



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,

Hala H. Laverdure

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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 _____

Would you be interested in extended care hours if available? Y N

Parent Signature _____

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

Program:	Group Child Care:	School Age Care:
Child's Name:	Eye Color:	Skin Color:
Home Address:	Hair Color:	Height:
Telephone:	Sex:	Weight:
Date of Admission:	Age at Admission:	
Date of Birth:	Primary Language:	
Identifying Marks:		
Allergies / special diets:		

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name:	Parent/Guardian Name:
Relationship to child:	Relationship to child:
Home Address:	Home Address:
Home Telephone #:	Home Telephone #:
Bus. Name:	Bus. Name:
Bus. Address:	Bus. Address:
Bus. Telephone #:	Bus. Telephone #:
Hours at Work:	Hours at Work:

ADDITIONAL INFORMATION:

Child's Physician/Clinic: _____

Address: _____ Phone: _____

Chronic health conditions: _____

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

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: _____

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: _____

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: _____

MEDICATION CONSENT FORM
102 CMR 7.05(2)(c)

Name of child: _____

Name of medication: _____

Prescription: _____ Non-Prescription: _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Name and phone number of prescribing physician:

Directions for storage: _____

**I, _____, (parent or guardian) give permission
to authorized staff member(s) to administer medication to my child as indicated above.**

Parent/Guardian Signature

Date

Doctor's Signature _____
(for non-prescription medication)

**GROUP CHILD CARE AND SCHOOL AGE CHILD CARE
FIRST AID AND EMERGENCY MEDICAL CARE
CONSENT FORM
102 CMR 7.09(3)**

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid 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*)

1. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	
2. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	
3. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	

Health Insurance Coverage: _____	Policy #: _____
Parent(s) Name: _____	Phone(w) Phone (h)
Parent(s) Name: _____	Phone(w) Phone (h)

Parent/Guardian Signature

Date

