



Associated Early Care & Education, Inc.

95 Berkeley Street, Suite 306, Boston, MA 02116

Telephone 617-695-0700 Fax 617-695-9590

Program/Provider _____

Intake/Reassessment Date _____

By _____

Admission Date _____

Termination Date _____

CHILD ENROLLMENT FORM - PART I

CHILD'S NAME _____ NICKNAME _____ BIRTH DATE ____/____/____

FIRST MIDDLE LAST

ADDRESS _____ TELEPHONE _____

NUMBER AND STREET APT. # CITY/TOWN ZIP CODE

BIRTH PLACE _____ ETHNIC ORIGIN _____ PRIMARY LANGUAGE _____

HEIGHT _____ WEIGHT _____ HAIR COLOR _____ EYE COLOR _____ SEX _____ IDENTIFYING MARKS _____

CHILD LIVES WITH: BOTH PARENTS MOTHER FATHER OTHER _____

PLEASE SPECIFY

MOTHER/LEGAL GUARDIAN'S NAME _____ FATHER/LEGAL GUARDIAN'S NAME _____

FIRST MIDDLE LAST FIRST MIDDLE LAST

BIRTH DATE ____/____/____ BIRTH DATE ____/____/____

PLACE OF EMPLOYMENT/SCHOOL _____ PLACE OF EMPLOYMENT/SCHOOL _____

ADDRESS _____ ADDRESS _____

TELEPHONE _____ HOURS _____ TO _____ TELEPHONE _____ HOURS _____ TO _____

WHO IS AUTHORIZED TO PICK CHILD UP FROM DAY CARE: HOURS DAY CARE IS TO BE PROVIDED _____ TO _____

1) _____ TELEPHONE _____

FIRST LAST RELATIONSHIP TO CHILD

2) _____ TELEPHONE _____

FIRST LAST RELATIONSHIP TO CHILD

3) _____ TELEPHONE _____

FIRST LAST RELATIONSHIP TO CHILD

4) _____ TELEPHONE _____

FIRST LAST RELATIONSHIP TO CHILD

EMERGENCY CONTACTS

1) NAME _____ 2) NAME _____

FIRST MIDDLE LAST FIRST MIDDLE LAST

ADDRESS _____ ADDRESS _____

TELEPHONE _____ RELATIONSHIP TO CHILD _____ TELEPHONE _____ RELATIONSHIP TO CHILD _____

3) NAME _____ 4) NAME _____

FIRST MIDDLE LAST FIRST MIDDLE LAST

ADDRESS _____ ADDRESS _____

TELEPHONE _____ RELATIONSHIP TO CHILD _____ TELEPHONE _____ RELATIONSHIP TO CHILD _____

DATE _____ SIGNATURE _____ / _____

PARENT

LEGAL GUARDIAN

CHILD ENROLLMENT FORM

PART II

HEALTH INFORMATION

CHILD'S DOCTOR OR CLINIC WHERE CHILD RECIEVES HEALTH CARE:

CLINIC NAME/DOCTOR'S NAME

ADDRESS

TELEPHONE

DO YOU HAVE HEALTH INSURANCE OR RECEIVE MEDICAL ASSISTANCE? YES NO

HEALTH INSURANCE NAME: _____

POLICY NUMBER: _____

MEDICAID NUMBER: _____

HAS YOUR CHILD HAD ANY PAST ILLNESSES, HOSPITALIZATIONS OR PHYSICAL PROBLEMS, ETC.?
 YES NO

IF YES, EXPLAIN: _____

DOES YOUR CHILD HAVE ANY ALLERGIES? YES NO

IF YES, EXPLAIN: _____

IS YOUR CHILD ON ANY REGULAR MEDICATIONS? YES NO

IF YES, EXPLAIN: _____

DATE OF CHILD'S LAST COMPLETE PHYSICAL EXAM: ____/____/____.

WHERE? _____

DATE OF CHILD'S LAST DENTAL EXAMINATION: ____/____/____.

WHERE? _____

CHILD'S DEVELOPMENT

ANY PROBLEMS DURING BIRTH OR PREGNANCY? _____

ANY CONCERNS ABOUT YOUR CHILD'S DEVELOPMENT SUCH AS SPEECH & LANGUAGE, VISION & HEARING, HEIGHT & WEIGHT, WALKING, TOILETING, RELATIONSHIPS WITH OTHERS, ETC.?

AGE (IN MONTHS) WHEN CHILD:

SAT ALONE _____ WALKED ALONE _____ USED WORDS _____

ABOUT THE CHILD

DESCRIBE CHILD'S PERSONALITY:

HAS CHILD BEEN IN DAY CARE BEFORE? YES NO

IF YES, WHAT WERE THE GENERAL EXPERIENCES: _____

DOES YOUR CHILD HAVE DIFFICULTY SEPARATING FROM YOU?

DOES YOUR CHILD HAVE THE OPPORTUNITY TO PLAY WITH OTHER CHILDREN?:

CHILD ENROLLMENT FORM

PART III

DOES YOUR CHILD HAVE ANY STRONG FEARS? _____

HOW DOES CHILD INDICATE WHEN HE/SHE IS UPSET? _____

WHEN YOUR CHILD IS FEELING UPSET, ANGRY OR FRIGHTENED, WHAT HELPS HIM/HER FEEL BETTER? _____

IMPORTANT PEOPLE IN CHILD'S LIFE (AT HOME AND OUTSIDE THE HOME): _____

CHILD'S RELATIONSHIP WITH SIBLINGS: _____

CHILD'S FAVORITE ACTIVITIES AND TOYS: _____

PREFERENCES AND RESTRICTIONS REGARDING T.V.: _____

ANY FAMILY PETS: _____

ANY MAJOR EVENTS OR CHANGES IN CHILD'S LIFE THAT MIGHT EFFECT HIS/HER BEHAVIOR? _____

HOW DO YOU THINK HE/SHE WILL ADJUST TO DAY CARE? _____

WHAT DO YOU EXPECT YOUR CHILD TO GAIN FROM HIS/HER EXPERIENCES IN DAY CARE? _____

DISCIPLINE

WHAT IS THE PRIMARY TYPE OF DISCIPLINE YOU USE WITH YOUR CHILD(REN)? _____

IS THIS TYPE OF DISCIPLINE EFFECTIVE? YES NO USUALLY SOMETIMES

EATING

ANY EATING PROBLEMS? _____

ANY FOOD ALLERGIES? _____

ANY SPECIAL EATING HABITS? _____

ARE THERE ANY FOODS YOU DO NOT WANT YOUR CHILD TO EAT FOR RELIGIOUS, PERSONAL OR MEDICAL REASONS? YES NO

IF YES, PLEASE LIST: _____

FOR INFANTS: (FEEDING SCHEDULE, MILK/FORMULA, BABY FOOD AMOUNTS, ETC.) _____

SLEEPING

DOES YOUR CHILD USUALLY NAP? YES, WHAT TIME? _____ NO

WHAT ARE THE SLEEPING ARRANGEMENTS FOR YOUR CHILD? _____

FAVORITE TOY OR BLANKET WHEN SLEEPING? _____

REGULAR BEDTIME? _____

DOES CHILD HAVE NIGHTMARES OR OTHER PROBLEMS SLEEPING? _____

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. Your provider will place your infant on his/her back unless there is a written physician's order that specifies otherwise.*

I have read (or have had read to me) and understand the above policy regarding back to sleep (SIDS): Parent/Guardian Initials: _____

TOILETING

IS CHILD TOILET TRAINED? YES, AT WHAT AGE? _____; NO _____

IS THE CHILD SUBJECT TO DIAPER RASH? YES NO
BABY POWDER, CREAM OR OINTMENT USED? _____

CHILD ENROLLMENT FORM

PART V

HEALTH/MEDICAL INFORMATION & PERMISSION

CHILD'S NAME: _____

PROGRAM/PROVIDER _____

PLEASE CHECK ONE BOX BESIDE EACH ITEM

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I AGREE

I DO NOT AGREE

1. HEALTH

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- A. That in accordance with the parent handbook provided to me by the Program/Provider, I am responsible for making sure that my child has a physical examination before entering the Program/Provider home, and once a year thereafter, and that I must secure all necessary immunizations for my child.
- B. That qualified Program Staff/Provider will provide First Aid and/or CPR if the Staff/Provider believe it is needed.
- C. That in the event of a medical emergency, the Program/Provider will attempt to contact me or a guardian of my child, but may secure emergency medical care for my child at _____, or at another facility chosen by the Program if in the judgment of the Program Staff/Provider at the time of emergency my child would be better cared for at another facility.

I AGREE

I DO NOT AGREE

2. RECORDS

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- A. That I will provide to the Program Staff/Provider proof of birth and immunization records concerning my child, as required.
- B. That the Program/Provider will maintain a written record as to my child's participation in the program and that in general access to this record will be available only to me, the Program Staff/Provider and certain funding agencies; and that I have received a statement of rules concerning this record entitled "Records and Confidentiality" .
- C. That I will inform the Program/Provider immediately regarding any change in: home address/telephone number; work/school address/telephone number; emergency contacts/pick-up authorization names/addresses/telephone numbers.

I AGREE

I DO NOT AGREE

3. PUBLICITY

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- A. That in order to develop public understanding of the Program's services and to assist in the education and training of people who work with children, pictures, sound tapes, visual tapes and films of my child which are developed under the supervision of the Program and which show my child participating in the activities of the program may be used in newspapers, displays, posters or bulletin boards, other publications, on radio and television and in programs of education and training.

I AGREE

I DO NOT AGREE

4. VISITS TO HOME AND TO PROGRAM

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- A. That Program Staff/Provider may visit me at my home at my convenience.
- B. That I may, and am encouraged to, visit the Program/Provider.

I AGREE

I DO NOT AGREE

5. TRANSPORTATION

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- A. That the Program Staff/Provider may take my child on occasional field trips, such as to museums, parks or farms.
- B. That on these trips, my child may walk, travel by public transportation or rented buses, or in rare instances travel in cars driven by Program Staff/Provider.
- C. That my child may be transported daily between my home and the Program/Provider, as required.

I AGREE

I DO NOT AGREE

6. ATTENDANCE/ABSENCE

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- A. That I will make sure that my child attends the Program/Provider every day that he/she is able to do so.
- B. That I will notify the Program Staff/Provider if my child will be absent.

DATE _____

_____/_____/_____
 PARENT

_____/_____/_____
 LEGAL GUARDIAN