Small World Preschool
& Childcare Center

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

Program: Group Child Care: School Age Care:
Child's Name: Eye Color: Skin Color:
Home Address: Hair Color: Height:
Telephone: Sex: Weight:
Date of Admission: 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:
Cell Phone: Cell Phone:
Business Name: Business Name:
Business Address: Business Address:
Business Telephone: Business 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

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 a 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 in lap? _____ High chair? _____

*Does your child eat with a 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 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: _____

EMERGENCY CARD INFORMATION

Child's Name: _____
Date of Birth: _____

Child's Home Address: _____

_____ Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. _____
(Name, Address, Phone Number)

2. _____
(Name, Address, Phone Number)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Name, Address, Phone Number)

EMERGENCY CONTACT PERSON (S)

1. _____
(Name, Address, Phone Number)

2. _____
(Name, Address, Phone Number)

MEDICAL EMERGENCY TREATMENT

I hereby give _____
(Name of program)
permission to administer basic first aid and/or CPR to my child _____
(Name)
and/or take my child _____, to a hospital for medical treatment when
(Name)
I cannot be reached or when delay would be dangerous to my child's health.

_____ _____
(Parent Signature) (Date)

INSURANCE INFORMATION (OPTIONAL)

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

CONSENT FORM
100CMR 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 Contact (In order to be contacted)

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

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

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**

FirstAidEmergencyCareConsent20050701

We need four permission slips to be placed into our files.

Photographs:

We would like to take pictures of your children and we need your permission. We will be using these photos

throughout our classroom displays as well as placing them on our webpage and facebook page.

Walking Field Trips:

We frequently take walks during the week and we need your permission to take your child along. Some examples of such excursions are: the local cemetery the local elementary school playground, the fire station, police station, library, lunch, or ice cream trips to town. Any field trips requiring business or other transportation will need an additional permission slip to be signed prior to departure.

Sunscreen:

All efforts are made to avoid excessive sun exposure to children in our care; however, as we are outside on a daily basis we feel that children require the additional protection that sunscreen has to offer. Permission is required for the application of topical creams and ointments.

Insect Repellent:

Sometimes, in the later afternoon, the mosquitoes seem plentiful and it is necessary to apply bug repellent. We typically use DEET free products which are effective for a shorter period of time but, for our use, seem acceptable. We will apply as sparingly as possible and only when necessary, with most of the application to be placed on clothing as opposed to exposed skin areas.

Wading Pools:

Small World uses small pools during the summer which typically contain two or fewer feet of water. Children are always within site of teaching staff.

PLEASE SIGN THE SLIPS BELOW (TO BE PLACED IN EACH INDIVIDUAL FILE)

_____

Date: _____

Child's Name: _____

I give Small World Preschool and Child Care Center permission to take photos of my child for the classroom _____, the website _____, and our facebook page.

I give Small World Preschool and Child Care Center permission to take walking field trips with my child _____.

I give Small World Preschool and Child Care Center permission to apply sunscreen on my child on an as needed basis _____.

I give Small World Preschool and Child Care Center permission to apply bug repellent as necessary on my child _____.

I give Small World Preschool and Child Care Center permission to allow my child to use the "kiddie" pools which are emptied and cleaned daily _____.

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: **Small World Preschool**
52 Sugarloaf Street
South Deerfield, MA 01373

GCCPhysicianStatement20050701

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
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		**Haemophilus influenzae type b (e.g., Hib, HepB-Hif, DTaP-Hib)**	1	
	2			2	
	3			3	
				4	
Diphtheria, Tetaus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		**Measles, Mumps, Rubella (MMr)**	1	
	2			2	
	3				
	4				
	5				
	6				
	7				
Polio (e.g., IIPdV, DTaP-HepB-IPV)	1		**Varicella (Var)**	1	
	2			2	
	3				
	4				
Pneumococcal Conjugate (PCVT)	1		**Pneumococcal Polysaccharide (PPV23)**	1	
	2			2	
	3				
	4				
Hepatitis A (HepA)	1		**Influenze Inactivated (Intramuscular) or Live (Intranasal)**	1	
	2			2	
				3	
			Other:		

Revised June 2004

Serologic Proof of Immunity **Check One**

Test (if done)	Date of Test	Positive	Negative
Measles			
Mumps			
Rubella			
Varicella*			
Hepatitis B			

Chickenpox History
Does this person have a physician-certifies reliable history of chickenpox? _____ Yes _____ No Reliable history may be based on: ● Physician interpretation of parent/guardian description of chickenpox ● Physical diagnosis of chickenpox, or ● Serologic proof of immunity.

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: _____