CHILD ENROLLMENT FORM

Date of Application: _____ Date of Enrollment: _____ Last Day of Enrollment: _____

Attention Provider: This information must be kept current at all times and shall be kept file for one year after the child ceases to be enrolled in the family child care home.

Child's Name: _____ Child's Date of Birth: _____
Child's Address: _____ City: _____ Zip Code _____

Parent/Gaurdian Name: _____Address: _____
City: _____ Zip Code: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Emergency Contact # (____) _____e-mail Address: _____

Employer: _____ Work #: (_____) _____
Employer's Address: _____ City: _____ Zip Code _____

Parent/Gaurdian Name: _____Address: _____
City: _____ Zip Code: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Emergency Contact # (____) _____ e-mail Address: _____

Employer: _____ Work #: (_____) _____
Employer's Address: _____ City: _____ Zip Code _____

My Child's Weekly Child Care Schedule:

Day(s)	**Hours**
Monday _____	_____
Tuesday _____	_____
Wednesday _____	_____
Thursday _____	_____
Friday _____	_____
Saturday _____	_____
Sunday _____	_____

Signature of Parent or Guardian: _____ **Date**: _____

WRITTEN PERMISSION FORM

Child's Name: _____ Child's Date of Birth: _____

Child's Address: _____ City: _____ Zip Code _____

Persons permitted to remove the child from the child care home on behalf of parent.

Name: _____ Address: _____ City: _____ Zip Code: _____
Phone #: (____)_____ Relationship _____

Name: _____ Address: _____ City: _____ Zip Code: _____
Phone #: (____)_____ Relationship _____

In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.

Name: _____ Address: _____ City: _____ Zip Code: _____
Phone #: (____)_____ Relationship _____

Name: _____ Address: _____ City: _____ Zip Code: _____
Phone #: (____)_____ Relationship _____

Child's Emergency Medical Care Provider:

Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____

Child's Physician: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____

Child's Dentist: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____

My family child care provider and or approved substitute, have my permission to:

- Transport my child for any activity away from the family child care home. The provider is responsible for notifying me of days and times that these activities will occur ___ Yes ___ No
- Allow my child to participate in any activity away from the child care home ___ Yes ___ No
- Transport my child in case of an emergency to the Emergency Medical Care Provider, Physician or Dentist listed above and or to seek medical attention in an emergency at: _____ ___Yes ___ No
  (name of hospital or walk-in clinic)
- Include my child in swimming when recreational swimming is part of the family child care program
  ___ Yes ___ NO I understand it is my responsibility to outline these provisions to the provider
- Arrange for transitioning of my child to and from school including, but not limited to, transportation, exact bus pick up and drop off locations, and supervision to be provided during transitioning ___ Yes ___ No
  I understand that I must provide written permission and instructions specifying these arrangements.

The provisions outlined on this form have been worked out in consultation with me and my family child care provider. ___ Yes ___ No

Signature of Parent or Guardian: _____ **Date**: _____

Attention Provider: This information must be kept current at all times. Carry a copy of this form, the Enrollment form and the Child Health Assessment Record during any off-premises activity.

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity	
Primary Health Care Provider:	❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander	
Name of Dentist:	❑ White, not of Hispanic origin ❑ Other	
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance?	Y	N	If your child does not have health insurance, call **1-877-CT-HUSKY**
Does your child have dental insurance?	Y	N	
Does your child have HUSKY insurance?	Y	N	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT** ____ in/cm ____% ***Weight** ____ lbs. ____ oz / ____% **BMI** ____ / ____% ***HC** ____ in/cm ____% (Birth – 24 months) ***Blood Pressure** ____ / ____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**

❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)

❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess

❑ Referral made to: _____

***Hearing Screening**

❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)

❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess

❑ Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

Lead poisoning (≥ 10ug/dL)

❑ No ❑ Yes

***TB:** High-risk group? ❑ No ❑ Yes

Test done: ❑ No ❑ Yes Date: _____

Results: _____

Treatment: _____

***Dental Concerns** ❑ No ❑ Yes

❑ Referral made to: _____

Has this child received dental care in the last 6 months? ❑ No ❑ Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*IMMUNIZATIONS ❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** _____

Seizures ❑ No ❑ Yes: Type: _____ _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*_____

_____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

_____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: _____ **Birth Date:** _____ REV. 8/2011

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____
Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

CHILD CARE INCIDENT LOG

CHILD'S NAME:_____

Important: The purpose of this log is to record accidents, incidents leading to a report made to Department of Children & Families, observations of the child made by the provider, injuries, illnesses and unusual behaviors that occur at the family child care home, and important discussions with parents.

Note: This log shall be made available upon request to the Office, and shared with the parent(s) no later than the next business day.

Date	Time and location of occurrence	Person(s) Present	Description / Action Taken by the Provider including, but not limited to, transportation to a hospital emergency room, doctor's office or other medical facility

Emergency Numbers:

Emergency Caregiver Name:
Phone:

FIRE: 911 or
POLICE: 911 or
AMBULANCE: 911 or
OEC Child Care Licensing: 1-800-282-6063 **or** 1-860-500-4450

Poison Control: 1-800-222-1222
Child Abuse Care Line: 1-800-842-2288

Child's Name:			**Notes/Other:**
A. Parent			
☐ Work:	☐ Home:	☐ Cell:	
B. Parent			
☐ Work:	☐ Home:	☐ Cell:	

Child's Name:			**Notes/Other:**
A. Parent:			
☐ Work:	☐ Home:	☐ Cell:	
B. Parent:			
☐ Work:	☐ Home:	☐ Cell:	

Child's Name:			**Notes/Other:**
A. Parent:			
☐ Work:	☐ Home:	☐ Cell:	
B. Parent:			
☐ Work:	☐ Home:	☐ Cell:	

Child's Name:			**Notes/Other:**
A. Parent			
☐ Work:	☐ Home:	☐ Cell:	
B. Parent			
☐ Work:	☐ Home:	☐ Cell:	

Child's Name:			**Notes/Other:**
A. Parent			
☐ Work:	☐ Home:	☐ Cell:	
B. Parent			
☐ Work:	☐ Home:	☐ Cell:	

Child's Name:			**Notes/Other:**
A. Parent			
☐ Work:	☐ Home:	☐ Cell:	
B. Parent			
☐ Work:	☐ Home:	☐ Cell:	