Easton Learning Adventures Preschool
115 Main Street, North Easton, MA 02356
(508) 230-7445

Enrollment Packet Face Sheet

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

Street: _____ Age as of Sept. 1st _____

City, State, Zip: _____ Home Phone: _____

Child's Primary Language(s) _____ Date of Admission: _____

Gender: □Male □Female Identifying Marks: _____

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

Height: _____ Weight:_____

Parent/Guardian Name: _____ Relationship to Child: _____

Place of Employment: _____ Work Phone: _____

Street: _____ Cell Phone: _____

City, State, Zip: _____ Email: _____

Days/Hours @ Work: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Place of Employment: _____ Work Phone: _____

Street : _____ Cell Phone: _____

City, State, Zip: _____ Email: _____

Days/Hours @ Work: _____

Siblings:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

How did you hear about us? _____

Transportation Plan:
I understand that Easton Learning Adventures Preschool does not provide any transportation to and from the center. I understand that it is my responsibility to get my child to and from school each day.

_____ _____
Signature Date

Field Trip Consent:
I give permission for my child to be taken on community field trips in Easton. I understand that I will be given advance notification before each trip.

_____ _____
Signature Date

Photo Release Consent:
I agree to permit Easton Learning Adventures Preschool to take pictures of my child as part of school activities and to allow the use of these photos for school projects, the school's website and other publicity purposes.

_____ _____
Signature Date

Oral Health Non-Participation Consent:
I do not wish to have my child participate in tooth brushing while at Easton Learning Adventures Preschool.

_____ _____
Signature Date

I agree to inform the school in writing if any of the above information changes throughout the school year.

_____ _____
Signature Date

Developmental History and Background Information

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: _____
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)? _____

_____

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 experiences with other children: _____

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.

_____

_____

Is there anything else we should know about your child?

_____

_____

Parent/Guardian Signature: _____ Date: _____

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First Aid and Emergency Medical Consent Form

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

I authorize the staff, trained in the basics of first aid, to give my child first aid when appropriate. I understand every effort will be made to contact me in the event of an emergency requiring medical attention for my child. In the event that I cannot be reached, I authorize school staff to transport my child to the nearest medical facility and/or to
and/or secure medical treatment for my child.

_____ _____
Signature *Date*

Physician

Child's Physician: _____ Health Insurance Co. _____
Practice Name: _____ Health Plan # _____
Street: _____ Policy # _____
City, State, Zip: _____
Phone: _____

Emergency Contacts: To be contacted in the order listed after attempts to reach BOTH parents/guardians have failed. The school and its staff have permission to release my child to each person listed below.

1

Name: _____ Relationship to Child: _____
Street: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Cell Phone: _____
Do you give permission for child to be released to this person? YES _____ NO _____

2

Name: _____ Relationship to Child: _____
Street: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Cell Phone: _____
Do you give permission for child to be released to this person? YES _____ NO _____

3

Name: _____ Relationship to Child: _____
Street: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Cell Phone: _____
Do you give permission for child to be released to this person? YES _____ NO _____

I agree to inform the school in writing if any of the above information changes throughout the school year.

_____ _____
Signature *Date*

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Allergy Information Form

This form must be completed for each child enrolled in the program. If your child has no allergies, please indicate that below, sign, date and return to us. Thank you!

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

Class Enrolled In: ☐Toddlers ☐3 Year Old ☐4 Year Old ☐Pre-K

My child has: ☐ Allergies ☐ no known allergies

Allergy Description:

If you checked off that your child has allergies, please list the allergies below and describe them as accurately as possible in the section labeled "Description/Restrictions". For example, if your child has a nut allergy, please be specific as to whether your child is allergic to peanuts, tree nuts or both. Also, if your child has a milk allergy or is lactose intolerant, please tell us about any dietary restrictions. For example, can he or she have baked goods containing milk products? What products must be avoided. You must also complete an Individual Health Care Plan Form.

Type of Allergy: _____

This allergy requires: ☐Prescription Medication ☐Non-prescription medication ☐ No Meds

Description/Restrictions: _____
_____
_____

Type of Allergy: _____

This allergy requires: ☐Prescription Medication ☐Non-prescription medication ☐ No Meds

Description/Restrictions: _____
_____
_____

Please keep in mind you will need a letter form your child's physician if you want us to administer non-prescription medications to your child. If your child carries a prescription medication, the medication must be delivered to the office, not the classroom teacher. It must be in its original packaging with the pharmacy label clearly affixed. Do not leave any medication in your child's possession, cubby, or in his or her classroom. There may be addition forms that need to be completed before the medication can safely be stored in the classroom's emergency backpack.

I have accurately described the nature of my child's allergy and will supply the school with any medication necessary to treat this allergy. I agree to accurately complete and return all related paperwork to the office prior to the start of school. If any of the above information changes, I agree to inform the school in writing.

_____ _____
Signature *Date*

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Medical Form

Dear Physician: _____ is enrolled at Easton
Child's Name
Learning Adventures Preschool which is licensed by the Department of Early Education and Care. The department regulations require that the MEDICAL HISTORY & IMMUNIZATION FORM be completed and signed by the child's physician or source of health care. A prompt response is appreciated.

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

IDENTIFICATION

Child's Name: _____ Date of Birth: _____

Parents' Names: _____ Phone #: _____

Address: _____

Date of Child's Examination: _____

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

_____

_____

_____

Has this child been screened for lead poisoning? ☐ YES ☐NO

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 Easton Learning Adventures?

_____

_____

_____

Physician's Signature: _____

Date: _____

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Dear Families:

In an attempt to strengthen our home-school connection here at Easton Learning Adventures, we are asking each family to share some of their family traditions, practices, culture and language so that they may incorporated into each classroom's daily curriculum. Please take a few minutes as a family to answer the following questions and return it with your completed enrollment packet.

Child's Name: _____ Class Enrolled In: _____

Parents/Guardians Names: _____

Nickname Child Prefers to be called: _____

Primary Language(s) Spoken at Home: _____

Religious Practices:

_____
_____
_____
_____

Holiday Traditions:

_____
_____
_____
_____

Favorite Family Activities:

_____
_____
_____
_____

Favorite Family Recipes:

_____
_____
_____
_____

Would you be interested in volunteering to share your family's culture with the students?

☐ YES ☐ NO