



Child's Enrollment Form

Child Information

Child's Name: _____ Date of Birth: _____ Age at Admission: _____

Child's Home Address: _____ Date of Admission: _____

Home Phone Number: _____ Cell Phone Number: _____

Sex: _____ Identifying Marks: _____ Eye Color: _____ Height: _____ Weight: _____

Hair Color: _____ Skin Color: _____ Primary Language: _____

Parent/Guardian Information

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Relationship to Child: _____ Relationship to Child: _____

Home Address: _____ Home Address: _____

Home Phone Number: _____ Home Phone Number: _____

Cell Phone Number: _____ Cell Phone Number: _____

Email Address: _____ Email Address: _____

Business Name: _____ Business Name: _____

Business Address: _____ Business Address: _____

Business Phone Number: _____ Business Phone Number: _____

Hours at Work: _____ 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, restraining orders pertaining to the child? If Yes please attach: _____

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: _____



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 _____

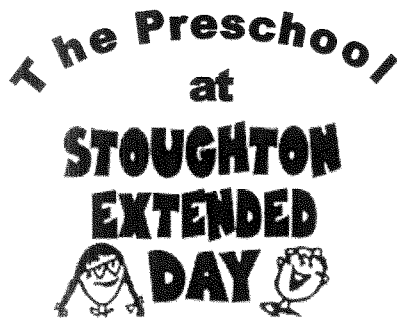
Health Insurance Coverage _____ Policy # _____

Parent/Guardian Name: _____ Phone _____ Cell _____

Parent/Guardian Name: _____ Phone _____ Cell _____

Parent /Guardian Signature

Date (valid for one year)



P.O. Box 257, 137 Walnut Street, Stoughton, MA 02072-0257 781-341-0886 Fax 781-341-0885

Child(ren)'s Name: _____

Photo Permission

I do / do not (circle one) give permission for the above stated child(ren) to be photographed as part of the Stoughton Extended Day Program and may be used for promotional material web page displays, and any other materials associated with Stoughton Extended Day, Inc.

Parent / Guardian Signature: _____ Date: _____

Walking Trip Permission

I do / do not (circle one) give permission for the above stated child(ren) to go on walking trips to the C.A.P.P. playground, Stoughton Public Library, and to the surrounding neighborhood of the Jones School.

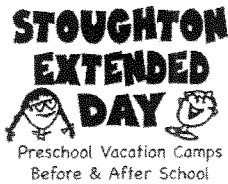
Parent / Guardian Signature: _____ Date: _____

Sunscreen and Bug Repellent Release

I do / do not (circle one) give permission for the above stated child(ren) to have sunscreen and/or bug repellent applied by SED staff. You, the parent or guardian, must supply the sunscreen/bug repellent in the original container(s) labeled with you child's name. SED will make every effort to apply the sunscreen and /or bug repellent as directed. However, SED has no control over which products or brands are provided and their effectiveness. You must understand that if your child does get burned or bitten, neither SED nor its staff may be held responsible. You should also apply the sunscreen/bug repellent to your child before arriving at camp.

Parent / Guardian Signature: _____ Date: _____

***We also need a copy of your child(ren)'s immunizations from your child's Physician. This must include a current lead screening.**



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:

- ___ SUPERVISED WALK
- ___ UNSUPERVISED WALK
- ___ PUBLIC/PRIVATE/VAN
- ___ PROGRAM BUS/VAN
- ___ CONTRACT/VAN
- ___ PRIVATE TRANS. ARRANGED BY PARENT
- ___ PARENT DROP OFF
- ___ OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

- ___ SUPERVISED WALK
- ___ UNSUPERVISED WALK
- ___ PUBLIC/PRIVATE/VAN
- ___ PROGRAM BUS/VAN
- ___ CONTRACT/VAN
- ___ PRIVATE TRANS. ARRANGED BY PARENT
- ___ PARENT PICK UP
- ___ OTHER

I give permission for my child to be released from the program at the end of the program day as stated above and /or I give permission to the following people to receive my child at the end of the day. (If no one is authorized other than the parent/legal guardian please indicate below "NO ONE".)

***IF A CHILD IS PROTECTED BY A RESTRAINING ORDER PLEASE SUBMIT ORDER TO THE PROVIDER.**

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ CELL _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ CELL _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ CELL _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ CELL _____

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:** _____

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 _____