

Children's Records must be maintained for at least five (5) years after a child has left the program

# FAMILY CHILD CARE ENROLLMENT PACKET FACE SHEET

**\*PHOTO OF CHILD  
(\*Optional)  
PLUS  
PHYSICAL  
DESCRIPTION**

**Please fill out these forms completely. If a question does not apply to your child, write N/A (not applicable). The forms must be in the educator's possession on or before the first day your child begins care. Please notify your educator if any of the information changes.**

Eye Color \_\_\_\_\_  
Hair Color \_\_\_\_\_ Sex \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## General Information

Date of Admission \_\_\_\_\_ Age at Admission: \_\_\_\_\_

Date of Discharge \_\_\_\_\_

Reason for Discharge: \_\_\_\_\_  
\_\_\_\_\_

Child's full name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Nickname \_\_\_\_\_

Primary Language of Child \_\_\_\_\_ Primary Language of Parents \_\_\_\_\_

Allergies/Special Diets \_\_\_\_\_

Name of Parent(s)/Guardian(s) \_\_\_\_\_

Home address (if different) \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

## **Parent(s)/guardian(s) business address/location during child care:**

Parent/Guardian: \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Where: \_\_\_\_\_ Where: \_\_\_\_\_

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

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Instructions: \_\_\_\_\_ Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Emergency Contact/Authorized pick-up person**

In the event of an emergency when I may not be reached, the Educator may contact the following individuals (in the order given) whom I authorize to take my child from the child care premises.

(1) Name: \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

(2) Name: \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

**TRANSPORTATION PLAN / AUTHORIZED PICK- UP**

<b>My child will arrive to the program by:</b>	<b>My child will depart the program by:</b>
<input type="checkbox"/> Parent Drop-Off	<input type="checkbox"/> Parent Pick Up
<input type="checkbox"/> Supervised Walk	<input type="checkbox"/> Supervised Walk
<input type="checkbox"/> Unsupervised Walk	<input type="checkbox"/> Unsupervised Walk
<input type="checkbox"/> Public/Private Van	<input type="checkbox"/> Public/Private Van
<input type="checkbox"/> Bus	<input type="checkbox"/> Program Bus/Van
<input type="checkbox"/> Private Transportation Provided by Parent	<input type="checkbox"/> Private Transportation Provided by Parent

In the space below, please note any important information regarding transportation of your child to and from the program (i.e.--indicate who will be supervising children during transport or prior to their arrival at the program, who supervises the walk from a bus stop, etc.)

---



---



---

I additionally authorize the following individual to take my child from the child care premises. (Please let me know at the beginning of the day when your child will be picked up by one of the authorized individuals.)

Name \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Anticipated Days/Time of Attendance**

<u>Day</u>	<u>Arrival Time</u>	<u>Departure Time</u>	<u>Day</u>	<u>Arrival Time</u>	<u>Departure Time</u>
Monday	_____	_____	Friday	_____	_____
Tuesday	_____	_____	Saturday	_____	_____
Wednesday	_____	_____	Sunday	_____	_____
Thursday	_____	_____			

If applicable: Name of School Child Attends: \_\_\_\_\_

Copies of any custody agreements, court orders, restraining orders (if applicable)

Notes:

---



---



---

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

**Written Acknowledgement of Receipt of Parent Handbook**

I acknowledge that I have received a copy of the provider's parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook).

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

**Parental Visit Notice**

I understand that I may visit this family child care home unannounced at any time during the hours that my child is in care.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

**Child's Physician or Health Care Professional**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Information on allergies, special diets, chronic health conditions, special limitations, concerns including medications child is taking at home/school and possible side effects:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Insurance Information (OPTIONAL)**

Subscriber's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_

[ ] Copy of Insurance Card

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

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

## DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care programs 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: baby 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 program

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 physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child’s sleeping position with your educator. Your educator will place your infant on his/her back unless there is a written physician’s order that specifies otherwise.

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/child 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 child care 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: \_\_\_\_\_

## **Permissions (for each child enrolled)**

**General Permission-(Basic Transport)** (Parents should not sign this permission unless specific places where your child is allowed to go are listed by your educator.) By signing this form, I am allowing my child to be taken off the child care premises.

I, hereby give \_\_\_\_\_ permission to take my child \_\_\_\_\_  
(educator/assistant)

off the premises of the family child care home for the following excursions: (specific places your child is allowed to go): \_\_\_\_\_

using the following forms of transportation: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Signature Date

**I do not want my child to be taken off the child care premises.**

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Signature Date

---

## **Permission - (Transport to Medical Facility and Receive Emergency Medical Treatment)**

**Medical Emergency Treatment** (Department of Early Education and Care recommends checking with your local hospital about the acceptability of this statement)

I, hereby give \_\_\_\_\_ permission to administer basic first aid and/or  
(educator/assistant)

CPR to my child \_\_\_\_\_, and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Signature Date

**Topical Medication/Ointments** (Please list only those medications/ointments which you will allow the educator(s) to administer to your child's skin): Ex: sunscreen, insect repellent (bug spray), diapering ointment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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

## Emergency Card Information

**REMINDER :** *This emergency card information is for the educator's first aid kit. The educator(s) must take first aid materials when leaving the child care premises.*

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

### Instructions to Reach Parent or Guardian

1. \_\_\_\_\_  
(Name, Address, Home and Cell Phone #)

2. \_\_\_\_\_  
(Name, Address, Home and Cell Phone #)

### Contact Information for Physician or Health Care Professional

1. \_\_\_\_\_  
(Physician's Name, Address, Phone #)

### Emergency Contact Person(s)

1. \_\_\_\_\_  
(Name, Address, Home and Cell Phone #)

2. \_\_\_\_\_  
(Name, Address, Home and Cell Phone #)

### Emergency Medical Treatment

I hereby give \_\_\_\_\_ permission to  
(Name of educator/assistant)

administer basic first aid and/or CPR to my child \_\_\_\_\_  
(Name)

and/or take my child \_\_\_\_\_, to a hospital for medical treatment  
(Name)

when I cannot be reached or when delay would be dangerous to my child's health.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

### Medical Insurance Information (Optional)

Subscriber's Name: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Copy of insurance card

Other pertinent medical information: \_\_\_\_\_

\_\_\_\_\_

Dear Physician: \_\_\_\_\_  
(Child's Name)

is enrolled in a family child care home which is 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 (1) 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 \_\_\_\_\_

(\*At least one (1) time between ages 9-12 months; Annually-Ages 2 & 3; at Age 4 if High Risk for Lead Poisoning)

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 educator? If so, please detail below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return this form and the child's immunization record to:  
\_\_\_\_\_  
Small Wonders Nursery & Daycare, Inc.  
\_\_\_\_\_  
21 Baptist St  
\_\_\_\_\_  
Swansea, MA 02777  
\_\_\_\_\_