CHILD'S FACE SHEET / ENROLLMENT FORM

For Center Use ONLY
Date of Admission: ________________
Age at Admission: ________________
Identifying Information Updated: __________

CHILD'S INFORMATION:

Child's Name: ______________________________
Date of Birth: ______________________________
Home Address: ______________________________
City/Zip: ______________________________
Telephone: ______________________________

Place of Birth: ____________________
(City/Town)
Primary Language: ____________________

Child's Identifying Information (required by Dept. of early Education & Care regulations):

Eye Color: ____________ Hair Color: ________________ Sex: ______________

Height: ________________ Weight: ____________________ Skin Color: ______________

Identifying Marks: ____

Allergies: ____

PARENT/GUARDIAN INFORMATION: **Please check one:** ☐ **Home Office** ☐ **MMLISI** ☐ **Babson**
Department ________________________

MM Assoc. SS#:		MM Assoc. SS#:(if applicable)	
Parent/Guardian Name:		Parent/Guardian Name:	
Relationship to child:		Relationship to child:	
Home Address:		Home Address:	
City/Zip:		City/Zip:	
Home Telephone:		Home Telephone:	
Cell/Pager #:		Cell/Pager #:	
Business Name:		Business Name:	
Address:		Address:	
City:		City:	
Work Number:		Work Number:	
E-MAIL ADDRESS:		**E-MAIL ADDRESS**:	

If parents cannot be contacted, notify: (also include names on emergency release form)

Name:		Name:	
Address:		Address:	
City:		City:	
Relationship to child:		Relationship to child:	
Daytime Phone #:		Daytime Phone #:	

Siblings/Ages: ____

Child's Physician /Clinic: ______________________________ Telephone #: ____________________

Parent/Guardian Signature:____ Date: ____________________

Are there any special custody arrangements staff should be aware of? ______ If so, please describe:

____

AUTHORIZATION AND CONSENT FORM

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 Children's House, Inc. to secure emergency transportation for my child to the nearest hospital and to secure the necessary medical treatment. I understand the teachers in the childcare center are trained in the basics of First Aid and selected staff are CPR certified. I authorize them to give my child first aid when appropriate. I also understand that any expenses incurred will be borne by me.

_______________ Date   _______________________________________ Parent Signature

Insurance information can be found on Emergency Card and Medical Records Review Form.

Field Trips

Emergency information and first aid kit will be taken on all field trips. Parent(s) will be notified of any event requiring emergency medical attention at the earliest possible time.

Authorized Persons

I hereby authorize the Children's House, Inc. to release my child to the following persons (other than parents):

Name ________________________________ Relationship ______________________

Address ___________________________ Tel # (home)________________(work)______________

Name ________________________________ Relationship ______________________

Address ___________________________ Tel # (home)________________(work)______________

Name ________________________________ Relationship ______________________

Address ___________________________ Tel # (home)________________(work)______________

_______________ Date   _______________________________________ Parent Signature

A copy of this form is available upon request.

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 (must have physician documentation): ______________________________
____
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 you child at the center: ____________
____
What is used at home? potty-chair? ________ 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 waking, etc.) _____________

SOCIAL RELATIONSHIPS

How would you describe your child: ____

____

Previous experience with other children / daycare: ____

Reactions 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?

____

____

____

Children's House strives to be sensitive to the needs of all families enrolled. Please share any additional information that might be useful in program planning, event planning, etc. throughout the year (i.e. information on religion, home language, ethnic history, culture and family structure.)

____

____

____

Parent/Guardian Signature: ____ Date: _________________

DIAPERING / TOPICAL OINTMENT & CREAM PERMISSION FORM*

7:07(16) (1)

The following preparations may be used on my child as needed:

Children's House provides:

- ❖ Baby Wipes

Parents would provide

- ❑ A & D Ointment
- ❑ Desitin/Balmex
- ❑ Vaseline
- ❑ Sunblock
- ❑ Other ___________________________

Date: _____________ Parent Signature _____________________________________

This form is to be updated yearly:

Parent Initials:	Date:	Parent Initials:	Date:
Parent Initials:	Date:	Parent Initials:	Date:
Parent Initials:	Date:		

DIAPPERM 01/99

CHILDREN'S HOUSE CHILD CARE CENTERS
Multiple Permission Form

Center Activities

I give permission for my child to use all of the play equipment and participate in all of the activities at Children's House.

Date   Signature of Parent

Antiseptic

I give permission for first aid certified staff members to use antiseptic as part of the first aid process if necessary (will not be used for minor injuries).

Date   Signature of Parent

Walking Trips and Field Trips

I give permission to Children's House staff to accompany my child on supervised walking trips (at MMCH site - children will not go off property). When the center plans to take my child on a field trip to a specific location outside the center, I will be notified and asked to sign a detailed permission slip.

Date   Signature of Parent

Photographs / Videotaping

I give permission to Children's House to take photographs/videotape of my child and to use them in classroom displays, classroom or center portfolios or during promotional events. I understand that he/she may be identified by name. I understand my child's photo will not be placed on the website or used in formal promotional materials (i.e. brochures, commercials) without my separate written consent.

Date   Signature of Parent

Observations/Educational Research

I give permission to Children's House to allow observation of my child by center visitors, Early Childhood Professionals, and/or college students.

Date   Signature of Parent

Email, Address & Phone Number

I give permission to Children's House to release (to enrolled parents/staff only) my **email address**, **home address** and **phone number** for the purpose of parent communication, parent references, or use by children's parents for birthday parties, play groups, etc. (Cross out any items you do not wish to allow - ok to only allow work phone # - please make notation if preferred).

Date   Signature of Parent

Transitioning

I give permission to my child's teachers to exchange information regarding my child when he/she transitions to another classroom.

Date   Signature of Parent

This form is to be updated yearly:

Parent Initials:	Date:	Parent Initials:	Date:
Parent Initials:	Date:	Parent Initials:	Date:
Parent Initials:	Date:		

COMPREHENSIVE HEALTH TEAM
PARENTAL CONSENT FORM

I, parent/guardian of ___________________________________ D.O.B. __________,

hereby give permission for member(s)of the Comprehensive Health Team of the Springfield Early Care and Education Partnership to observe my child at MassMutual Children's House. I understand that in order to assist the staff in meeting my child's needs the team members may recommend specific speech and language activities, motor activities, behavioral strategies to try in the classroom, provide vision and/or hearing screening and may suggest additional services which may benefit my child.

By signing this permission form, I understand that I am allowing the team member and the staff at MassMutual Children's House to share information with each other and appropriate program staff regarding my child.

I also understand that I have the option of meeting with the team member(s) prior to my child's being observed or any time thereafter.

Parent/Guardian Signature: ______________________________ **Date:** ___________

POLICY AGREEMENT

____
Child's Name

I, ____, have read and understand the Children's House policies as outlined in the Parent Handbook and agree to abide by them.

____
Parent's Signature

____
Date

On the reverse side, we have outlined certain polices which we feel are important to keep in mind. However, we suggest you use the handbook to familiarize yourself with ALL our polices.

1. 9-hour slot will be ______ a.m. to ______ p.m.
2. Tuition will be due one week in advance, payable on Friday for the following week.
3. For payments received after 5:30p.m. Monday, a $5.00 late fee will be assessed.
4. A $25.00 fee will be paid for any returned check. If two checks are returned within six months, tuition will be paid by cash or money order.
5. A $10.00 fee per ¼ hour (or any part of) will be paid for a child picked up past closing time. The fee is to be paid in CASH directly to the staff attending the child. This is a fine, not a program option.
6. Vacation time will require full payment in order to hold a place for your child.
7. Three (3) weeks written notice MUST be submitted to Center Director indicating date of withdrawal. Children's House reserves the right to bill for (3) week's tuition, if less than three (3) weeks or no notice is given. Withdrawal prior to declared date will require full financial responsibility.
8. A $40.00 non-refundable registration fee will be assessed upon enrollment and each September thereafter for the duration of the child's enrollment.
9. Illness policy information can be found on pages 9-13 of the handbook.
10. Field trip information can be found on pages 17-18 of the handbook.

CHILD CARE CENTERS

MEDICAL RECORD

Dear Physician: *The child indicated below is enrolled in an early childhood program which is licensed by the Department of Early Education & Care. The Department of Early Education & Care requires the Medical History and Immunization form to be completed and signed by the physician or source of health care. A prompt response is appreciated.*

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

IDENTIFICATION (To be completed by Parent/Guardian)

Name of Child: ____Date of Birth: ___________
Child's Address: ________________________________ Child's Home Phone: ___________
City, State, and Zip Code: ____

Name of Parent/Guardian #1: ____
Address (include City, State, Zip)**: ____**
Home Phone: __________________________ Work Phone: __________________________

Name of Parent/Guardian #2: ____
Address (include City, State, Zip)**: ____**
Home Phone: __________________________ Work Phone: __________________________

EXAM/HEALTH INFORMATION (To be completed by Physician)

Date of Examination of Child: ____

What is your general opinion concerning the child's general health and appearance?

____
____
____

Has this child been screened for lead poisoning? Yes _________ No _________

If yes, date screened: ________________ ***Please note:*** *Lead Screenings are mandated for children between 9-12 months and annually thereafter until 48 months. Proof of any one of those screenings at entry to kindergarten is acceptable.*

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the day care provider? If so, please detail below:

____
____
____

Physician's Signature: _____________________________________Date: ______________

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: ______________________________

Date of Birth: / / **Sex:** ☐female ☐male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
	4			4	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	1		**Measles, Mumps, Rubella** (MMR)	1	
	2			2	
	3		**Varicella** (Var)	1	
	4			2	
	5		**Meningococcal** Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	6			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Hepatitis A** (HepA)	1	
	2			2	
	3		**Pneumococcal Polysaccharide** (PPV23)	1	
	4			2	
	5		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
Pneumococcal Conjugate (PCV7)	1			2	
	2			3	
	3		**Other:**		
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date:** / /

Signature:

Facility name:

NON-PRESCRIPTION MEDICATION RECORD

I hereby authorize ***Children's House, Inc.*** to administer the following medication to my child ______________________________________. **D.O.B.** ____________________

Diagnosis/Allergy Requiring Medication: _________________________________
Side Effects **(Staff Should Be Aware Of):** ____
Is child currently taking any other medications? ___________
If yes, what?____

Name of MEDICATION: ____

DOSAGE/Route: ____
All medication should be accompanied by a labeled dosing cup, syringe or medication spoon.
Last dose of this medication was given at: _________________________

Date(s) in which medication is to be given at center _____________________________
Time(s) in which medication is to be given (must be specific) __________________________

I give consent for this information to be clarified/verified by the pharmacy and/or pediatric office.

Parent's Signature: ____
Date: _________________ **Phone:** ________________ **Cell:** __________________

For Staff Use Only

☐ Staff Initials — Current Authorization for administering of non-prescription medication has been verified in child's file and is signed by physician and parent/guardian.

☐ The Medication Consent form has been completed.
☐ The medication is in a safety cap container.
☐ The original label is on the medication container.
☐ The name of the child above is on the container. The child being given the medication is clearly identified.
☐ The medication is not expired.
☐ The dose, name of drug, route and frequency of administration given on the label is consistent with parental instructions given above and information on Authorization to Administer Non-Prescription Medication form.

Received by (Staff Member): _____________________________ **Date:** ___________
Medication can be administered only if ALL items above are checked.

Date	Time	Medication	Dose	Staff Signature	Witness Initial

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION

I hereby authorize ***Children's House, Inc.*** to administer the following medication(s) to my child ____. D.O.B. ______________

☐ **Tylenol**
Route*: ______________________
Dosage: ______________________

☐ **Motrin**
Route*: ______________________
Dosage: ______________________

☐ **Teething Medication**
Product Name: __________________
Route*: _______________________
Dosage: _______________________

☐ **Cough/Cold Medication**
Product Name: __________________
Route*: _______________________
Dosage: _______________________

☐ **Medicated Ointments/Creams**
Product Name: __________________
Route*: _______________________
Dosage: _______________________

☐ **Other**
Product Name: _________________
Route*: _______________________
Dosage: _______________________

Parent Signature: ____
Phone #: ______________________ **Cell #:** __________________

Physician's Signature (or Stamp)**:** _______________________________________
Phone #: ____________________

Date: _________________________ *This form expires one year from the date signed.*

☐ Generic Equivalent Acceptable (Physician Initial if Acceptable)

***Route: Topical, Oral (pill or liquid), Injection, Nasal Spray, Inhaler, Drops, etc.)**

worddoc/shareddoc/studentform/non-presmed 09/22/2006