Family ACCESS
Early Learning Center

For Center Use
Date of Admission: _____
Age at Admission: _____

CHILD'S ENROLLMENT FORM

CHILD INFORMATION:

Child's Name: _____ Date of Birth _____

Home Address:_____ Home Telephone: _____

Primary Language: _____

Child's Identifying Information (required by the Department of Early Education and Care regulations):

Eye Color: _____ Hair Color: _____ Sex: _____

Height: _____ Weight: _____ Ethnicity (optional):_____

Skin Color (optional): _____ Identifying Marks: _____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name _____ Relationship to child _____

Home address _____ Reachable Phone _____

Place of Work _____ Occupation _____

Parent/Guardian Name _____ Relationship to child _____

Home address _____ Reachable Phone _____

Place of Work _____ Occupation _____

ADDITIONAL (NEEDS) INFORMATION REQUIRED

Does your child have any Special Diets? Concerns/Conditions? Please list any so that we may better serve your child. YES __ NO ___ If yes, please list and fill out any necessary forms and attach.

_____

Individual Health Plan (IHP) for child with Chronic Health Conditions? Allergies: YES ___ NO ___ If yes, complete and attach IHP form: Includes Epi Pen, Allergies, Asthma, Seizures or other life threatening conditions.

Copies of any custody agreements, court orders, and restraining orders pertaining to child? YES ___ NO _____ If yes, please attach.

Individual Education Plan (IEP) through the school, Or other testing done? YES ___ NO ___ If yes, please attach.

_____

A staff review of all enrollment packets must be completed prior to your child attending the program to ensure all necessary paperwork has been submitted. Please make sure you submit all paperwork so we can provide care on the date needed. Parent or Guardian must take responsibility for updating this information. Forms are valid for one year.

Parent/Guardian Signature _____ Date _____

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IDENTIFICATION AND EMERGENCY INFORMATION

Name of Child: _____ D.O.B.: _____ Age: _____
Last First Nickname

Address: _____ Phone: _____
Address City State Zip

Primary Parent/Guardian: _____

Employment/School: _____ Phone: _____ Hours: _____

Cell/Reachable #: _____ e-mail address: _____

Parent/Guardian: _____

Employment/School: _____ Phone: _____ Hours: _____

Cell/Reachable #: _____ e-mail address: _____

Child's Physician: _____ Phone: _____

I give my permission to the following people to receive my child at the end of the day. All authorized individuals must show photo identification in order for us to release your child. If no one other than the parent/ guardian is authorized to pick up your child, please indicate below by writing "NO ONE".

Name _____ Relationship to child _____

Address _____ Reachable Phone # _____

Name _____ Relationship to child _____

Address _____ Reachable Phone#_____

Name _____ Relationship to child _____

Address _____ Reachable Phone # _____

Parent/Guardian Signature _____ Date _____

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First Aid and Emergency Consent

Child's Name _____ Date of Birth _____

I authorize staff in the childcare 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 treatment for my child.
Physician's Name_____ Address _____Phone_____

Child's Allergies/Medication(s): _____

Chronic Health Condition(s): _____

Emergency Contacts (Place in the order you want them to be contacted. Parents will be contacted first)

1. Name _____ Address _____
Relationship to child _____ Reachable Phone # _____
Do you give permission for your child to be released to this person? Yes ____ No ____

2. Name _____ Address _____
Relationship to child _____ Reachable Phone # _____
Do you give permission for your child to be released to this person? Yes _____ No ____

3. Name _____ Address _____
Relationship to child _____ Reachable Phone # _____
Do you give permission for your child to be released to this person? Yes _____ No ____

Required Information in the Event of a Medical Emergency

Health Insurance Co: _____Policy# _____
Parent/Guardian Name: _____Phone: _____ Cell: _____
Parent/Guardian Name: _____ Phone: _____Cell: _____

_____ _____
Parent/Guardian Signature Date

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GENERAL PERMISSIONS

Child's Name: _____

FIELD TRIPS: I give my consent to Family ACCESS for my child to go on local community field trips. These trips may include: Newton Police Station, walks around West Newton Square, Webster Park, Albemarle Park, West Newton Post Office, CVS, and other West Newton businesses.

Parent/Guardian Signature _____ Date _____

SUN SCREEN: I hereby authorize the Family ACCESS, to reapply sun screen, provided by parent to my child. I will send my child to school with sunscreen on. Family ACCESS has permission to reapply when going outdoors, or as directed_____.

Parent/Guardian Signature _____ Date _____

WATER ACTIVITIES: I hereby give my consent for my child to participate in water play inclusive of sprinklers, wading pools, etc.

Parent/Guardian Signature _____ Date _____

INTERNAL PHOTOGRAPHS: I hereby give my consent for Family ACCESS to use any pictures and or videos of my child, taken in the course of his/her participation at Family ACCESS for newsletters and mounted on bulletin boards at Family ACCESS.

Parent/Guardian Signature _____ Date _____

EXTERNAL PHOTOGRAPHS: I hereby give my consent for Family ACCESS to use any pictures or videos of my child, taken in the course of his/her participation in Family ACCESS for general marketing or publicity purposes for the agency.

Parent/Guardian Signature _____ Date _____

PARENT DIRECTORY: I hereby give my consent for Family ACCESS to use my child's name and family email, in the Family ACCESS parent directory.

Parent/Guardian Signature _____ Date _____

REFERENCE: I hereby give my permission for Family ACCESS to give my name, email address and phone number out to families of potential students.

Parent/Guardian Signature _____ Date _____

DIAPER CREAM: (if applicable) I give Family ACCESS staff members permission to apply Diaper cream to my child. I have provided the diaper cream for this purpose. The item has been given to my child's teacher and labeled with my child's name on it.

Parent/Guardian Signature _____ Date _____

TOPICAL, NON- MEDICATED – NON -PRESCRIPTION PERMISSION FORM (if applicable): I give Family ACCESS staff members permission to apply _____, a topical, non-prescription medication to my child. This items is not to be applied to an open wound or broken skin and is used solely for prevention. The item has been given to my child's teacher and labeled with my child's name on it.

Parent/Guardian Signature _____ Date _____

TRANSPORTATION PLAN

Child's Name: _____

My child will arrive at the program by:

_____ Parent or authorized person dropping off
_____ Newton Schools
_____ Other (Please specify) _____

My child will depart from the program by:

_____ Parent or authorized person picking up
_____ Newton Schools
_____ Other (Please specify) _____

If your child is enrolled in Newton Early Childhood Program please specify their schedule (days and arrival time to Family ACCESS):
_____

I give permission for my child to be released from the program at the end of the day as stated above or I give permission to release my child to the authorized individual listed on my child's identification form. Any other transportation requests must be stated in writing and maintained in the child's file or the above plan must be implemented. This permission is valid for one program year from the date of the signature.

Parent/Guardian Signature _____ Date _____

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Massachusetts Tooth Brushing Regulation Form

Massachusetts is the first state to regulate tooth brushing at daycares and preschools requiring that all children who eat a meal or attend school for more than four hours brush their teeth at school. The Department of Early Education and Care, who licenses us, tells us we need to provide this in our day, but parents themselves, can opt out.

Please read this NY Times article (http://www.nytimes.com/2010/01/29/education/29brush.html?_r=1) for some perspective on this.

Please fill out this form stating whether you opt in or out. Thank you for your cooperation.

In the event that my child _____(Child's name) attends Family ACCESS for the required time (over 4 hours) to brush teeth

☐ I **do not** want his/her teeth brushed in school.

☐ I **do** want his/her teeth brushed in school.

Parent Signature: _____ Date: _____

Family ACCESS tooth brushing method includes:

1) Family ACCESS will provide a toothbrush to send home in your child's lunchbox.

2) Please send it back in your child's lunchbox after washing daily (as you see fit) and we will be sure your child brushes their teeth after lunch.

3) If there is no toothbrush in your child's lunchbox, we will hope to see it the next day and continue to have it go back and forth. If the toothbrush does not come back, we will assume you no longer want to participate in tooth brushing at school. If this is not the case, please let us know and we can distribute a new toothbrush to your child and the start the process over.

4) Family ACCESS will replace your child's toothbrush every three months

5) If your child is sick, we recommend you disinfect or replace the toothbrush

6) We will provide individual cups of water for your child to dip their toothbrush in while brushing (no toothpaste)

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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.

FAMILY
List all family members (include names, ages, and how your child addresses each member)
Name Relationship Age In/Out of Home Child's Name for
_____
_____
_____
_____
_____
_____

DEVELOPMENTAL HISTORY

Age began sitting _____ crawling _____ walking _____ talking _____
*Does your child pull up? _____ * Crawl? _____ * Walk with support? _____
Any speech difficulties? _____
Speech intervention/therapy provider? _____
Special words to describe needs _____
*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 or 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: _____
child eats with hands _____ spoon _____ fork _____

Foods refused: _____
*Is your child fed held in lap? _____ High chair? _____

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? Potty-chair? _____ Special child seat? _____ Regular seat? _____
How does child indicate bathroom needs (include special words): _____
Is child ever reluctant to use the bathroom? _____
Does child have accidents? _____
Does your child use diapers during the daytime? _____ night time? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____
Does child become tired or nap during the day (include when and how long)?
_____
When does 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.)
_____

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.

SOCIAL RELATIONSHIPS

How would you describe your child: _____
_____
Previous experience with other children/child care _____
Reaction to strangers: _____ Ability 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? _____
_____

Has your child been referred to or currently utilize counseling/therapy of any kind? If so, please note the provider: _____
_____

Describe your child's schedule on a typical day:
_____
_____

What would you like your child to gain from this child care experience?
_____
_____

DAILY SCHEDULE:
Please describe, by approximate time, your child's current daily activities, i.e., awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.

A.M.	P.M.

Is there anything else you would like us to know about your child?
_____
_____
_____
_____

Parent/Guardian Signature _____ Date _____

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Denver II Developmental Screening Test Permission

Dear Parent/Guardian,

We are pleased to announce that we will continue with our annual screening again this fall to all children 5 years and under in our Early Learning Center programs. We will use the Denver II Developmental Screening Test, as we have now done for the past couple of years.

This screening tool looks at four areas of child development - social-emotional, fine motor, language, and gross motor. The Denver II is the most internationally recognized and used developmental screening test. It is used in a variety of settings including: pediatric offices, public health clinics, early intervention programs, home visitation programs, Early Start and Head Start programs, childcare centers, and preschools. The Denver II may be used to monitor a child's development as well as a screen for any areas of concern.

Developmental screening is considered a "best practice" for early education and child care settings. Measuring your children's skills early in their EEC experience and then several months later will assist us in addressing any specific developmental concerns and also help us determine the effectiveness of our programming.

The screen is quick, simple and usually fun for children. It typically takes less than 20 minutes. Your child will be screened by the clinician from the Parents Program, who regularly visits your child's class and is familiar with your child. We will share screening results once completed

Please complete and return the form below to your child's teacher. Please contact Susan Sklan, Director of the Parents Program (ssklan@familyaccess.org, ext. 125) or Suzy Blevins, Early Childhood Specialist (sblevins@familyaccess.org, ext. 133) with any questions.

Thank you,

Cate Brooks
Director, ELC

- -

I, ______________________________, parent of ____________________ give permission for my child to be screened using the Denver II Developmental Screening Test. I will be contacted prior to the screening. I understand that information regarding screening results will be shared upon completion and scoring of the test.

Parent/Guardian Signature ____ Date ______________

If your child was born more than 2 weeks before the expected date of delivery and is less than 2 years of age, please indicate how many weeks your child was premature. This information will allow for more accurate screening results.

Premature: Yes _____ No _____

Number of weeks premature: _____________________

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Record of Physical Exam and Immunizations
Use this form or one provided by Child's Physician

Dear Physician:

_____ is enrolled in an early childhood program licensed by the Department of Early Education and Care. **The Department of Early Education and Cares regulations require documentation from a physician evidence of an annual physical examination, updated immunizations, and lead screening in accordance with Department of Public Health's recommended schedules. A copy of a health form signed by physician is acceptable documenting child is healthy and can participate in a child care program along with immunization record and lead testing.**

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

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:

_____

Immunization form attached: Yes _____ No _____

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:
_____
_____
A copy of an Individualized Health Plan and Food or Asthma Action Plan for a chronic medical condition along with medication consent forms for Epi Pen, inhaler, or any medication that will be administered at Family ACCESS.

Physician's Signature: _____ Date: _____

Comments: _____