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

CONSENT FOR CHILD TO LEAVE THE PROGRAM
(MUST BE AGE 9 OR OLDER)

Program Name: _____

Address: _____

_____

I, _____ authorize my child, _____
(Parent/Guardian's Name) (Child's name)

to leave the program. This permission is in effect from _____ to _____.
(Date) (Date)

Activity/Location	Method of Transportation	Leave/Return Time	Restrictions

I understand that the program has the right to rescind the above privilege if my child's behavior warrants the limitation.

I recognize that my child will not be supervised by staff while s/he is away from the program.

I understand I am responsible for my child once s/he leaves the program.

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Program Staff Signature) (Date)

SAMPLE CONTRACT FOR CHILDREN 9 YEARS AND OLDER
FOR LEAVING THE PROGRAM

Program Name:_____

Address:_____

I_____, understand that the permission I have received
(Child's Name)
to leave the program is a privilege granted to me. This privilege is based on my parent(s)/ guardian(s) and the staff's expectations of my ability to be responsible for my safety and well-being while I am away from the program.

By signing this contract I agree to the following:

I will always check in with a staff person when arriving and before departing from the program.

I will go only to the destinations agreed to by my parent(s)/guardian(s) and will inform staff of my destination each time I leave the program.

I will act in a safe and courteous manner while I am away from the program.

I will return to the program at or before the time designated by my parent(s)/guardians(s) or by the staff. If I am going to be returning late, I will call the program to inform them of when I will be returning and why I am late.

I will abide by all restrictions listed by my parent(s)/guardians(s) on the authorization and consent form.

Further, I will understand that if I do not abide by the agreements made above, both my parent(s)/guardian(s) and /or the program, as a consequence for my actions may take away my privilege to leave the program for a time period deemed appropriate by them.

_____ _____
(Child's Signature) (Date)

As _____ parent/guardian, I agree with this contract.
(Child's Name)

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Program Staff 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)

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

OFF SITE ACTIVITIES PERMISSION FORM

Section 1 - Program completes prior to parental consent

Program: _____

Name of Educator(s) responsible for child: _____

Name of off-site location and address: _____

_____

Date of off-site activity: _____ Time Leaving Program:_____ Time Returning to Program:_____

Method of Transportation: _____ Fee associated with activity (if any): _____

NOTE Each child must carry on his/her person the name, address, and telephone number of staff or child care program whenever she/he is off the premises in care of the program.

Section 2 – Parent/Guardian completes prior to off-site activity

I give permission for my child to attend the above identified off-site activity

Child's Name: _____ Child's Date of Birth: _____

Parent's/Guardian's Name: _____ Phone Number: _____

I authorize child care program staff to secure necessary emergency medical treatment

Name of child's Physician, Address, phone number: _____

_____

Child's allergies, health conditions, or Individual Health Plan: _____

_____

Health Insurance Plan and Policy #: _____

Emergency Contact Name: _____ Contact #: _____

_____ _____

(Parent/Guardian Signature) (Date)

This form must accompany each child on the off-site activity

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

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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 (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)