

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 _____ Cell _____

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date (valid for one year)

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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Massachusetts Department of Public Health  
**CERTIFICATE OF IMMUNIZATION**

Name: \_\_\_\_\_

Date of Birth:        /        /

Sex:     female     male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
		4			
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		<b>Measles, Mumps, Rubella</b> (MMR)	1	
	2			2	
	3		<b>Varicella</b> (Var)	1	
	4			2	
	5		<b>Hepatitis A</b> (HepA)	1	
	6			2	
	7				
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1	
	2			2	
	3		<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
<b>Pneumococcal Conjugate</b> (PCV7)	1		<b>Other:</b>	3	
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

\* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) \_\_\_\_\_

Date:        /        /

Signature: \_\_\_\_\_

Facility name: \_\_\_\_\_

Meeting House Child Care Center  
848 Beacon Street  
Newton Centre, MA 02459

Permission is granted for \_\_\_\_\_ to receive during the next 12 months the following over-the-counter medications as needed while in child-care. It is understood that attempts to reach the parent(s) will be made prior to the administration of acetaminophen, ibuprofen or diphenhydramine.

(Dosages are provided in milligram amounts; the amounts will vary depending on the concentration of the preparation. Feel free to amend this form to meet individual preferences.)

Weight at last exam: \_\_\_\_\_ pounds

Acetaminophen (Tylenol®)      **80 mg for every 12 pounds** every 4 hours for discomfort or fever > 101°

Dose: \_\_\_\_\_ mg

Ibuprofen (Advil® or Motrin®)      **50 mg for every 11 pounds** every 6-8 hours for severe discomfort or fever unresponsive to acetaminophen

Dose: \_\_\_\_\_ mg

Diphenhydramine (Benadryl®)      **6.25 mg (1/2 teaspoon) for every 11 pounds** every 4-6 hours for mild allergic reactions, up to 50 mg (4 teaspoons)

Dose: \_\_\_\_\_ mg

Sunscreen (as needed)

Other: \_\_\_\_\_

Pediatrician \_\_\_\_\_ Date \_\_\_\_\_

Parent(s) \_\_\_\_\_ Date \_\_\_\_\_

**INFANT SNACKS**  
**(up to age 14 months)**

Whole Milk  
Water

Oyster crackers  
Fig Newtons  
Cheerios  
Cheddar gold fish  
Pretzels fish  
Saltines  
Round snack crackers

Animal Crackers  
Graham cracker  
Pancakes  
Wheat Bread  
Bagels  
Kix  
Mini Waffles

Gerber Puffs - Banana , Strawberry/Apple, Veggie, Sweet Potato and Sweet Corn

Blueberries  
Bananas  
Grapes (cut in quarters)  
Canned pears and peaches  
Veggie Stix

Frozen Peas  
Cucumber  
Watermelon  
Cantaloupe

Applesauce  
Strawberries  
Honeydew  
Cooked Carrots

Cream cheese  
Cheddar cheese  
American cheese  
Vanilla Yogurt

Cottage Cheese  
Hummus  
Butter and Margarine

Two snacks are served daily. Water is offered throughout the day. If there is anything on this list you **do not** wish for your child to have please circle the item(s) and pass it back to us.

A weekly menu is posted in your child's classroom.

Occasionally classrooms will be cooking foods for snacks. We will make every effort to assure that ingredients used are allergen free. If you have any concerns, please talk with your child's teachers about checking recipe ingredients in advance.

Child's Name: \_\_\_\_\_

Parent's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Topical Medication (non-prescription)

I authorize the Meeting House Child Care Center staff to administer the following to my

Child \_\_\_\_\_.  
Child's name

Diaper rash or rash prevention:

1. \_\_\_\_\_

2. \_\_\_\_\_

Sunscreen:

1. \_\_\_\_\_

2. \_\_\_\_\_

First Aid cream for cuts, splinters, scrapes:

1. \_\_\_\_\_

2. \_\_\_\_\_

Neosporin: Check if okay \_\_\_\_\_

Other creams and ointments:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Field Trip Authorization and Consent Form

I, \_\_\_\_\_, hereby give permission for my child \_\_\_\_\_,  
to participate in supervised walks and strolls around Newton Centre with the teachers of Meeting  
House Child Care Center.

.

I understand that my child may be taken to interesting area sites, such as Crystal Lake, where  
s/he will explore and play under the supervision of a qualified teacher.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Facebook and Directory Information Form

Please fill out the following information for your child to be included in this year's facebook and directory.

<i>Child's Name</i>		<i>Child's Birthday</i>	
<i>Child's nickname</i>			
<i>Address</i>			
<i>Parent's Names</i>			
<i>Sibling's Names and Ages</i>			
<i>Preferred contact information (please note work, cell or home)</i>			
<i>Days child attends MH</i>		<i>Child's Classroom</i>	
<i>Parents' Email addresses</i>			
<i>Parent's professions</i>			
<i>Family fun activities</i>			

Please either attach (via paper clip) or email a picture of your family (preferably the whole family). Please indicate who is in the picture (i.e. from left to right, Jane, Jane's Mom, Jane's Dad, and Jane's Dog). You can email the pictures to [facebook@meetinghousechildcare.com](mailto:facebook@meetinghousechildcare.com).

Please return this form by September 15<sup>th</sup> to be included in the hard copy of the Facebook and Directory.

## Digital Imaging Authorization and Consent Form

I, \_\_\_\_\_, hereby give permission for my child \_\_\_\_\_, to have his/her image captured both on film and electronically by the staff of Meeting House Child Care Center.

Please select one option below.

I give MHCCC authorization to take pictures and videos of my child to be distributed to the MHCCC community and consent to the use of images of my child on the center website.

I give MHCCC authorization to take pictures and videos of my child to be distributed to the MHCCC community, but do not consent to use of any images of my child on the center website.

I do not give MHCCC authorization to take pictures and videos of my child.

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Signature

Date