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? _____

_____

_____ _____

Parent/Guardian 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: _____

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)

IDENTIFICATION

Name of Child:
Date of Birth:
Address:
Phone #:
Name of Parents:
Address of Parents:
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? **(*at least one (1) time between ages 9-12 months; Annually-Ages 2&3, at Age 4 if High Risk 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 the child care educator? If so, please detail:
Comments:
Please return this form and the child's immunization record to:

_____ _____

Physician's Signature **Date**

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)*

1. Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____

Do you give permission for child to be released to this person? Yes_____ No_____

2. Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____

Do you give permission for child to be released to this person? Yes_____ No_____

3. Name_____

Address_____

Relationship to child_____

Home Phone_____ Cell Phone_____

Do you give permission for child to be released to this person? Yes_____ No_____

4. 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_____

Parent/Guardian Name: _____ Phone_____

_____ _____

Parent /Guardian Signature Date (valid for one year)

MEDICATION CONSENT FORM

Name of child: _____

Name of medication: _____

Please [X] one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Topical Non-Prescription *(applied to open wound/ broken skin)* _____

My child has previously taken this medication_____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____ Date_____

I, _____, (parent or guardian)

(**print name**)

gives permission to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date_____

For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only**)

INDIVIDUAL HEALTH CARE PLAN FORM

Plan must be renewed annually or when child's condition changes

Check all that apply….

Plan was created by:

_____ Parent
_____ Doctor or Licensed Practitioner
_____ Program's Health Care Consultant
_____ Older school age child (9+ yrs. of age)
_____ Other: _____

Plan is maintained by:

_____ Director
_____ Assistant Director
_____ Child's Educator
_____ Other: _____

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

SMALL GROUP and LARGE GROUP TRANSPORTATION PLAN and AUTHORIZATION

Child's name:_____

My child will arrive at the program:

____Parent drop off

____Supervised walk

____Unsupervised walk

____Public/private/van

____Program bus/van

____Contract van

____Private transportation arranged by parent

____Other

My child will depart from the program:

____Parent pick up

____Supervised walk

____Unsupervised walk

____Public/private/van

____Program bus/van

____Contract van

____Private transportation arranged by parent

____Other

Child's name:_____

My child will arrive at the program:

____Parent drop off

____Supervised walk

____Unsupervised walk

____Public/private van

____Program bus/van

____Contract van

____Private transportation arranged by parent

____Other

My child will depart from the program:

____Parent pick up

____Supervised walk

____Unsupervised walk

____Public/private van

____Program bus/van

____Contract van

____Private transportation arranged by parent

____Other

Parent /Guardian Signature_____ Date _____

Refer to the first aid and emergency medical care consent form for release information.

OFF SITE ACTIVITIES PERMISSION FORM

Section 1 - Program completes prior to parental consent

Program: _____

Name of Educator(s) responsible for child: _____

Name of off-site location and address: _____

_____

Date of off-site activity: _____ **Time Leaving Program:**_____

Time Returning to Program:_____

Method of Transportation: _____

Fee associated with activity (if any): _____

****NOTE** Each child must carry on his/her person the name, address, and telephone number of staff or child care program whenever she/he is off the premises in care of the program.**
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Section 2 – Parent/Guardian completes prior to off-site activity

I give permission for my child to attend the above identified off-site activity

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

Parent's Guardian's Name: _____ **Phone Number:** _____

I authorize child care program staff to secure necessary emergency medical treatment

Name of child's physician, address, phone number: _____

_____

Health Insurance Plan and Policy #: _____

Emergency Contact Name: _____ **Contact #**_____

_____ _____
(Parent/Guardian Signature) **(Date)**

This form must accompany each child on the off-site activity.

ANTICIPATED DAYS/TIME of ATTENDANCE:

Please place a check [✓] next to each day your child will be attending the program.

Child's Name: _____

Day:	Arrival Time:	Departure Time:
Monday: _____		
Tuesday: _____		
Wednesday: ____		
Thursday: ____		
Friday: _____		

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

Notes:

_____

_____

_____

AFTER SCHOOL PROGRAM REGISTRATION FORM

2019-2020

Child's Name: _____

Date of Birth: _____ Age: _____

Home Address: _____

City/Town: _____ Zip Code: _____

Hours: 2:30 – 6:00 p.m. Monday to Friday **Cost:** $40/day

Parents will receive an invoice at the beginning of the month that is included in their child's tuition. Parents will **NOT** be billed for days the school is closed. Parents will **NOT** receive a refund for times their child is absent from Extended Day.

Please circle your selections.

Toddlers: (15 months – 2.9 years) M T W TH F

Preschool: (2.9 – 6 years) M T W TH F

Parent (Print Name): _____

Parent Signature: _____

Date: _____

PARENT ADMISSION CONTRACT

I, the parent of _____ have read the Needham Montessori School *Parent & Health and Safety Handbook*, and agree to support the school by following all the ground rules and policies as set out as well as any modifications of ground rules and policies that might have to be made by the school administration during the course of the year.

I will adhere to the terms of the school's tuition payment plan written in the *Parent & Health and Safety Handbook*.

Parent Visit Notice

I understand that I may visit Needham Montessori School at any time during the hours that my child is in care.

_____ _____

Parent Signature Date

_____ _____

Home Phone Number

_____ _____

Cell Phone Number

_____

Address