The Commonwealth of Massachusetts
Department of Early Education and Care

Child's Enrollment Form

Child Information

Child's Name:_____ Date of Birth:_____

Age at Admission:_____ Date of Admission:_____

Child's Home Address:_____

Home Phone Number:_____

Primary Language:_____ Identifying Marks:_____

Eye Color:_____ Hair Color:_____ Skin Color:_____

Sex:_____ Height:_____ Weight:_____

Parent/Guardian Information

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Additional Information

Child's Physician:_____

Address:_____ Phone Number:_____

Allergies/Special Diets?_____

Individual Health Plan for child with a chronic health condition? If yes, please attach._____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach._____

Special limitations or concerns? _____

_____

School Age Only

Current School:_____

School Address:_____ School Phone Number:_____

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**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care 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 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*)
Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No_____

Name_____
Address_____
Relationship to child_____
Home Phone_____ Cell Phone_____
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone_____ Cell_____

Parent/Guardian Name: _____ Phone_____ Cell_____

_____ _____
Parent /Guardian Signature Date (valid for one year)

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

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.

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 your 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/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)

Transportation Plan/ Authorized Pick up List

Child's name: _____

My child will be dropped of by:

_____ Parent/ Guardian

_____ Other _____ _____
Name Relationship to child

My child will be picked up by:

_____ Parent/ Guardian

_____ Other _____ _____
Name Relationship to child

Please list the persons authorized to pick up your child. Each authorized person must be at least 18 years of age. Each person will be required to show a valid ID if the staff member has not met him or her before.

I authorize the following persons to pick up my child from Milestones Childcare Center and Preschool:

Authorized Person	**Phone number**	**Relationship to child**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Signature Date

Daily Walk Permission Form

I give my child_____permission to go on daily neighborhood walks with the Milestones staff.

Signature_____ Date_____

Milestones Childcare handbook agreement

I, _____ have read and understand the Milestones Childcare Center & Preschool handbook.

(Please initial each policy)

_____ I understand the deposit is non-refundable and that no cash refunds will be giving at the time of departure.

_____ I understand that I must give a 30-day written notice (30 days prior to the departing month's billing cycle) to apply the deposit and failure to do so will result in the loss of my deposit.

_____ I understand that holidays, snow days and sick days are billable days.

_____ I understand the healthcare policy (I have one hour from the initial call to pick up my sick child/ren and they must remain home symptom free WITHOUT medication for 24 hours before they can return).

_____ I understand drop off cut-off is 9:30am (10:30am for appointments).

_____ I understand that pickup is by 5:30pm and there is a $1/minute late fee to be paid directly to the educator at pick up.

_____ I understand the monthly tuition is due on the 15th of each month and there is a $20/day late fee for any late payments.

_____ I understand that my childcare may be disrupted if requested forms/emergency medication are not brought in before the expiration date.

_____ _____

Signature Date