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?
_____

_____

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:***

_____ _____
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

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

Off Site Permission Form

I give my child _____
permission to take neighborhood walks.

_____ _____
Parent/Guardian signature Date

*First aid bags are brought with us at all times.

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____

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

MY 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

CHILD'S NAME:_____

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

MY 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

PARENT /GUARDIAN SIGNATURE_____ DATE_____

REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

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 (marked *) as appropriate to the age of your child.

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

*Are disposable or cloth diapers used? _____*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 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)

Dear Physician: _____
(Child's Name)
is enrolled in an early childhood program licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____
Address: _____ Phone # _____
Name of Parents: _____
Address: _____
Date of Examination of Child: _____
What is your opinion concerning the child's general health and appearance:
_____
_____
_____
Has this child been screened for lead poisoning? Yes _____ No _____
If Yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:
_____
_____
_____
Physician's Signature:
_____
Date: _____ Comments:
_____
_____
_____
Please return to Program:
_____

EMERGENCY CARD INFORMATION

Child's Name:_____
Date of Birth:_____
Child's Home Address:_____
_____ Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1._____
(Name, Address, Phone #)
2._____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone#)

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #)
2. _____
(Name, Address, Phone #)

MEDICAL EMERGENCY TREATMENT

I hereby give _____
(Name of program)
permission to administer basic first aid and/or CPR to my child _____ and/or take my child (Name)

_____, to a hospital for medical
(Name)
treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____
(Parent Signature) (Date)

INSURANCE INFORMATION (OPTIONAL)

Company Name:_____ Policy _____
Participating Hospital:_____
Special Instructions:_____