



The Commonwealth of Massachusetts  
Department of Early Education and Care  
**Child's Enrollment Form**

**Child's Name**

**D.O.B**

**Reachable Phone Numbers-**

**# & Name-**

**# & Name-**

(Note: In case of emergency, parents will be asked  
to pick children up within 30 minutes of calling.)

**# & Name-**

**# & Name-**

**Preferred Email(s)-** (all correspondence will be sent to this/these emails)

**Child's Information**

Age at Admission

*Date of Admission (Office Use Only)*

Child's Home Address

Primary 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 ( ☐ check if same as above)

Reachable Phone Number

Business Name

Email Address

Business Address

Business Phone Number

Hours at Work

**Parent/Guardian Information**

Parent/Guardian Name

Relationship to Child

Home Address ( ☐ check if same as above)

Reachable Phone Number

Business Name

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

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 \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Age began sitting \_\_\_\_\_ crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

Any speech difficulties? \_\_\_\_\_ Words to describe needs \_\_\_\_\_

Language spoken at home \_\_\_\_\_

**Infants and Toddlers** (marked \*) as appropriate to the age of your child at admission.

\*Any history of colic? \_\_\_\_\_ \*Does your child pull up \_\_\_\_\_ \*Crawl \_\_\_\_\_ \*Walk with support \_\_\_\_\_

\*Does your child use pacifier/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 \_\_\_\_\_

**Infants and Toddlers** (marked \*) as appropriate to the age of your child at admission.

\* If infant is on a special formula-describe its preparation in detail \_\_\_\_\_

\* Is your child fed in lap/High chair? \_\_\_\_\_ \*Does your child eat with spoon/Fork/Hands? \_\_\_\_\_

### TOILET HABITS

Is your child ever reluctant to use the bathroom? \_\_\_\_\_

Does your child have accidents? \_\_\_\_\_

**Infants and Toddlers** (marked \*) as appropriate to the age of your child at admission.

\*Are disposable or cloth diapers used? \_\_\_\_\_

\*Is there a frequent occurrence of diaper rash? \_\_\_\_\_ Treatment? \_\_\_\_\_

\*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? Potty chair? Special child seat? Regular seat? \_\_\_\_\_

\*How does your child indicate bathroom needs? \_\_\_\_\_

## **SLEEPING HABITS**

When does your child go to bed at night? and get up in the morning? \_\_\_\_\_

Describe any special characteristics or needs \_\_\_\_\_

Does your child sleep in a crib? Bed? \_\_\_\_\_

Does your child become tired or nap during the day \_\_\_\_\_

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.

## **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. \_\_\_\_\_

Is there anything else we should know about your child? \_\_\_\_\_

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 \_\_\_\_\_

Allergies/Special Diets/Chronic Health Conditions \_\_\_\_\_

**Emergency Contacts- Including Parents (In order to be contacted)**

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

Reachable Phone Number \_\_\_\_\_ Alt. Phone Number \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

Reachable Phone Number \_\_\_\_\_ Alt. Phone Number \_\_\_\_\_

Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

Reachable Phone Number \_\_\_\_\_ Alt. Phone Number \_\_\_\_\_

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) \_\_\_\_\_

## OFF SITE ACTIVITIES PERMISSION FORM

### Section 1 - Program completes prior to parental consent

**Program:** The Longfellow Children's Center

**Name of Educator(s) responsible for child:** Karen/Bridget Mahoney & TC Leger

**Name of off-site location and address:**

The Longfellow Club  
524 Boston Post Rd Wayland Ma 01778

**Method of Transportation:** By foot

**\*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.

### 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 \_\_\_\_\_

Child's allergies, health conditions, or Individual Health Plan \_\_\_\_\_

Health Insurance Plan and Policy # \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Contact # \_\_\_\_\_

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

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

\_\_\_\_\_  
Date

## The Longfellow Children's Center Transportation Plan

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

### MY CHILD WILL ARRIVE AT THE PROGRAM

\_\_\_\_\_ Parent Drop Off  
\_\_\_\_\_ Supervised Walk  
\_\_\_\_\_ Unsupervised Walk  
\_\_\_\_\_ Public/Private Van  
\_\_\_\_\_ Program Van  
\_\_\_\_\_ Contract Van  
\_\_\_\_\_ Private Trans. Arranged by Parent  
\_\_\_\_\_ Family Member/Babysitter/Nanny  
          \*already listed on release form  
\_\_\_\_\_ Other

### MY CHILD WILL DEPART FROM THE PROGRAM

\_\_\_\_\_ Parent Pick Up  
\_\_\_\_\_ Supervised Walk  
\_\_\_\_\_ Unsupervised Walk  
\_\_\_\_\_ Public/Private Van  
\_\_\_\_\_ Program Bus/Van  
\_\_\_\_\_ Contract Van  
\_\_\_\_\_ Private Trans. Arranged by Parent  
\_\_\_\_\_ Family Member/Babysitter/Nanny  
          \*already listed on release form  
\_\_\_\_\_ Other

## Parent and Guardian Agreement

☐ I have received the Parent Handbook and fully understand the policies, guidelines and all the information regarding payments, transportation, children's information, holidays, early releases and snow days.

☐ I understand that I will receive any updates regarding changes to the "Parent Handbook" in a timely manner and also understand that the "Parent Application Forms" will need to be completed again in full, each year that my child attends the program.

☐ I agree to all the policies, guidelines and regulations

☐ Longfellow has the permission to photograph my child for educational, classroom and promotional purposes. No names will be used.

I give permission to apply the following topical, nonprescription solutions

☐ Sunscreen

☐ Eye Wash

☐ Hand Sanitizer

☐ Diaper Cream

☐ Antibacterial Ointment/Wash

☐ Longfellow has my permission to share my email on Google Photos (this will allow all parents access to daily classroom updates and photos)

☐ *I have some questions and would like you to contact me before I sign*

---

Parent Guardian Signature

Date