used for going to the bathroom:

Sleeping Habits

Does Child Nap? Yes ☐ No ☐ For how long?

Social Relationships

How would you describe your child in social settings?

Reaction to strangers?

Does your child prefer to play: ☐ Alone ☐ in small groups

Favorite toys and activities?

Does your child have any fears? Explain:

What comforts your child when he or she is upset?

Does your child bite? Yes ☐ No ☐ If so, explain

Does child have temper tantrums? Yes ☐ No ☐ If yes, please describe tantrums

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Toddler Group ~Developmental History

What would you like us to call your child at Group?

Family Information

Please describe who lives in the child's home (one parent/guardian, both parents/guardians, other members of the household):

What does your child call family members?

Language(s) spoken at home:

Are books read in languages other than English?

Are there words in home language that we should know?

Does your child use any special words to describe needs?

Have there been any major changes in the family lately (new baby, new home/move, divorce)?

What do you, as a family, hope to get out of your experience here at PCCD/Playgroups?

Is there anything else you would like us to know about your child?

Has your child been evaluated for a developmental issue?

If yes, please indicate the date and describe the findings of the evaluation:

Has your child ever been diagnosed with a special need?

If so, is he/she receiving any special services and/or have an IFSP?

Any speech difficulties?

List any concerns about your child's development:

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

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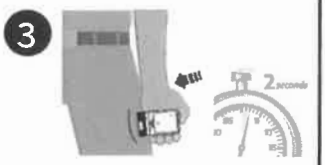
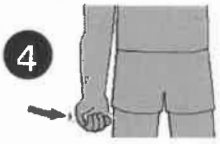
FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



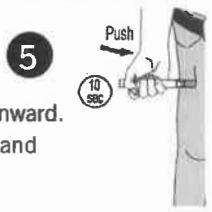
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN



1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

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