CHILDREN'S CORNER

Pre-enrollment Package

Thank you for your interest in Children's Corner! The following are the required pre-enrollment forms that must be completed before your child's first day at Children's Corner. Please take your time to fill these out carefully and be sure to let us know if you have any questions. This information is important to maintain the safety and health of your child.

We look forward to providing your family with exceptional child care services!

Respectfully,

Alina A. Laverdure

Alina A. Laverdure
Director

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Child Registration Form

Child's Name _____

Parent's Name(s) _____

Address _____

_____

Telephone _____

Alternate Telephone _____

E-mail Address _____

Days Required (circle)

M T W T F

Arrive/Depart Times

_____ **IN** _____ **OUT**

Start Date _____

Child's Date of Birth _____

Parent Signature _____

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

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☐

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)

EMERGENCY CARD INFORMATION

Child's Name:_____
Date of Birth:_____

Child's Home Address:_____

_____ Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1._____
(Name, Address, Phone #)

2._____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone#)

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

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
(Name)
treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____
(Parent Signature) (Date)

INSURANCE INFORMATION (OPTIONAL)

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

PARENT PERMISSION FOR PHOTOGRAPHS, VIDEOS AND NEIGHBORHOOD WALKS

I understand that photographs and/or videos will be taken of the children attending the Children's Corner Child Care Center occasionally. These photos/videos may be used for teaching, documentation or research, personal remembrances for staff and parents and occasionally for public or promotional purposes.

I give my permission to Children's Corner Child Care Center to take pictures and/or video my child.

_____	_____	_____
Parent's Signature	Child's Name	Date

I give consent for my child, _____, to take part in neighborhood walks under proper supervision.

_____	_____
Parent's Signature	Date

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: _____

_____

_____

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

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

Please Return

SAMPLE

Oral Health Non-Participation Form

In January 2010, EEC issued new regulations for child care programs that include a requirement that educators assist children with brushing their teeth if children are in care for more than four hours or if children have a meal while in care [606 CMR 7.11(11)(d]. This regulation is intended to:

- Help children learn about the importance of good oral health
- Provide information and resources regarding good oral health to child care programs and families
- Help address the high incidence of tooth decay among young children in Massachusetts, which is associated with numerous health risks.

EEC licensed programs must comply with this regulation. However, parents may choose that their child (ren) not participate in tooth brushing while present at the child care program.

You do not need to fill out this form to have your child (ren) participate in tooth brushing while they are in child care. However, if you <u>do not</u> want your child to brush his or her teeth while s/he is attending the child care program, please fill out the information found below. A separate form must be filled out for each child in care. This form must be renewed annually and will be kept in your child's record at the program. Should you change your mind and wish for your child to participate in tooth brushing, this form may be withdrawn at any time by requesting in writing that it be removed from your child's file. Thank you.

I do not wish to have my child participate in tooth brushing while in care at

_____
(Name of Program)

Child's Name: _____

Parent/Guardian's Name: _____

Signature: _____

Date: _____

If you have any questions or concerns, please call:

_____ at _____
(Contact Person at Program) (Phone Number)

Please return

Updated Contact Information

Dear Parents:

Please fill all the information below.

As soon as I collect all the information below and enter it in my computer, I will start e-mailing you reminders, memos, Holiday closures, severe weather delays or closings and keep you up-to-date on all the areas above.

Child's First Name **Child's Last Name**

Mom's Information

Mom's First Name **Mom's Last Name**

Home phone # **Work phone #** **Cell phone #**

Mom's E-Mail address

Dad's Information: (Optional)

Dad's First Name **Dad's Last Name**

Home phone # **Work phone #** **Cell phone #**

Dad's E-Mail address

Please Return

Children's Corner Child Care Center

Administering Medication

Dear Parents:

With concerns about medication and the children's safety , the Massachusetts Department of Early Education and Care (EEC) recently adopted a new revised regulation about administering medication to children in child care setting, number 606 CMR 7.11 (1) (b) and 7.11 (2) (a-l).

Effective January 2010, all the following steps for administering medication will be followed without exceptions.

Prescription Medication

- Prescription medication must be brought to school in its **original container** and **includes** the **child's name**, **the name of the medication**, **the dosage**, **the number of times per and the number of days the medication is to be administered.** This prescription label will be accepted as the written authorization of the physician.

- The center **will not administer any medication contrary to the directions on the label** unless so authorized by written order by the child's physician.

- The parents must fill out the **Authorization for Medication Form** before the medication can be administered.

Non-prescription Medication

- Non-prescription medication will be given **only with written consent of the child's physician.** The center **will accept a signed statement from the physician listing the medication(s), the dosage and criteria for its administration.** This statement will be valid for one year from the date that it was signed.

- Along with written consent of the physician, the center will also need written parental authorization. The parent must fill out the **Authorization for Medication form**, which allows the center to administer the non-prescription medication in accordance with

the written order of the physician. The statement will be valid for one year from the date it was signed.

- The center will make every attempt to contact the parent prior to the child receiving the non-prescription medication unless the child needs medication urgently or when contacting the parent will delay appropriate care unreasonably.

Topical Ointments and Sprays

- Topical ointments and sprays such as petroleum jelly, sunscreen and bug spray, etc. will be administered to the child with written parental permission. The signed statement from the parent will be valid for one year and include a list of topical non-prescription medication.
- When topical ointments and sprays are applied to **wounds, rashes,** or **broken skin,** the Center will follow its written procedure for **non-prescription** medication which includes the **written order of the physician**, which is valid for a year, and the **Authorization for Medication form signed by the parent.**

All Medications

- **The first dosage must be administered by the parent at home in case of an allergic reaction.**
- All medications **must be given to the teacher directly** by the parent.
- All **unused** medication **will be returned** to the parent.

Chronic Medical Conditions

- **Prior** to administering any medication for a **chronic condition,** such as **Asthma, blood glucose injections,** etc... **All staff must have successfully completed training given by the child's health care practitioner or with his / her written consent, given by the child's parent or the program's health care consultant** that specifically addresses the child's medical condition, medication and other treatment needs.

Please sign here to acknowledge that you have read this note regarding the newly adopted revised regulation regarding administering medication in child care setting.

Child's Name: _____

Parent / Caregiver's Name: _____

Signature: _____

Date: _____

Comments:

_____

_____

_____

Please Return