

# School Age/K.O.T.G.

Route 37, Village Green  
New Fairfield, CT 06812  
(203) 746-5994



## Background Information Form

PLEASE PRINT OR TYPE ALL INFORMATION

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_

Birthdate \_\_\_\_\_ Place of Birth \_\_\_\_\_

Is any language other than English used in the home? \_\_\_\_\_

If so, describe \_\_\_\_\_

Address \_\_\_\_\_  
Street

Town \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Name of Mother or Guardian \_\_\_\_\_ Cell \_\_\_\_\_

Mother's home address \_\_\_\_\_ Home phone \_\_\_\_\_

Mother's occupation/company name \_\_\_\_\_ Work phone \_\_\_\_\_

Mother's work address \_\_\_\_\_ email \_\_\_\_\_

Name of Father or Guardian \_\_\_\_\_ Cell \_\_\_\_\_

Father's home address \_\_\_\_\_ Home phone \_\_\_\_\_

Father's occupation/company name \_\_\_\_\_ Work phone \_\_\_\_\_

Father's work address \_\_\_\_\_ email \_\_\_\_\_

Marital status of Parents \_\_\_\_\_ Custody \_\_\_\_\_

Visiting arrangements \_\_\_\_\_

Is there anyone to whom your child cannot be released? \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Relative or friend authorized to pick up your child:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Office Only**  
**School Age/K.O.T.G.**

M	T	W	Th	Fri
_____	_____	_____	_____	_____
A.M. only <input type="checkbox"/>				

List siblings and their ages: \_\_\_\_\_

Are there other members of the household? If so, list first name, age and relationship: \_\_\_\_\_

Does your child nap? \_\_\_\_\_ When? \_\_\_\_\_

What time does your child go to bed at night? \_\_\_\_\_ Wake up? \_\_\_\_\_

Does your child have any special fears? \_\_\_\_\_

Does your child have any problems with vision or hearing? If so, please explain: \_\_\_\_\_

Does your child have any medical or emotional problems? If so, please explain: \_\_\_\_\_

Do you have concerns about any aspect of your child's development? \_\_\_\_\_

Circle illnesses that your child has had: Chicken Pox Mumps Measles Chronic Ear Infections

Does your child have frequent Colds?  Sore Throats?  Stomach Aches?  Fevers?

Has your child had any serious accidents or operations? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

Does your child play well alone?  In groups?  Does your child accept correction easily? \_\_\_\_\_

What method of behavior control is used in your home? \_\_\_\_\_

Please note items below that describe your child:

Happy  Stubborn  Attentive  Aggressive

Impulsive  Shy  Quiet  Good-natured

Dependent

Other \_\_\_\_\_

Has your child been cared for by someone besides the family? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

Has your child gone to preschool, daycare, or had other group play experiences before? \_\_\_\_\_

If so, please describe previous experiences: \_\_\_\_\_

What do you hope will be included in your child's School Age program? \_\_\_\_\_

## **Parent Section**

Do you have any special talents or interests or know any interesting people or businesses that would be of interest to children? Would these individuals be willing to share their knowledge with the children? Please list below: \_\_\_\_\_

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## **Acceptance of School Policies**

Upon acceptance of your child to the Bright Beginnings School Age program it is necessary for each parent to have a conference with the Director and review the policy statement and complaint system.

I have read and understand all of the operating procedures of Bright Beginnings. I agree with the arrangements that have been made for my child.

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_

## **Consent Forms/Emergency Consent**

I give my permission to the person in charge at Bright Beginnings to make whatever emergency, i.e. first aid, disaster evacuation, measures as judged necessary for the care and protection of my child while under the supervision of the Center. These measures may include, but are not limited to the following:

1. Attempt to contact a parent or guardian
2. Attempt to contact the child's physician
3. Attempt to contact the parent through any of the authorized persons listed to pick up the child in emergency or medical situations
4. In the event that #1-3 are not successful,
  - a) call another physician
  - b) call the paramedics
  - c) have the child taken to an emergency hospital
  - d) release the child taken to an authorized emergency contact

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_

## **Field Trip Consent**

I give consent for my child, \_\_\_\_\_, to go on excursions from Bright Beginnings. I understand that all parents will be notified in advance of such trips.

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_

The School Age Program go on walking excursions to Town Park, Library, and other local destinations.

## **Photo Release Agreement**

The undersigned hereby relinquishes all rights for use and reproduction of photographs taken at Bright Beginnings. Bright Beginnings reserves all rights to use the said photographs, at no cost to Bright Beginnings, in promotional and publicity materials for the center.

Photograph subject name \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

## **Address/Records Consent**

I give permission to release my address, phone number, and email with parents of the Center

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_

I give permission to forward my child's records to the school systems.

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_

## **Permission to be Transported**

SCHOOL AGE

I give permission to New Fairfield Bright Beginnings, Inc. to release my child to the public bus-ing system or any other form of transportation. This includes back and forth from public school, field trips, town beach and in the event of an emergency.

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_