

2026-2027 BEFORE & AFTER SCHOOL PROGRAM REGISTRATION

Welcome to the 2026-2027 Before & After School Program!

Please read below for details about the required documents for registration. If you have any questions or concerns, feel free to contact the Before & After School Coordinator, Alex White, at awhite@bgcberkshires.org

REQUIRED DOCUMENTS:

CHILD'S ENROLLMENT FORM(S)

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM
Please make sure to have **updated** emergency contact information.

PERMISSION FOR USE OF ON-SITE SWIMMING POOL

PITTSFIELD PUBLIC SCHOOLS DAY CARE BUS REQUEST FORM

We highly recommend returning this form back to the coordinator as soon as possible, as bus spots fill up quickly. Bus form submissions will begin on 06/01/2025. Any forms submitted after this date will be processed as soon as possible, but availability may be limited.

ADDITIONAL REQUIRED DOCUMENTS (IF NECESSARY) PLEASE READ CAREFULLY:

INDIVIDUALIZED HEALTH CARE PLAN & MEDICATION CONSENT FORM

This form is for students who have allergies or require medication that needs to be administered by a certified staff member at the Boys & Girls Club of the Berkshires. Both forms must be signed by your child's doctor. Additionally, all necessary medications, including EpiPens, must be provided prior to your child's anticipated start date. Please note that Allergy & Medication Plans must be submitted yearly.

CONFIRMATION OF PROVIDER

This form is for all parents who currently have a voucher. Boys & Girls Club of the Berkshires uses Seven Hills Company for vouchers. Please submit this form in advance in order to receive your voucher agreement for your anticipated start date. If you do not have a voucher and want to apply you will need to fill out this form and contact Seven Hills Company

Please note: We are unable to guarantee a spot or placement until we receive bus assignments from the Pittsfield Bus Company. These notifications typically arrive in late July or early August. To ensure your child is considered for enrollment, all required paperwork and online registration must be completed and submitted at least two weeks prior to your child's anticipated start date.

For new families: Registration is not complete until you've submitted the required documents and the online form. Please complete registration by using the following link:

<https://schools.procareconnect.com/register/a4eeca9e-ff3d-4349-b732-422df80f54d4>

The Commonwealth of Massachusetts
Department of Early Education and Care

Child's Enrollment Form

Child Information

Child's Name: _____ Date of Birth: _____

Age at Admission: _____ Date of Admission: _____

Child's Home Address: _____

Home Phone Number: _____

Primary Language: _____ Identifying Marks: _____

Eye Color: _____ Hair Color: _____ Skin Color: _____

Sex: _____ Height: _____ Weight: _____

Parent/Guardian Information

Parent/Guardian Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

•-----•

Additional Information

Child's Physician: _____

Address: _____ Phone Number: _____

Allergies/Special Diets? _____

Individual Health Plan for child with a chronic health condition? If yes, please attach. _____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach. _____

Special limitations or concerns? _____

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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:**

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Parent/Guardian Signature

Date

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

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 and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____
Address: _____
Phone Number: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (*In order to be contacted*)

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 _____

| | |
|---------------------------------|------------------------|
| Health Insurance Coverage _____ | Policy # _____ |
| Parent/Guardian Name: _____ | Phone _____ Cell _____ |
| Parent/Guardian Name: _____ | Phone _____ Cell _____ |

Parent /Guardian Signature

Date (valid for one year)

SCHOOL/ _____ GRADE _____
AGENCY _____

DAY CARE BUS REQUEST FORM 2025-2026

NOTE: DAY CARE TRANSPORTATION MUST BE 5 DAYS A WEEK AT THE SAME LOCATION AND ON THE SAME BUS. ANY CHANGES DURING THE YEAR TO THIS ARRANGEMENT MUST BE IN WRITING.

Section A- Parent

Date _____

I am requesting that _____
(Student name)

Be picked up at this daycare before school

Be dropped off at this daycare after school

Day Care address _____

Signature of parent _____

Parent Telephone #: Home _____ Cell _____

Section B- Day Care Provider

As the day care provider for the above student, I accept the responsibility for this child to

Be picked up at this daycare before school

Be dropped off at this daycare after school

Day Care Provider Name (Print) _____

Day Care Provider Signature _____

Day Care telephone number: _____ cell _____

Section C- Please End Daycare

(Sign here only to end your daycare arrangement)

Parent Signature _____ Date _____

MUST BE RESUBMITTED YEARLY STARTING JUNE 1st
FAX – 447-7573

EEC Individual Health Care Plan Form

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Name of child: | Date of Birth: |
| Name of chronic health care condition: | |
| Description of chronic health care condition: | |
| Symptoms: | |
| Medical treatment necessary while at the program: | |
| Who has been trained and will be administering this treatment while the child is at the program: | |
| Potential side effects of treatment: | |
| Potential consequences if treatment is not administered: | |
| (Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.) | |

Name and Phone Number of Licensed Health Care Practitioner (please print): _____

Parental/Guardian Signature: _____ Date: _____

Program Administrator Signature: _____ Date: _____

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Topical Non-Prescription (**applied to open wound/ broken skin**) _____

My child has previously taken this medication _____

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

Child's Health Care Practitioner Signature _____ **Date** _____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date** _____

For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only**)



MASSACHUSETTS CHILD CARE RESOURCE & REFERRAL

CONFIRMATION OF PROVIDER

Once you have chosen the child care provider who will care for your child(ren), you can have **the provider complete** this form to help confirm the information we need to issue the voucher. If you will be using more than one provider, use one form per provider. Please Print Clearly.

Parent Name: _____

FID (if applicable): _____ **Phone Number (Optional):** _____

Child #1: _____ **Child #2:** _____

Child #3: _____ **Child #4:** _____

Program Type: Child # 1: _____; Child # 2: _____; Child # 3: _____; Child #4: _____

Please use the following **Program Type Abbreviations** when completing the section above:

Family Child Care:

NU (Under 2 w/ Independent Provider);

NO (Over 2 w/ Independent Provider);

SU (Under 2 w/ System Provider);

SO (Over 2 w/ System Provider);

Center Based Child Care:

IN (Infant); TO (Toddler); PS (Preschool); HS (Headstart);

BA (Before & After School); BS (Before School); AS (After School);

SCO (School Closures Only); SA (School Age – Summer Only)

PROVIDER INFORMATION - To be completed by the Child Care Provider OR System Admin:

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| What is your program/agency name, address and phone number? <small>(Systems: Please write the FCC providers Name, Physical Address, and then your agency)</small> | |
| What is the <u>expected</u> date of enrollment for the child(ren)? <small>(This date should only be filled out when you have officially received all required documentation from the family for this child to attend your program.)</small> | |
| Until what date will you hold a spot for the child(ren)? <small>(If the voucher must start after the date provided, the Child Care Resource and Referral Agency will contact you to confirm the opening. Otherwise, this form will serve as confirmation for the child to enroll)</small> | |
| Please circle one <small>(Full time = Full Day Part Time = Half Day INT = Vacation Days/Non School Days)</small> | Full time Part time INT |
| Please circle the days care will be provided | Su Mo Tu We Th Fr Sa |
| Please circle one- Is the parent requesting transportation services to be included on the voucher? <small>(Subject to approval by the Child Resource and Referral Agency)</small> | No One Way Two Way |

This form is NOT confirmation that a voucher will be issued. Pursuant to your Voucher Agreement, you will only be reimbursed for **enrolled children with a signed, current voucher.** Children are not considered enrolled in subsidized care until **the first day the child actually attends the program following the start date indicated on the voucher.**

Provider/System Admin Signature

Date

Provider/System Admin Name (Printed)

Provider Email

Provider Phone Number

PAYMENT POLICY

After School Program billing is done through Vanessa Gagnon in the Finance Office. If you have any questions or concerns about billing, please contact Vanessa via her contact information at the bottom of this page. The After School Program is a 5-day program, which means when you enrolled in the program, you signed your child up for 5 days per week. You will still be charged even if they do not attend five days per week.

Absences: If at any time your child is absent on a day in which they are enrolled, you are still charged for that day at your regular rate and are responsible for that payment. Please remember to call or message the program when your child will be absent.

Holidays: There are holidays that fall on various days during this school year where school is not open, but the After School Program is. Please check with the program director or staff for more information.

School Closings: Please refer to our website and social media to determine if we are still open on days that school is closed.

Delinquent Accounts: Monthly payments are due by the seventh (7th) of each month. If your payment is not received by the seventh, your child will not be able to attend the program and the After School Program Coordinator will contact you when your child arrives at the club. If your account is more than two weeks past due, the After School Program Coordinator and/or Vanessa Gagnon will schedule a meeting with you to get back on track. If you disregard our attempts to contact you, it may result in your child's dismissal from the After School Program. In order to participate in the After School Program along with all other club programs, you must remain current with your payments. **Consistent late payments will result in termination of your child's slot.**

***Payment Policy Agreement**

I have read and understand the parent handbook policies. I agree to make monthly childcare payments by the seventh of each month that my child is enrolled in the Boys & Girls Club of the Berkshires Before and After School Program. I understand that consistent late payments will result in termination of my child's slot in the program along with any other programs that they are enrolled in at the Club.

Parent Name: _____ Date: _____

Parent Signature: _____ Date: _____

Alex White, Program Coordinator
awhite@bgcberkshires.org
413-448-8258 ext. 25

Vanessa Gagnon
vgagnon@bgcberkshires.org
413-448-8258 ext. 33

For Office Use Only: ____/____/____ DATE RECEIVED