



Agassiz Baldwin Community

20 Sacramento Street Cambridge MA 02138
Phone: 617-349-6287 Fax: 617-497-4388
www.agassiz.org

Sacramento Street Preschool

Start Date:

Quickbooks:

Filemaker:

Deposit Received:

Application Received:

Child's First Name: _____ Last Name: _____

Address: _____

City: _____ Zip: _____ Home Phone: _____

Date of Birth: _____ Age*: _____ Primary Language: _____

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____ Gender: _____

Race: _____ Identifying Marks: _____ Child's Nickname: _____

*Your child must be 2 years and 9 months old to start at Sacramento Street Preschool as mandated by the Department of Early Education and Care. They may join the program as soon as they turn 2 years and 9 months.

Parent/Guardian #1 Name: _____ Daytime Phone: _____

Place of Employment: _____ Days/Hours: _____

Home Address & Phone if different from child's: _____

E-mail: _____ Cell Phone: _____

Parent/Guardian #2 Name: _____ Daytime Phone: _____

Place of Employment: _____ Days/Hours: _____

Home Address & Phone if different from child's: _____

E-mail: _____ Cell Phone: _____

Rate for the for 2011-2012 school year.

Please register my child for the schedule indicated below. Check one below.

Tuesday/Thursday

___ 8:30am-Noon

(\$322 per month)

___ 8:30am-2:30pm

(\$491 per month)

Monday/Wednesday/Friday

___ 8:30am-Noon

(\$468 per month)

___ 8:30am-2:30pm

(\$738 per month)

Monday through Friday

___ 8:30am-Noon

(\$707 per month)

___ 8:30am-2:30pm

(\$1072 per month)

Registration Requirements:

- Registration cannot be accepted without the following:
 - All information on this form is completed.
 - Non-refundable deposit equal to one month's tuition.
- Please remit completed form and non-refundable deposit to Agassiz Baldwin Community, 20 Sacramento Street, Cambridge, MA 02138.

Registration Questions

- Contact Micah Eglinton-Woods, Administrative Assistant, at (617) 349-6287 x19 or mwoods@agassiz.org.

Program questions and scholarship information

- Contact Jacy Edelman, Director of Children's Programs, at (617) 349-6287 x11 or jedelman@agassiz.org.

2011-2012 Registration & Emergency Form

DEVELOPMENTAL HISTORY/BACKGROUND FORM

PLEASE NOTE: Regulations for child care facilities licensed by MA EEC require this information to be on file to address the needs of children while in care. Please complete the entire form.

CHILD'S NAME: _____

Date of Birth: _____

Developmental History

Language/s spoken at home: _____

Any speech difficulties: _____

Age child began talking: _____ walking: _____ crawling: _____ sitting up: _____

Special words used to describe needs: _____

Health

Any known complications at birth: _____

Serious illnesses and/or hospitalization: _____

Special physical conditions or disabilities: _____

Medications taken regularly: _____

Special Health needs

Reaction/Symptom

Allergy/ Clinical Illness	Severe	Moderate	Minor	Medical treatment necessary

Eating Habits

Special characteristics or difficulties: _____

Favorite foods: _____

Foods refused: _____

Sleeping Habits

Does child become tired or nap during the day? _____ If so, at what time and for how long? _____

At what time does s/he go to sleep at night? _____ Wake up in the morning? _____

Does child sleep in a crib? _____ In own bed? _____ Other? _____

Describe any special characteristics or needs (e.g. stuffed animal, story, mood upon waking, etc.): _____

Toilet Habits

Is child toilet trained?	Has toilet training been attempted?	
Describe any toileting procedure to be used at preschool:		
How does child indicate bathroom needs?		
Is child reluctant to use toilet?	Does child have bathroom accidents?	
What toilet is used at home (regular seat, special child seat, potty)?		
Are diapers used?	Disposable or cloth?	Day, night, or both?
Is there frequent occurrence of diaper rash?	If so, how is it treated? (powder, special lotion, other)	
Are bowel movements regular?		How many per day?
Is there a problem with diarrhea?		

Social Relationships

How would you describe your child?	
Previous experience with other children or in child care:	
Reactions to strangers:	Able to play alone?
Favorite toys and activities:	
Fears (animals, the dark, etc.):	
How do you comfort your child?	
What is the method of discipline/behavior management used at home?	
What would you like your child to gain from this preschool experience?	

Daily Schedule

Please describe your child's daily schedule on a typical day including activities, eating, napping, playtime, sleeping, bedtime:	
Is there anything else you would like us to know about your child including recent changes in family life, moving, or a new sibling?	

Parent/Guardian Signature:	Date:
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YOUR CHILD IN PHOTOS PERMISSION

We love to capture our memories on film! Photos are an important way for kids to track their years and remember the fun times they've had. On occasion ABC might use these photos for marketing purposes (newsletters or brochures). We kindly ask your permission to take photos of your child.

_____ Yes, I authorize ABC to take photos of my child for nostalgia and/or marketing purposes.

_____ No, I **DO NOT** authorize ABC to take photos of my child for nostalgia and/or marketing purposes.

Child's Name: _____ Date: _____

Parent/Gaurdian Name: _____

Parent/Gaurdian Signature: _____

ARRIVAL/DEPARTURE OPTIONS

Please check relevant arrival options:

Please check relevant departure options:

My child will arrive to Preschool by:

My child will depart Preschool by:

_____ Parent/guardian drop off

_____ Parent/guardian pick up

_____ Private van

_____ Private van

_____ Other (describe): _____

_____ Other (describe): _____

PLEASE INITIAL EACH STATEMENT:

_____ If my child will be absent, I will call the Preschool to notify them.

_____ I understand that pick-up time is Noon and 2:30PM respectively. A late fee will be assessed after those times.

_____ I understand that tuition is due in advance on the first of each month, and I agree to pay the monthly tuition for the number of days for which my child is registered.

_____ I understand that the non-refundable deposit may be applied to June 2012 tuition. If my child withdraws from the program prior to that time, the deposit will not be refunded or applied to any other month.

I understand that each family is expected to thoroughly read the parent handbook that I will receive with the welcome packet before my child starts school.

I understand that all these items must be completed in order for my registration to be processed:

- Completed application
- Completed emergency form
- Completed physician form
- Non-refundable deposit equal to one months tuition

Parent/Caregiver Signature: _____

Date: _____

EMERGENCY CARD INFORMATION FORM

PLEASE NOTE: This sheet is for the Sacramento Street Preschool first aid kit which will be taken along when leaving the premises. This is required by Mass. Department of Early Education and Care.

Child's Name: _____ Date of Birth: _____

Child's Home Address: _____

_____ Phone: _____

INSTRUCTIONS TO REACH PARENT OR GUARDIAN

Name: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

Name: _____ Cell Phone: _____

Work Phone: _____ Home Phone: _____

CONTACT INFORMATION FOR PEDIATRICIAN OR SOURCE OF HEALTH CARE

Name: _____ Phone: _____

Address: _____

EMERGENCY CONTACT PERSONS (OTHER THAN PARENTS/GUARDIANS)

List names, daytime telephone numbers (including cell numbers if relevant), and addresses of at least two (2) persons (*other than parents/guardians*) to contact in the **event of an emergency**.

Name: _____ Relation to child: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Name: _____ Relation to child: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Name: _____ Relation to child: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

AUTHORIZATION FOR CHILD PICK-UP (OTHER THAN PARENTS/GUARDIANS)

1.) Name: _____ Relationship to child: _____

Address: _____ Phone: _____

2.) Name: _____ Relationship to child: _____

Address: _____ Phone: _____

3.) Name: _____ Relationship to child: _____

Address: _____ Phone: _____

4.) _____ Other than parent/guardian, no one is authorized to pick up my child.

Emergency Medical Treatment

I hereby give Sacramento Street Preschool permission to administer first aid and /or CPR to my child _____ and/or take abovementioned child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health. My preference for hospital if possible is _____.

Parent/Guardian Signature: _____ **Date:** _____

Medical Insurance Information (Optional):

Subscriber's Name: _____

Type of Insurance: _____

Policy Number: _____

GENERAL PERMISSION

I hereby give the Sacramento Street Preschool permission to take my child, _____ off the premises of the school for the following destinations. These will be walks, and if the school transports my child by vehicle, there will be a separate permission:

- Alden Tot Lot
- Walks within the Agassiz neighborhood
- Sacramento Field

Parent Signature: _____ **Date:** _____



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Sacramento Street Preschool

Dear Physician,

_____ is enrolled in the Sacramento Street Preschool, which is licensed by the Mass. Department of Early Education and Care. Their regulations require that the Medical History Form be completed and signed by the child's physician or source of health care. Additionally, evidence that the child has been successfully immunized in accordance with the current U.S. Department of Health and Human Services recommended schedules must be submitted and signed by the physician or source of health care. You are welcome, but not required, to use the certificate of immunization on the back of this form.

Evidence of a physical exam is valid for one year from the date the child was examined and shall be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone: _____

Name of Parents/Guardian: _____

Address: _____

Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance: _____

Has the child been screened for lead poisoning? Yes: _____ No: _____ If yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the Sacramento Street Preschool staff? If so, please elaborate: _____

Physician's Signature: _____ Date: _____

Other Comments:

Please return this form and the child's immunization record to:

Sacramento Street Preschool
20 Sacramento Street
Cambridge, MA 02138
617 349-6287

See Back

CERTIFICATE OF IMMUNIZATION

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

If combination vaccine is administered, 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		Rotaviruses (e.g., RVS: 3-dose series, RV1: 2-dose series)	1		
	2			2		
	3			3		
	4		Measles, Mumps, Rubella (MMR, MMRV)	1		
		2				
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap)	1		Varicella (Var, MMRV)	1		
	2			2		
	3		Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	4			2		
	5			Influenza Inactivated (intramuscular) or Live (intranasal)	1	
	6				2	
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP- IPV/Hib)	1			3		
	2			4		
	3			5		
	4			6		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib)	1		Pneumococcal Polysaccharide (PPV23)	1		
	2			2		
	3		Hepatitis A (HepA, HepA-HepB)	1		
	4			2		
	5		Human Papillomavirus (HPV)	1		
		2				
Pneumococcal Conjugate (PCV7)	1		Other:	3		
	2					
	3					
	4					

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
<input type="checkbox"/> 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: _____

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years — United States • 2015

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹	HepB		HepB		^{see footnote 1}	HepB						
Rotavirus ²				RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	^{see footnote 2}	DTaP				DTaP
<i>Haemophilus influenzae</i> type b ⁴				Hib	Hib	Hib ⁴	Hib					
Pneumococcal ⁵				PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus				IPV	IPV	IPV						IPV
Influenza ⁶						Influenza (Yearly)						
Measles, Mumps, Rubella ⁷							MMR			^{see footnote 7}		MMR
Varicella ⁸							Varicella			^{see footnote 8}		Varicella
Hepatitis A ⁹							HepA (2 doses)				HepA Series	
Meningococcal ¹⁰											MCV	

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2015, for children aged 0 through 6 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of

the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions (<http://www.cdc.gov/vaccines/imz/downloads/ACIP-List-List-1.htm>). Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7877.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)
At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (see later than age 1 week).

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. The final dose should be administered no earlier than age 24 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg (anti-HBs) after completion of at least 2 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).

4-month dose:

- Administration of 4 doses of HepB to infants is permissible when combination vaccines containing HepB are administered after the birth dose.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (minimum age 14 weeks if 5 doses). Vaccination should not be initiated for infants aged 16 weeks or older (i.e., 16 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 8 days.
- If Rotarix[®] is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4 through 6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- PRP-OMP (Pedvaxim[®] or Comvax[®] [Hib-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TRT-HIB[®] (DTaP-Hib) should not be used for doses at ages 2, 4, or 6 months but can be used as the final dose in children aged 12 months or older.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine PCV2; 2 years for pneumococcal polysaccharide vaccine PPSV2)

- PCV is recommended for all children younger than 6 years. Administer 1 dose of PCV to all healthy children aged 24 through 60 months who are not completely vaccinated for their age.

- Administer PPSV to children aged 2 years or older with certain underlying medical conditions (see [MMWR 2009;49\(No. RR-9\)](#)), including a cochlear implant.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 48 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if aged 6 through 36 months or 0.5 mL if aged 3 years or older.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA also is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See [MMWR 2009;58\(No. RR-7\)](#).

10. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV] and for meningococcal polysaccharide vaccine [PPSV2])

- Administer MCV to children aged 2 through 10 years with terminal complement component deficiency, asplenia or functional asplenia, and certain other high-risk groups. See [MMWR 2009;58\(No. RR-7\)](#).
- Persons who received PPSV 2 or twice years previously and who remain at increased risk for meningococcal disease should be revaccinated with MCV.

The Recommended Immunization Schedule for Persons Aged 0 Through 6 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/imz/), the American Academy of Pediatrics (<http://www.aap.org/>), and the American Academy of Family Physicians (<http://www.aafp.org/>).