



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
Owner



OFFICE USE ONLY CLASSROOM ENTERING _____
DAYS: _____
DROP OFF TIME: _____ PICKUP _____

CHILD'S REGISTRATION 2022/2023 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:** _____

DESIRED 2022-2023 SCHEDULE	
DAY	SCHEDULED HOURS
<input type="checkbox"/> Monday	Time in _____ Time out _____
<input type="checkbox"/> Tuesday	Time in _____ Time out _____
<input type="checkbox"/> Wednesday	Time in _____ Time out _____
<input type="checkbox"/> Thursday	Time in _____ Time out _____
<input type="checkbox"/> Friday	Time in _____ Time out _____

Reminders:

- Please refer to our summer leave of absence policy in our handbook on page 14 if you are planning on changing your schedule for the Summer.
- Our full day program allows for a maximum of 9 hours per day.

Parent Signature: _____ **Date:** _____



ENROLLMENT CONTRACT REGISTRATION

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)

POLICIES

- I will support the policies of TMY Early Learning Center, Inc. as stated in this **REGISTRATION** and the **PARENT HANDBOOK**. *(Updated parent handbook can be found on our website)* _____
- I have read and understand The Magical Years Video Surveillance Policy. _____
- 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 understand the vacation policy as stated in the parent handbook. _____
- I understand that with the FULL DAY program (52 weeks) I am responsible for a summer program fee due in April. _____
- 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). _____

TUITION AND FEES

- 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 Procure 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 a fee is assessed for late pickup or extra hours for child(ren). _____
- 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. _____

COVID-19

- 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, Illness Policy and COVID Health & Safety Plan. _____
(All updated COVID 19 information can be found on our website)

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:



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

***Please Note: Parents/Guardians will be contacted first. Please do not use this space for your contact information. In the event you are unable to be reached please add below contacts who we can contact in the event of an emergency.**

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 the Integrated Preschool or Public School and they provide transportation to and from the Center, you must provide a Notice of Authorization for Transportation form. Please contact your Center Director for this form.

AUTHORIZATIONS

- Yes No I/we give consent for my child's photo to be used on the Procure Connect App. This app is only available to TMY families and only families in your child's class can see any photos posted.
- 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 Consent for my child to to appear on The Magical Years Private Facebook Group for the Center in which my child(ren) are enrolled. Only currently enrolled families are authorized to view this page
- 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.

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). NA
- Yes No I give permission for my child (over the age of 2) to use hand sanitizer.

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



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 this procedure is subject to change at any time.
2. _____ 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 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. I have read and understand The Magical Years Illness Policy.
3. _____ I understand that it is recommended for my child ages 2 and up 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.
4. _____ 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 with is advised to self-isolate, quarantine, or has tested positive, or is presumed positive for COVID-19.
5. _____ 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.
6. _____ I have read and understand The Magical Years COVID-19 Health and Safety Plan and updated policies, procedures, and illness action plan which can be found on The Magical Years website.
7. _____ I understand if there is a confirmed case of COVID 19 (Child or Staff) and we are advised by the DPH/BOH/EEC to close a classroom, 50% of one week tuition will be waived. **This applies to the exposed classroom only.**

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 20, 2022**

**A Summer Program Fee
 will be due by April 1st
 Toddler: \$65.00 Preschool \$115.00**

