

**Child Enrollment Packet**

**Before & After School**

**Enrollment Packet**

**This Manual is the property of Playful Minds, LLC**

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**www.playfulmindslc.com**

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# Enrollment Form

## Child information

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Name:** |  | **Primary Language:** |  |
| **Street:** |  | **Skin Color:** |  |
| **City/State/Zip:** |  | **Hair Color:** |  |
| **Date of Birth:** |  | **Eye Color:** |  |
| **Age at Admission:** |  | **Identifying Marks:** |  |
| **Admission Date:** |  | **Height:** |  |
|  |  | **Weight:** |  |

## Parent information

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Guardian 1:** |  | **Parent/Guardian 2:** |  |
| **Relationship to Child:** |  | **Relationship to Child:** |  |
| **Street:** |  | **Street:** |  |
| **City/State/Zip:** |  | **City/State/Zip:** |  |
| **Phone Number\*:** |  | **Phone Number\*:** |  |
| **Personal Email:** |  | **Personal Email:** |  |
| **Employer:** |  | **Employer:** |  |
| **Street:** |  | **Street:** |  |
| **City/State/Zip:** |  | **City/State/Zip:** |  |
| **Bus. Phone Number:** |  | **Bus. Phone Number:** |  |
| **Work Hours:** |  | **Work Hours:** |  |

***\*This should be the phone number that is used for your primary contact purposes and through which we can reach you quickly.***

## School age children’s current school information

|  |  |  |  |
| --- | --- | --- | --- |
| **Current School:** |  | **Phone Number:** |  |
| **Street:** |  | **City/State/Zip:** |  |

# Tuition payment & child schedule contract

This agreement contains the financial terms that are agreed to between the parent and Playful Minds, LLC for the Before & After School program for School Age Children..

|  |  |  |  |
| --- | --- | --- | --- |
| **Child name** |  | **Parent’s name** |  |
| **Street** |  | **Phone** |  |
| **City/state/zip** |  | **Email** |  |

**Indicate the location and sessions to enroll the student:**

**CHICOPEE, MA LOCATIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Playful Minds  999 Memorial Ave  Chicopee | Bowie School  80 Dare Way  Chicopee | Lambert Lavoie Sch. 99 Kendell St  Chicopee | Stefanik School  720 Meadow St  Chicopee | Streiber School  40 Streiber Dr  Chicopee | Fairview School  26 Memorial Ave  Chicopee |
| Before | After school only | After school only | After school only | After school only | After school only |
| &/or After |  |  |  |  |  |

**OTHER LOCATIONS**

**Enrollment Changes:**

***Two weeks’ in advance notice (in writing to Playful Minds) is required if you want to make any changes to your child’s enrollment,***

|  |  |  |  |
| --- | --- | --- | --- |
| Genera  200 Birnie Ave  Springfield, MA | Genera (Preschoolers) | Enfield  115A Elm St  Enfield, CT | State St  649 State St  Springfield, MA |
| Before | After school only | Before | Before |
| &/or After |  | &/or After | &/or After |

**Indicate the day(s) to enroll the student:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Monday |  | Tuesday |  | Wednesday |  | Thursday |  | Friday |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Deposit:** The first week’s tuition and security deposit pay-ments are due before the child’s entry into the program.  **Payments.** *There is no discount or deduction from the tuition for student absences, family vacations, inclement weather days, holidays, teacher training days, etc.* Tuition can ONLY be paid through the Bright Wheel (<https://mybrightwheel.com/>) tuition payment section. *Playful Minds DOES NOT accept checks, money orders, or credit cards directly.*  **Payment frequency.** Parents have the option to pay tuition either weekly or monthly; however, the payment schedule cannot deviate from the option indicated on this form.  **Payment schedule.** Weekly payments are due every Friday before the week the payment is being made for. Monthly payments are due on the 1st of each month.  **Late payment fees.** Payments are considered late after 3 days. If payments are late, a $10.00 fee is assessed and will automatically be added to the parent’s account. Payments later than one week will result in suspending your child until the past due balance is paid in full. Payments are to be made regardless of absenteeism. |  | **Late pickup fee.** A parent late picking up their child from Playful Minds will be charged $10.00 for the first 15 minutes and $5.00 for each additional 5 minutes or portion thereof. This fee is due at time of pick up or no later than the following day.  **NEFW Voucher Eligibility.** Please refer to vouchers for contract amount and dates of service. Any period of time not covered by a NEFW voucher will be billed at private rates. **Parent initials:**  **The parent selected the following payment schedule:**  **Weekly**  **Monthly**  **PAYMENTS**  **Deposit $**  **Tuition payment $** |

# First Aid and Medical Consent Form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child’s name** |  | **Date of birth** |  | |
| **Home street** |  | **City/town** |  | |
| **Phone number** |  |  |  |
|  |  |  |  |

## Parent/guardian contact information

List names in the order in which you would like us to contact first.

|  |  |  |  |
| --- | --- | --- | --- |
| Name (1) |  | Phone number |  |
| Home street |  | City/town |  |
| Name (2) |  | Phone number |  |
| Home street |  | City/town |  |

## Emergency contact persons

List names in the order in which you would like us to contact first.

|  |  |  |  |
| --- | --- | --- | --- |
| Name (1) |  | Phone number |  |
| Home street |  | City/town |  |
| Name (2) |  | Phone number |  |
| Home street |  | City/town |  |

## Pediatrician or person that provides health care to your child

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Phone number |  |
| Home street |  | City/town |  |

## Allergies/chronic health conditions

|  |
| --- |
|  |

## Insurance information (optional)

|  |  |  |  |
| --- | --- | --- | --- |
| Company |  | Policy &/or member # |  |

## Emergency medical treatment authorization

**I hereby give the Playful Minds permission to administer first aid/CPR to my child or take my child to a hospital for treatment when I cannot be reached or when delay would be dangerous to my child’s health.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name** |  | **Date** |  |
| **Parent signature** |  |  |  |

# 

# Small Group & Large Group Transportation Plan & Authorization

Refer to First Aid and Medical Consent Form for release information.

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Name:** |  | **Date of Birth:** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TRANSPORT #1**  **My child will arrive at the program by:** | | | **My child will arrive at the program by:** | | | | | | |
|  | Parent drop off | |  | | Parent drop off | | | | |
|  | Supervised walk | |  | | Supervised walk | | | | |
|  | Unsupervised walk | |  | | Unsupervised walk | | | | |
|  | Public/private van | |  | | Public/private van | | | | |
|  | Program bus/van | |  | | Program bus/van | | | | |
|  | Contract van | |  | | Contract van | | | | |
|  | Private transportation arraigned by parent | |  | | Private transportation arraigned by parent | | | | |
|  | Other: | |  | | Other: | | | | |
| **Complete the following 2 sections if the child will be transported to/from more than one location or by additional methods/person(s).** | | | | | | | | | |
| **TRANSPORT #2** | | | | | | | | |
| **My child will arrive at the program by:** | | | **My child will arrive at the program by:** | | | | | | |
|  | Parent drop off | |  | | Parent drop off | | | | |
|  | Supervised walk | |  | | Supervised walk | | | | |
|  | Unsupervised walk | |  | | Unsupervised walk | | | | |
|  | Public/private van | |  | | Public/private van | | | | |
|  | Program bus/van | |  | | Program bus/van | | | | |
|  | Contract van | |  | | Contract van | | | | |
|  | Private transportation arraigned by parent | |  | | Private transportation arraigned by parent | | | | |
|  | Other: | |  | | Other: | | | | |
| **TRANSPORT #3** | | | |  | |  | | |
| **My child will arrive at the program by:** | | | **My child will arrive at the program by:** | | | | | | |
|  | Parent drop off | |  | | Parent drop off | | | | |
|  | Supervised walk | |  | | Supervised walk | | | | |
|  | Unsupervised walk | |  | | Unsupervised walk | | | | |
|  | Public/private van | |  | | Public/private van | | | | |
|  | Program bus/van | |  | | Program bus/van | | | | |
|  | Contract van | |  | | Contract van | | | | |
|  | Private transportation arraigned by parent | |  | | Private transportation arraigned by parent | | | | |
|  | Other: | |  | | Other: | | | | |
| **Parent name:** | |  | | | | | **Date:** |  | | |
| **Parent signature:** | |  | | | | |  |  | | |

# Permission/Release Form

|  |  |  |  |
| --- | --- | --- | --- |
| **Child Name:** |  | **Date of Birth:** |  |

**I understand and I am aware that my child might be involved with the following:**

|  |  |  |
| --- | --- | --- |
| Yes | No | Photographs of my child may be taken during center hours and used for publicity. |
| Yes | No | Student teachers in the course of their studies may observe my child’s classroom. |
| Yes | No | Member(s) of various agencies may be providing services to other children in my child’s class. I give permission for my child to be in the same class while these observations/services are being provided to other children. I understand that if there are any concerns about my child, I will be notified immediately. |

## Exception to giving permission:

I understand in the event that my family has been involvement with the Department of Children and Families (DCF), your child may be interviewed by social worker while in our care.

## Additional written permission:

With the exception of the DCF, a signed written approval will be required for any interview with other agencies/organizations.

With my signature, I give my permission for general observation to be completed as outlined above. I understand the circumstances in which I will be contacted for a separate written approval.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name:** |  | **Date:** |  |
| **Parent signature:** |  |  |  |

# Permission to apply products

|  |  |  |  |
| --- | --- | --- | --- |
| **Child name** |  | **Date of birth** |  |

**Product Requirements**

* All products are provided by the parent and given the classroom teacher.
* All products must be in ointment or cream form. (Aerosol spray is NOT allowed.)
* All product packages must be labeled with the child’s name.

**Product Types**

I give Playful Minds Learning Center, LLC permission to apply the following skin protection products to my child.

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | Sunscreen of SPF-15 or higher. |
| **Yes** | **No** | Topical bug repellent. |
| **Yes** | **No** | Hand sanitizer (60% alcohol or greater) – Communicable disease prevention: COVID-19. *Hand sanitizer is provided by PMLC.* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name:** |  | **Date:** |  |
| **Parent signature:** |  |  |  |

# Permission to Leave Premises

|  |  |  |  |
| --- | --- | --- | --- |
| **Child Name:** |  | **Date of Birth:** |  |

I give Playful Minds, LLC permission to take my child off premises to close-by destinations. Activities may include nature walks, walks to the local park, and the like. These activities are planned and incorporated into the classroom schedule.

**Additional written permission:**

I understand that if a field trip is planned and the children are being taken to further destinations (such as the zoo or a farm), I will be asked to complete an addition consent form.

With my signature, I , give my permission my child to be taken to close-by destinations as outlined above. I understand the circumstances in which I will be contacted for a separate written approval.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name:** |  | **Date:** |  |
| **Parent signature:** |  |  |  |

# Parent involvement

|  |  |  |  |
| --- | --- | --- | --- |
| **Child Name:** |  | **Date of Birth:** |  |

Please refer to the Parent Handbook for additional information about parent involvement which includes information about parental rights and ways to be involved and to provide input to the program.

## Parent Grievance Procedure

We value parent involvement as an essential part of our program. We also recognize that on occasion parents/guardians have a grievance in relation to our program and/or procedures. As a parent/guardian, you have the right to offer suggestions/feedback about the program and policies. However, in efforts to provide quality care and services to our families we ask that you adhere to the following procedures:

* Be sure that your child is signed in and accounted for by the classroom teacher(s).
* Direct your concerns and/or complaint to the Program Director.
* Request a private meeting with the Program Director to discuss the issues at hand.

Emotional outbursts that appear to be threatening in nature will not be tolerated. This behavior can be grounds for immediate termination without notice of your child’s enrollment.

If you have spoken with the Program Director and still feel that the issues is not resolved, please contact Paige Thompson-Westcott at the main office by calling 413-636-5696.

## Incidents Involving Parents

An “incident” is deemed to be any event in which the policies of the program are not being adhered to and/or the safety of the staff and/or children is perceived to be in jeopardy. When such an incident occurs, staff are to immediately implement the following procedure.

* Staff inform the Program Director (or the Lead Teacher in the Program Directors absence) of the incident.
* The Program Director contacts the Main Office for direction in the appropriate action to be taken.
* If the incident is of a severe and/or dangerous nature, staff will immediately contact the local Police Department for support in the matter at hand. Staff is to follow up with the Program Director to inform of actions taken.
* Any violent outburst or displays of aggressive behavior towards staff by parents will result in immediate termination of your child’s enrollment.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name:** |  | **Date:** |  |
| **Parent signature:** |  |  |  |

# Student Expectations

Parents must review the following list with their child to know and understand the rules we expect them to follow each day. These expectations have been put in place to ensure a happy and fulfilling experience.

**Students are expected to:**

* Be respectful to all administrators, peers, and all other staff at all times.
* Be respectful to the property of and the property of others.
* To always use please and thank you.
* To clean up after themselves and throw out their trash.
* To recycle whenever possible.
* To use appropriate language at all times and are expected not to bully any other children.
* To ask a counselor to go anywhere.
* To take responsibility for their actions and tell the truth, even if it means admitting to wrongdoing.
* To take responsibility for their own property by keeping track of what items they bring with them..
* To leave all toys, video games, and other electronics at home. They are not allowed at Before & After programs..
* To not draw or use pretend weapons, including guns, at any time.
* Participate in activities politely without exhibiting rough or aggressive behavior.
* To keep their hands, feet, and the rest of their bodies to themselves. Any fighting will be brought directly to the director.

**Unacceptable behaviors or actions – read thoroughly.** Any violation listed below can result in an Incident Report being written and possibly filed with state authorities, a Parent and Director Meeting occurring, and probable suspension or expulsion from a Before and/or After Program. Therefore, students:

* Will not use obscene or vulgar language.
* Must not leave the premises without permission.
* Will not speak or act disrespectfully to any peer or adult.
* Will not threaten, harass, or physically harm another person.
* Will not intentionally destroy or vandalize any property.
* Will not use or take anyone else’s property without their permission.
* Will not possess or distribute indecent literature.
* Will not take, sell, or distribute any drugs, medication, or alcohol on the property.
* Will not possess any object the staff deems dangerous.

Please review this information with your child, fill in this form and return this portion to the director.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name** |  | **Child** |  |
| **Parent signature** |  | **Date** |  |

# Electronic devices prohibited

**Electronic devices are not allowed at camp, so we can:**

* Encourage your children to spend more time in the outdoors.
* Promote socialization between campers.
* Remove the divider between "the haves and the have-nots" in each group.
* Reduce the stress associated with the damage to and theft of electronics.
* Give your children a much-needed break from the world of technology.
* Allow your children to fully embrace and "plug into" the connections they make with other campers as they "unplug" from their electronics.
* Ensure that your children are not exposed to age-inappropriate material.
* Ensure that your children cannot post their camp photos on the Internet.
* Ensure that your children are not focusing on situations revolving around their friends, not at camp.

**Electronic devices include (but are not limited to):**

* Cell phone
* Laptops, netbooks, tablets, iPads, e-Readers
* Gameboys, PlayStation Portable, Sony's handheld video-game device, Nintendo DSS, or other handheld gaming systems
* iPod, MP3 players
* Digital cameras

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name** |  | **Child** |  |
| **Parent signature** |  | **Date** |  |

# Asthma Action Plan

**The colors of the traffic light help with asthma management.**

**GREEN** **means Go Zone!**

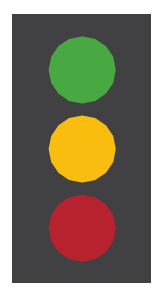
**Use controller medicine.**

**YELLOW** **means Caution Zone!**

**Add quick-relief medicine.**

**RED** **means Danger Zone!**

**Get help from a doctor.**



|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Child name** |  | | | | **Date of plan** |  | |
| **Date of birth** |  | | | | **Doctor/nurse name** |  | |
| **Parent name** |  | | | | **Doctor/nurse phone** |  | |
| **Parent phone** |  | | | |  | |  |
| **Personal best peak flow** | |  | **Goal for child** |  | | | |
| **Important! Avoid these things that make asthma worse** | | | |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Go!**  **You're doing well!** | **Use these daily controller medicines:** | | | | | |
| You have ALL of these:   * Breathing is good * No cough or wheeze * Sleep through the night * Can go to school and play | **Peak flow from**    **To** | **Medication** | **Route** | **How much** | **How often** | **Times** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Go!**  **You're doing well!** | Continue with green zone **controller medicines and add:** | | | | | |
| You have ANY of these:   * First sign of a cold * Cough * Mild wheeze * Tight chest * Coughing, wheezing or trouble breathing at night | **Peak flow from**    **To** | **Medication** | **Route** | **How much** | **How often** | **Times** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **CALL THE DOCTOR/NURSE** | | | | |
| **Go!**  **You're doing well!** | **Take these and call the doctor now.** | | | | | |
| Your asthma is getting worse fast:   * Medicine is not helping * Breathing is hard and fast * Nose opens wide * Ribs show * Can’t walk well | **Peak flow from**    **To** | **Medication** | **Route** | **How much** | **How often** | **Times** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It’s important! If you cannot contact your doctor, go directly to the emergency room and bring this form. DO NOT WAIT.**  **Make an appointment with the doctor/nurse within two days of an ER visit or hospitalization.** | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor/NP/PA Signature:** |  | **Date:** |  |

**I give permission for the school, my child’s doctor/NP/PA or to share information about my child’s asthma.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Guardian Signature:** |  | **Date:** |  |

**Consent for the administration of medication in school:** I consent to have the school nurse or school personnel designated by the school nurse administer the medication as prescribed on the reverse side of the page.

**Authorization for student self-administration of medication in school:** I have instructed this student in the proper way to use his/her medications. Medications administered must be consistent with school policy, and a medication plan must be developed with the school nurse in accordance with the Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000) as printed below. Translated copies of the regulation can be obtained from the Massachusetts Department of Public Health, 250 Washington Street, Boston, MA 02118. It is my professional opinion that this student may self-administer the medication and may be allowed to carry and use his/her medications by him/herself.

|  |
| --- |
| **Comments/special instructions:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor/Nurse:** |  | **Date:** |  |
| **Parent/Guardian:** |  | **Date:** |  |
| **Medication administration plan completed:** |  | **Date:** |  |
| **School nurse signature:** |  | **Date:** |  |

Listed below are regulations governing the self-administration of prescription medication 105 CMR 210.006

1. Consistent with school policy, students may self-administer prescription medication provided that certain conditions are met. For the purposes of 105 CMR 2100.000, “self-administration” shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.
2. The school nurse may permit self-medication of prescription medication by a student provided that the following requirements are met:
3. the student, school nurse, and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which prescription medication may be self-administered;
4. the school nurse, as appropriate, develops a medication administration plan (105 CMR 210.005 (E)) which contains only those elements necessary to ensure safe self-administration of prescription medication;
5. the school nurse evaluates the student’s health status and abilities and deems self-administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of prescription medication;
6. the school nurse is reasonably assured that the student is able to identify the appropriate prescription medication, knows the frequency and time of day for which the prescription medication is ordered, and follows the school self-administration protocols;
7. there is written authorization from the student’s parent or guardian that the student may self-medicate unless the student has consented to treatment under M.G.L. c. 112,§ 12F or other authority permitting the student to consent to medical treatment without parental permission;
8. if requested by the school nurse, the licensed prescriber provides a written order for self-administration;
9. the student follows a procedure for documentation of self-administration of prescription medication;
10. the school nurse establishes a policy for the safe storage of self-administered prescription medication and, as necessary, consults with teachers, the student, and parent/guardian, if appropriate, to determine a safe place for storing the prescription medication for the individual student, while providing for accessibility if the student’s health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventive or emergency medication, whenever possible, a backup supply of the prescription medication shall be kept in the health room or a second readily available location;
11. the school nurse develops and implements a plan to monitor the student’s self-administration, based on the student’s abilities and health status. Monitoring may include teaching the student the correct way of taking the prescription medication, reminding the student to take the prescription medication, visual observation to ensure compliance, recording that the prescription medication was taken, and notifying the parent, guardian or licensed prescriber of any side effects, variation from the plan, or the student’s refusal or failure to take the prescription medication;
12. with parental/guardian and student permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self-administering a prescription medication.

# SEIZURE ACTION PLAN (SAP)

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Birth Date: |  |
| Address: |  | Phone: |  |
| Emergency Contact/Relationship |  | Phone: |  |

**Seizure Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Seizure Type | How Long It Lasts | How Often | What Happens |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |



How to respond to a seizure (check all that apply) 

First aid – Stay. Safe. Side.  Notify emergency contact at

Give rescue therapy according to SAP  Call 911 for transport to Click or tap here to enter text.

Notify emergency contact  Other: Click or tap here to enter text.

A picture containing text, clipart

Description automatically generated First aid for any seizure

When to call 911

* Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
* Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
* Difficulty breathing after seizure
* Serious injury occurs or suspected, seizure in water

When to call your provider first

* Change in seizure type, number or pattern
* Person does not return to usual behavior (i.e., confused for a long period)
* First time seizure that stops on its’ own
* Other medical problems or pregnancy need to be checked
* STAY calm, keep calm, begin timing seizure
* Keep me SAFE – remove harmful objects, don’t restrain, protect head
* SIDE – turn on side if not awake, keep airway clear, don’t put objects in mouth
* STAY until recovered from seizure
* Swipe magnet for VNS
* Write down what happens
* Other

Seizure Plan (continued)

**A picture containing text, first-aid kit, table

Description automatically generated** When rescue therapy may be needed:

WHEN AND WHAT TO DO

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If seizure (cluster, #, and lenght: |  | | | |
| Name of Med/RX: |  | How much to give (dose): |  |
| How to give Med/RX: |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| If seizure (cluster, #, and lenght: |  | | |
| Name of Med/RX: |  | How much to give (dose): |  |
| How to give Med/RX: |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| If seizure (cluster, #, and lenght: |  | | |
| Name of Med/RX: |  | How much to give (dose): |  |
| How to give Med/RX: |  | | |

How to give care after seizure

|  |  |
| --- | --- |
| What type of help is needed (describe): |  |
| When is person able to resume usual activity: |  |

# Special instructions

|  |  |
| --- | --- |
| First Responders: |  |
|  | |

|  |  |
| --- | --- |
| Emergency Department: |  |
|  | |

Seizure Plan (continued)

# Daily seizure medicine

|  |  |  |  |
| --- | --- | --- | --- |
| Medicine Name | Total Daily Amount | Amount of Tab/Liquid | How Taken  (time of each dose and how much) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Other information

|  |  |  |  |
| --- | --- | --- | --- |
| Triggersr: |  | | |
| Important Medical Historyr: |  | | |
| Allergies: |  | | |
| Epilepsy Surgery  (type, date, side effects):: |  | | |
| Device: | VNS  RNS  DBS | Date Implanted:: |  |
| Diet Therapy: | Ketogenic  Low Glycemic  Modified Atkins  Other (Describe below) | | |
|  | | | |
| Special Instructions: |  | | |
|  | | | |

Health care contacts

|  |  |  |  |
| --- | --- | --- | --- |
| Epilepsy Provider: |  | Phone: |  |
| Primary Care Provider: |  | Phone: |  |
| Preferred Hospital: |  | Phone: |  |
| Pharmacy: |  | Phone |  |

Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| My signature: |  | Birth Date: |  |
| Provider signature: |  | Phone: |  |

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# Individual Health Care Plan Form (EEC)

To be completed by a licensed health care provider.

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s Name:** |  | **Date of Birth:** |  |

|  |  |
| --- | --- |
| **Name of Chronic Condition:** |  |

**Description of the chronic health care condition.**

|  |
| --- |
|  |

**Symptoms.**

|  |
| --- |
|  |

**Medical treatment necessary while at the program.**

|  |
| --- |
|  |

**Who has to be trained and will be administering this treatment while the child is in the program.**

|  |
| --- |
|  |

**Potential side effects of treatment.**

|  |
| --- |
|  |

**Potential consequences if treatment is not administered.**

|  |
| --- |
|  |

**(Optional) Other recommendation: further tests, treatments, mitigating measures, accommodations etc. required to allow for the child’s full participation.**

|  |
| --- |
|  |

## Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Licensed Health Care Practitioner:** |  | **Phone #:** |  |
| **LHCP Signature:** |  | **Date:** |  |
| **Parent/guardian:** |  | **Date:** |  |
| **Program Admin Signature:** |  | **Date:** |  |

# Acknowledgment of receipt of Parent Handbook

|  |  |  |  |
| --- | --- | --- | --- |
| **Child name** |  | **Street** |  |
| **Parent name** |  | **City, State** |  |

The Playful Minds Learning Center LLC (PFML) Parent Handbook has been made available to me and was available for download on the PFML website, and that, if I am not able to access the website, I had the option of receiving a printed copy.

I understand the policies in this handbook are subject to change to maintain compliance with current and future issuing of local, state, and federal regulation. And that, changes in the handbook may also occur at the authorization of the owner to indicate improvements in procedures, information sharing with staff and families, and other reasons, provided such changes do not violate local, state, and federal law.

I understand my child’s enrollment at PFML could be terminated if any problems listed in the *Termination and Suspension* (but not limited to) policy described herein occur.

I acknowledge that PFML staff discussed the policies in the handbook with me. I was given the time to ask questions and have them answered to my ability to understand them.

I, the Parent/Guardian, have read, understand, and agree to follow the policies and procedures required of me in this handbook.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent signature:** |  | **Date:** |  |

I, the Parent/Guardian, acknowledge that PFML staff discussed the Child Guidance policy in this handbook with me. I was given the time to ask questions and have them answered to my ability to understand them.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent signature:** |  | **Date:** |  |