

# GROUP CHILD CARE AND SCHOOL AGE CHILD CARE CHILD'S ENROLLMENT FORM

Program:	Group Child Care:	School Age Care:
<b>Child's Name:</b>	Eye Color:	Skin Color:
Home Address:	Hair Color:	Height:
Telephone:	Sex:	Weight:
<b>Date of Admission:</b>	Age at Admission:	
Date of Birth:	Primary Language:	
Identifying Marks:		
Allergies / special diets:		

**PARENT/GUARDIAN INFORMATION:**

Parent/Guardian Name:	Parent/Guardian Name:
Relationship to child:	Relationship to child:
Home Address:	Home Address:
Home Telephone #:	Home Telephone #:
Bus. Name:	Bus. Name:
Bus. Address:	Bus. Address:
Bus. Telephone #:	Bus. Telephone #:
Hours at Work:	Hours at Work:

**ADDITIONAL INFORMATION:**

Child's Physician/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Chronic health conditions: \_\_\_\_\_

Special limitations or concerns: \_\_\_\_\_

**SCHOOL AGE ONLY**

Current School: \_\_\_\_\_ School Address: \_\_\_\_\_

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

**GROUP CHILD CARE AND SCHOOL AGE CHILD CARE  
FIRST AID AND EMERGENCY MEDICAL CARE  
CONSENT FORM  
102 CMR 7.09(3)**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid 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*)**

1. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person?    Yes                      No	
2. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person?    Yes                      No	
3. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person?    Yes                      No	

Health Insurance Coverage: _____	Policy #: _____
Parent(s) Name: _____	Phone(w)                      Phone (h)
Parent(s) Name: _____	Phone(w)                      Phone (h)

\_\_\_\_\_  
**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: \_\_\_\_\_

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

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 ROOM SNACKS

Whole Milk  
Cheerios  
Water

Oyster crackers  
Fig Newtons  
Graham crackers  
Cheddar gold fish  
Saltines  
Wheat round snack crackers  
Gerber Puffs- Banana, Strawberry/ Apple, Veggie, Sweet Potato and Sweet Corn

Apple sauce  
Banilla & Vanilla yogurt

Bananas  
Grapes (cut in quarters)  
Cucumber  
Diced Peaches

Cream cheese  
Cheddar cheese  
American cheese

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 me.

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:

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Parent's Signature:

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Date:

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## 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

## 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** \_\_\_\_\_

\*Note: 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 the 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 walking 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: \_\_\_\_\_

## 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.