

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: \_\_\_\_\_

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

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**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)

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)

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:**

**MY CHILD WILL DEPART FROM THE PROGRAM:**

\_\_\_ PARENT DROP OFF

\_\_\_ PARENT PICK UP

\_\_\_ SUPERVISED WALK

\_\_\_ SUPERVISED WALK

\_\_\_ UNSUPERVISED WALK

\_\_\_ UNSUPERVISED WALK

\_\_\_ PUBLIC/PRIVATE/VAN

\_\_\_ PUBLIC/PRIVATE/VAN

\_\_\_ PROGRAM BUS/VAN

\_\_\_ PROGRAM BUS/VAN

\_\_\_ CONTRACT/VAN

\_\_\_ CONTRACT/VAN

\_\_\_ PRIVATE TRANS. ARRANGED BY PARENT

\_\_\_ PRIVATE TRANS. ARRANGED BY PARENT

\_\_\_ OTHER

\_\_\_ OTHER

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CHILD'S NAME: \_\_\_\_\_

**MY CHILD WILL ARRIVE AT THE PROGRAM:**

**MY CHILD WILL DEPART FROM THE PROGRAM:**

\_\_\_ PARENT DROP OFF

\_\_\_ PARENT PICK UP

\_\_\_ SUPERVISED WALK

\_\_\_ SUPERVISED WALK

\_\_\_ UNSUPERVISED WALK

\_\_\_ UNSUPERVISED WALK

\_\_\_ PUBLIC/PRIVATE/VAN

\_\_\_ PUBLIC/PRIVATE/VAN

\_\_\_ PROGRAM BUS/VAN

\_\_\_ PROGRAM BUS/VAN

\_\_\_ CONTRACT/VAN

\_\_\_ CONTRACT/VAN

\_\_\_ PRIVATE TRANS. ARRANGED BY PARENT

\_\_\_ PRIVATE TRANS. ARRANGED BY PARENT

\_\_\_ OTHER

\_\_\_ OTHER

PARENT /GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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