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

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

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_____

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

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

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___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

Sick and Medication Policy

Only prescription medication will be given to your child. Please be sure to sign an authorization form from the Director.

If your child is sent home ill and a doctor's visit is not necessary, then your child must remain home for a 24 hour "get well period". Please have a back up person who can pick up your child if you cannot leave work. If your child has been seen by a doctor, please bring a note from the doctor stating that your child is no longer contagious and is well enough to attend. When your child returns to the center, if their condition should deteriorate and appear to be not improving, we would request another doctor's note stating that your child can be at the center.

We would use the following guidelines when we send a child home:

-Fever (Over 100 Degrees)

-Heavy or excessive coughing

-Discharge from the nose that is colored

-Vomiting or diarrhea

-An unusual rash

Photograph, Video and Internet Permission Form

I give permission to the Story Tree Children's Center for my child (ren) to be photographed, videotaped and posted via internet in the course of activities at the Story Tree Children's Center with the understanding that these photographs may be used by the Story Tree solely for promotional and advertising purposes as defined and authorized by the Story Tree Children's Center.

Name (s) of Children: _____

_____

Signature of Parent/Guardian: _____

Date: _____

ENROLLMENT AGREEMENT

CONTRACTED DAYS FOR EACH WEEK:	CONTRACTED HOURS FOR EACH DAY:
Monday	From:_____ to_____
Tuesday	From:_____ to_____
Wednesday	From:_____ to_____
Thursday	From:_____ to_____
Friday	From:_____ to_____

REGISTRATION FEE $35.00/child $60.00/family (YEARLY)

LATE PAYMENT $5.00/day (STARTING MONDAY)

LATE PICK UP FEE $10.00 per every 15 minutes (AFTER 4:30PM)

RETURNED CHECK FEE $30.00 (MONEY ORDERS OR CASH ARE REQUIRED IF CHECKS ARE RETURNED)

WITHDDRAWAL A TWO WEEK WRITTEN NOTICE (YOU MAY CHOOSE TO PAY THE TWO WEEKS AND NOT BRING YOUR CHILD)

To insure we are keeping proper staff/child ratios at all times we have set up contracts with your drop off/pick up times. Any day over nine hours you will be charged an additional $ 5.00 per hour per child. If you need to drop off earlier or pick up later than your contracted times, you will need prior approval and will be charged accordingly.

I, _____have read and understand the Parent Handbook and the Enrollment Agreement.

Signature _____.

Date _____.

Date: _____

Start Date: _____

Parent's Name(s): _____

_____

Phone: _____

Parent's email address:_____

Parent's email address:_____

Child/ren Name(s):_____

_____

Date of Birth: _____

Days: M T W TH F

Drop-off Time:_____

Pick-up Time:_____

Referred By: _____