Dear Family:

Thank you for your interest in our Early Childhood Program(s). Enclosed in this packet you will find all the necessary paper work to begin the enrollment process here at our Center. You will also find information pertinent to the program you are looking to enroll your child into.

Should you choose to enroll, our Parent Handbook and Center policies and procedures as well as information regarding our programs can be found on our website at: TheMagicalYears.org.

To officially enroll your child at The Magical Years, please complete the following steps:

- Complete all the paper work within this packet
- Provide the Center with an updated copy of your child(ren)'s immunizations along with their most recent physical. (Physicals are good for 1 year)
- Return the enclosed paper work along with registration fee and tuition deposit.

✔ Enrollment Fee ($75/individual $100/family)

✔ A deposit of 1 week's tuition which will be applied to your child's last week of childcare at the Center.

If at any time you have any further questions please feel free to contact the Center Director(s) at any time. We look forward to having your child(ren) and family part of our Center.

Warmest Regards,

Darcy Kennedy

Darcy Kennedy, M.Ed

The Magical Years
EARLY LEARNING CENTER, INC.

OFFICE USE ONLY
CLASSROOM ENTERING_____

DAYS:_____

DROP OFF TIME: _____ **PICKUP**_____

CHILD'S REGISTRATION FORM

CHILD'S NAME:_____ DOB:_____

Age at Admission:_____ **Date of Admission:** _____ **Right or Left Handed:**_____

Eye Color:_____ **Skin Color:** _____ **Hair Color:**_____ **Height:**_____ **Weight:**_____ **Sex:**_____

Primary Language:_____ **Identifying Marks:**_____

Child's Home Address:_____

Parent/Guardian Name: _____

Address:_____ _____

Reachable Phone Number:_____ Email Address: _____

Business Name:_____ Business Address: _____

Business Phone Number: _____ Hours at Work:_____

Parent/Guardian Name: _____

Address:_____ _____

Reachable Phone Number:_____ Email Address: _____

Business Name:_____ Business Address: _____

Business Phone Number: _____ Hours at Work:_____

PLEASE CHECK YOUR DESIRED DAY/SCHEDULE

Day	Full Day	Preschool Only Half Program
☐ Monday	Time In_____ Time Out_____	☐ 8:30-1:00
☐ Tuesday	Time In_____ Time Out_____	☐ 8:30-1:00
☐ Wednesday	Time In_____ Time Out_____	☐ 8:30-1:00
☐ Thursday	Time In_____ Time Out_____	☐ 8:30-1:00
☐ Friday	Time In_____ Time Out_____	☐ 8:30-1:00

Parent Signature:_____ **Date:**_____

School Age ONLY

Current School:_____

School Address:_____School Phone Number:_____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school. ***Parent/Guardian Initials:***_____

(Please turn over)

ENROLLMENT CONTRACT

NEWREG 2021-2022

Child's Name:_____ Parent/Guardian_____
(responsible for tuition)

I AGREE TO THE FOLLOWING TERMS:
(if possible, we request both parents/guardians initial the following statements)

- I will support the policies of The Magical Years Early Learning Center, Inc. as stated in this **REGISTRATION** and the **PARENT HANDBOOK**. _____
- I have read and understand The Magical Years Video Surveillance Policy. _____
- My commitment is to pay tuition weekly.
  Weekly payments for children enrolled are due on the Friday, prior to your child's scheduled week of attendance.
  Late Fee will apply for overdue tuition accounts. There is a $35.00 fee for insufficient funds. _____
- I understand I am responsible for all fees associated with using a credit card/ACH payment through the Procare Connect APP. _____
- I understand that 100% of tuition is due regardless of school cancellations due to holiday's, staff development, Center improvements or inclement weather. _____
- I understand I will be responsible for any legal fees associated with collecting any outstanding debt owed to The Magical Years Early Learning Center, Inc._____
- I understand that if I choose to withdraw my child from The Magical Years Program(s) I must give a 2 week notice to the Center Director. No Refunds will be given. _____
- I understand that I must give 2 weeks notice for any schedule changes. _____
- I give permission for my child(ren) to take part in ALL school-sponsored trips/activities on or off the school premises and absolve the school from liability because of any injury to my child(ren). _____
- I understand the vacation policy as stated in the parent handbook. _____
- I understand a fee is assessed for late pickup or extra hours for child(ren). _____
- I understand that with the FULL DAY program (52 weeks) I am responsible for a summer program fee due in April. _____
- I understand there is a re-registration fee due each January for all children in program.
  ($65.00 individual or $95.00/family) _____
- I understand Registration fee, program fee, re-registration fee, deposits, pizza lunch, Summer Program Fee and any misc. fees are non-refundable. _____
- I understand if I am Full-Day I am required to continue through the summer months either my regular schedule or a reduced schedule for 9 weeks. Please refer to parent handbook for full policy. _____
- I understand and agree to the COVID-19 tuition policy. _____
- I agree to follow all COVID 19 policies as stated in the Acknowledgement Disclosure, Action Plan and COVID Health & Safety Plan._____

_____ _____ _____

Parent Signature **Director Initials** **Date**

Tuition Contract (Continued)

Child(ren) Name_____

Date:_____

Number of Child(ren) _____

Registration Fee $_____ paid

Re-registration Fee $_____ paid

Summer Program fee $_____ paid

Deposit $_____ paid

Classroom(s)_____ Days_____ Tuition _____ Wkly Mo

Classroom(s)_____ Days_____ Tuition _____ Wkly Mo

Classroom(s)_____ Days_____ Tuition _____ Wkly Mo

Sibling Discount_____

Total Tuition_____

Date:_____ Change In Schedule_____

Date:_____ Rate Change_____

Summer Program

_____

_____

Misc Notes:

_____

_____

_____

NEW REG 2021-2022

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

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

___I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

___I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility to secure necessary medical treatment for my child.

Child's Physician Name: _____

Address: _____

Phone Number: _____

*Child's Allergies: _____ **Must complete IHCP form*

*Chronic Health Conditions: _____ **Must complete IHCP form*

Emergency Contacts (In order to be contacted) **Please note all Emergency contacts will be added to Procare Connect App*

Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____

Do you give permission for child to be released to this person? Yes_____ No_____

Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____

Do you give permission for child to be released to this person? Yes_____ No_____

Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____

Do you give permission for child to be released to this person? Yes_____ No_____

**Optional*

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____

Parent /Guardian Signature Date (valid for one year)

TRANSPORTATION PLAN

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

MY CHILD WILL ARRIVE AT THE PROGRAM:
___PARENT DROP OFF
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

CHILD WILL DEPART FROM THE PROGRAM:
___PARENT PICK UP
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

**Please note: If your child attends Integrated Preschool, you must provide a Notice of Authorization for Transportation*

AUTHORIZATIONS

❒ Yes ❒ No I/we give consent for my child's photo to be used on the Procare Connect App.

❒ Yes ❒ No I/we hereby give permission to allow the use of voice, video, image or likeness in photographs and/or video of my child by The Magical Years Early Learning Center Inc.
Consent **IS ALLOWED** for: Newsletter, Business Flyers, Company Website,
Video for advertising purposes either online or television.

❒ Yes ❒ No I give consent for my child to appear on The Magical Years Facebook Page and Instagram.

❒ Yes ❒ No I give my consent and permission for parents, college students, and or other visitors approved and authorized by The Magical Years Early Learning Center to observe and or volunteer in my child's classroom and other group settings.

❒ Yes ❒ No I give permission for The Magical Years Early Learning Center, Inc. to share my email address to other families within the center.

❒ **I DO NOT GIVE CONSENT FOR ANY OF THE ABOVE.**

❒ Yes ❒ No I give permission for staff to administer sunscreen while at the center (provided by parent).

❒ Yes ❒ No I give permission for staff to apply diaper cream as needed (provided by parent).

_____ _____
Parent /Guardian Signature Date (valid for one year)

(Please turn over)

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

PLEASE PROVIDE INFORMATION FOR INFANTS AND TODDLERS

DEVELOPMENTAL HISTORY

Age began sitting: _____ crawling: _____ walking: _____ talking: _____
*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____
Any speech difficulties? _____
Special words to describe needs _____
Language spoken at home _____ *Any history of colic? _____
*Does your child use pacifier or suck thumb? _____ *When? _____
*Does your child have a fussy time? _____ *When? _____
*How do you handle this time? _____

HEALTH

Any known complications at birth? _____
Serious illnesses and/or hospitalizations:_____
Special physical conditions, disabilities:_____
Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____
_____
_____
Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____
*If infant is on a special formula, describe its preparation in detail: _____
_____
Favorite foods: _____
Foods refused: _____
* Is your child fed held in lap?_____ High chair?_____
* Does your child eat with spoon?_____ Fork?_____ Hands?_____

TOILET HABITS

*Is there a frequent occurrence of diaper rash?_____
*Do you use: oil:_____ powder:_____ lotion:_____ other:_____
*Are bowel movements regular?_____ How many per day?_____
*Is there a problem with diarrhea?_____ Constipation? _____
*Has toilet training been attempted?_____

Please turn over

*Please describe any particular procedure to be used for your child at the center: _____
_____
*What is used at home? Pottychair? _____ Special child seat? _____ Regular seat? _____
*How does your child indicate bathroom needs (include special words): _____
Is your child toilet trained? _____
Is your child ever reluctant to use the bathroom? _____
Does your child have accidents? _____

SLEEPING HABITS
*Does your child sleep in a crib? _____ Bed? _____
Does your child become tired or nap during the day (include when and how long)? _____
_____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

When does your child go to bed at night? _____ and get up in the morning? _____
Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) _____

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

DAILY SCHEDULE
Please describe your child's schedule on a typical day. For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. _____
_____
_____
_____
Is there anything else we should know about your child? _____
_____
_____

_____ _____
(Parent/Guardian Signature) (Date)

Updated 12/10/20

COVID-19 Acknowledgement Disclosure

Please read and initial each statement below.

1. _____ I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter the facility beyond the designated drop-off and pick-up area. I understand that this procedure change is for the safety of all persons present in the facility and to limit to the extent possible everyone's risk of exposure. I understand that it is my responsibility to inform any Emergency Contact persons of the information contained herein.

2. _____ I understand that IF there is an emergency requiring me to enter the facility beyond the designated drop-off and pick-up area, I MUST sanitize my hands before entering and wear a mask. While in the facility I must practice social distancing and remain 6ft from all other people, except for my own child.

3._____ I understand that to enter upon the facility premises my child must be free from COVID-19 symptoms. If, during the day, any of the following symptoms appear my child will be separated from the rest of the people in the center. I will be contacted, and my child MUST be picked up from the facility within 30 minutes of being notified.

Symptoms include:

Child/member displays one of the following symptoms of Covid-19 while at the program or at home not related to a known cause: • Fever of (100.0°+), feverish, chills • Cough • Sore throat • Difficulty breathing • Nausea, vomiting, or diarrhea • New loss of taste or smell • New muscle aches	Can return 24 hours after symptom abates without medication or with written clearance by a healthcare provider
Child/member displays two or more symptoms of Covid-19, and/or one of these symptoms combined with a symptom from above • Fatigue • Headache • Runny nose or congestion • Any other signs of illness	Can return with written clearance by a Healthcare Provider or negative COVID test and symptom-free for 72 hours.

While we understand that many of these symptoms can also be related to non-COVID-19 related issues we must proceed with an abundance of caution during this Public Health Emergency. These symptoms typically appear 2-7 days after being infected so please take them seriously.

4. _____ I understand that regular health checks will be performed through the day which may includes temperature checks.

5. _____ I understand that it is recommended for my child to wear a mask. If you choose to have your child wear a mask you understand that we will do our best to enforce it to the best of our ability. Children will not be forced to wear a mask. I also understand I must provide 2 masks daily and they must be laundered regularly.

6. _____ I understand that my child will be required to wash their hands using CDC recommended handwashing procedures throughout the day using warm running water and rubbing with soap for at least 20 seconds.

7. _____ I will immediately notify The Magical Years Early Learning Center, Inc. Directors if I become aware of any person with whom my child or I have had contact exhibits any of the symptoms listed in Number 1 above, is advised to self-isolate, quarantine, or has tested positive, or is presumed positive for COVID-19. Further, I will immediately notify The Magical Years Early Learning Center, Inc. Directors if anyone from my place of employment is presumed positive or tests positive for COVID-19 whether or not I have had direct contact with that person.

8. _____ I understand that while present in the facility each day my child will be in contact with children, families and other employees who are also at risk of community exposure. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I understand that I play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined herein.

9. _____ I give permission for my child (age 2+) to use hand sanitizer. I understand my child will be supervised while using it and it will not replace consistent and effective handwashing.

10. _____ I understand that I must follow the MA state travel order at all times during a health emergency in order to keep all children, staff and families safe at our Center.

11. _____ I have read and understand The Magical Years COVID-19 Health and Safety Plan and updated policies, procedures, and action plan.

I, _____certify that I have read, understand, and agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by The Magical Years Early Learning Center, Inc. will result in termination of services. I acknowledge that care for my child will be terminated if it is determined that my actions, or lack of action unnecessarily exposes another employee, child, or their family member to COVID-19.

Child's Name: _____DOB:_____

Parent Signature _____Date_____

REMINDERS

PHYSICAL FORM:

Per the MA Department of Early Education and Care your child MUST have an updated physical on file. Physicals are to be updated Annually. Please be sure that their LEAD TESTING has been completed. Also, please ensure that your child has received their annual flu shot. Documentation must be on file. Mail/Email Physicals to:

Halifax Center
933 Plymouth St. Halifax, MA 02338
Email: themagicalyearshalifax@gmail.com
781-294-9292

Kingston Center
142 Pembroke St. Kingston, MA 02364
Email: themagicalyearskingston@gmail.com
781-585-3842

Pembroke Center
212 Schoosett St. Pembroke, MA 02359
Email: themagicalyearspembroke@gmail.com
339-793-2889

Just a friendly reminder our Summer Program will begin June 21, 2021

A Summer Program Fee will be due by April 1st
Toddler: $60.00 Preschool $110.00