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)**

SG/LG/SAEmergencyMedicalConsent20100122

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:** _____

hopkinton

CHRISTIAN PRESCHOOL

Transportation Plan and Authorization 7.13(1&2)

Child's Name: _____

My child will arrive at the program (check all that apply):

____ Parent drop off

____ Transportation arranged by parent (i.e., friend or family)

____ Other _____

My child will depart from the program (check all that apply):

____ Parent pick-up

____ Transportation arranged by parent (i.e., friend or family)

____ Other _____

I understand that HCP will not release my child to anyone without my authorization.

Parent Signature: Date:

FAITH COMMUNITY CHURCH

hopkinton

CHRISTIAN PRESCHOOL

Photography Authorization Form

From time to time during the school year, the Hopkinton Christian Preschool (HCP) or Faith Community Church of Hopkinton will take photographs or make audio or video recordings of children involved in HCP activities for educational, informational or promotional purposes. Occasionally, local newspapers seek permission to photograph children participating in the HCP educational program. At no time, will any photograph or recording of any child be sold for commercial purposes. *Please fill out and sign the appropriate statement below and return to HCP.*

Child's Name (please print) _____

To GRANT permission to use your child's picture

☐ **I GRANT** permission for photographs and recordings of my child taken by the Hopkinton Christian Preschool and/or Faith Community Church of Hopkinton to be used in print, on the church website (www.faithMA.org/www.hopkintonpreschool.org), in the church's newsletters or bulletins, programs, or in church video presentations. I understand that if I give notice to the Director of HCP or to the Faith Community Church Director of Children's Ministry that I object to any particular picture on the website, it will be removed as soon as possible. In all publications, I give permission to identify my child by (check one):

_____ first and last name

_____ first name only

_____ I do not want my child identified by name in any way

To Refuse permission to use your child's picture

☐ **I REFUSE** to grant permission for photographs and recordings of my child taken by the Hopkinton Christian Preschool and/or Faith Community Church of Hopkinton to be used in print, on the church's website (www.faithMA.org/www.hopkintonpreschool.org), in the church's newsletters or bulletins, programs or in church video presentations. Any photographs or presentations which include a recognizable picture of my child may not be used unless I change this statement with written permission.

Signature of parent_____ **Date**_____

Local media

_____ **Yes,** I give permission for the local media to photograph, audiotape and/or videotape my child to highlight educational purposes or activities. I give permission to identify my child by (check one):

_____ first and last name

_____ first name only

_____ **No,** I do not give permission for the local media to photograph, audiotape and/or videotape my child.

Signature of parent_____ **Date**_____