

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

Program:	Group Child Care:	School Age Care:
<b>Child's Name:</b>	Eye Color:	Skin Color:
Home Address:	Hair Color:	Height:
Telephone:	Sex:	Weight:
<b>Date of Admission:</b>	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

**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**

Jewish Community Center of the North Shore  
Preschool Program

Name \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone # (Home): \_\_\_\_\_ Cell #

(Name): \_\_\_\_\_ Cell # (Name): \_\_\_\_\_

Parent's Work # (Name): \_\_\_\_\_ Parent's Work #

(Name): \_\_\_\_\_

E-mail (Name): \_\_\_\_\_ E-mail

(Name): \_\_\_\_\_

Emergency Name: \_\_\_\_\_ Emergency

Telephone #: \_\_\_\_\_

## PERMISSION FORM

Classroom with children 4 and 5 years old may go on field trips during the school year. A permission slip with all the information is always sent home before the field trip. We make every effort to contact parents if permission slips are not returned. EEC requires the preschool to have a permission slip on file.

I do \_\_\_ do not \_\_\_ give my child \_\_\_\_\_ permission to go on field trips.

I do \_\_\_ do not \_\_\_ give permission to administer sunscreen to my child.

I do \_\_\_ do not \_\_\_ give permission for my child to be photographed and/or video taped for the JCCNS purpose of publicity.

I do \_\_\_ do not \_\_\_ want my address or phone number included on the class lists.

Parent 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: \_\_\_\_\_

# MASSACHUSETTS SCHOOL HEALTH RECORD

## Health Care Provider's Examination

Name \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_

### Medical History

### Pertinent Family History

### Current Health Issues

**Y**  **N**   
 Allergies: Please list: Medications \_\_\_\_\_ Food \_\_\_\_\_ Other \_\_\_\_\_  
History of Anaphylaxis to \_\_\_\_\_ Epi-Pen®:  Yes  No  
 Asthma: Asthma Action Plan  Yes  No (Please attach)  
 Diabetes:  Type I  Type II  
 Seizure disorder: \_\_\_\_\_  
 Other (Please specify) \_\_\_\_\_

**Current Medications (if relevant to the student's health and safety)** Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

### Physical Examination

Date of Examination: \_\_\_\_\_

Hgt: \_\_\_\_\_ (\_\_\_\_%) Wgt: \_\_\_\_\_ (\_\_\_\_%) BMI: \_\_\_\_\_ (\_\_\_\_%) BP: \_\_\_\_\_

(Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

### Screening:

(Pass) (Fail)  
Vision: Right Eye    
Left Eye    
Stereopsis

(Pass) (Fail)  
Hearing: Right Ear    
Left Ear

(Pass) (Fail)  
Postural Screening:    
(Scoliosis/Kyphosis/Lordosis)

**Laboratory Results:**  Lead \_\_\_\_\_ Date \_\_\_\_\_  Other \_\_\_\_\_

**The entire examination was normal:**

**Targeted TB Skin Testing:**  Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: \_\_\_\_; Results: \_\_\_\_ mm.

Referred for evaluation to: \_\_\_\_\_  Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations: \_\_\_\_\_

Y  N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: \_\_\_\_\_

Y  N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date \_\_\_\_\_

Please print name of Examiner. \_\_\_\_\_

Group Practice \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Please attach additional information as needed for the health and safety of the student.

MDPH 12/14/04

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	
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	1		
	2			2		
	3			3		
		4				
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		<b>Measles, Mumps, Rubella</b> (MMR)	1		
	2			2		
	3		<b>Varicella</b> (Var)	1		
	4			2		
	5					
		6		<b>Hepatitis A</b> (HepA)	1	
		7			2	
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1		
	2			2		
	3		<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1		
	4			2		
<b>Pneumococcal Conjugate</b> (PCV7)	1		<b>Other:</b>	3		
	2					
	3					
	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
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

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: \_\_\_\_\_

## 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 licenses programs must comply with this regulation. However, parents may choose that their child (ren) not participate in tooth brushing while present at the JCCNS Early Childhood 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 do not want your child to brush his or her teeth while s/he is attending our program, please fill out the information 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 our 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.

If you are planning to participate in this program, please send in a toothbrush and toothpaste with your child.

Thank you.

**I do not wish to have my child participate in tooth brushing while in care at the JCCNS Early Childhood Program**

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**Child's Name:** \_\_\_\_\_

**Parent/Guardian's Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If you have any questions or concerns, please call Stefanie, Joanne or Marilyn at 781-631-8330**

## ALLERGY INFORMATION

**CHILD'S NAME** \_\_\_\_\_

**ALLERGIC TO** \_\_\_\_\_

**DESCRIPTION OF REACTION** \_\_\_\_\_

\_\_\_\_\_

### PROCEDURE TO FOLLOW

- Medication \_\_\_\_\_
- Call \_\_\_\_\_
- Watch for \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature of Parent or Guardian:** \_\_\_\_\_

**PRESCHOOL PLUS REGISTRATION FORM  
2010-2011**

**PLEASE FIND BELOW THE FORM FOR EXTENDED HOURS. FILL OUT THIS FORM AND RETURN TO THE PRESCHOOL OFFICE BY AUGUST 13<sup>th</sup>. WE NEED THIS INFORMATION AS SOON AS POSSIBLE TO INSURE ADEQUATE STAFFING.**

**FEE IS \$8.90 PER HOUR. TOTAL OF 175 DAYS FOR THE YEAR. DOES NOT INCLUDE JEWISH OR NATIONAL HOLIDAYS OR VACATION WEEKS IN DECEMBER, FEBURARY AND APRIL.**

	<b>M 33</b>	<b>T 38</b>	<b>W 37</b>	<b>TH 33</b>	<b>F 34</b>	<b>Hourly Rate</b>	<b>Sub-Total</b>
7:30-9:00						X\$13.35 =	
8:00-9:00						X \$8.90 =	
8:30-9:00						X \$4.45 =	
12:00-2:00						X \$17.80 =	
12:00-3:30						X \$31.15 =	
12:00-5:00						X \$44.50 =	
12:00-6:00						X \$53.40 =	

**Total** \_\_\_\_\_

**Child's name** \_\_\_\_\_ **Account #** \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

Preschool plus invoices will be calculated monthly from September to June. Fee will be based on the number of days preschool is in session each month.