Child Enrollment Form for Emergency Child Care Program

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:_____

School Information:_____

Immunization Information: _____ Lead Screening: _____

Reason Eligible

DCF Involved: ☐ DTA/TAFDC Involved: ☐ Homeless: ☐ Critical worker: ☐

Explain: _____

Parent/Guardian Information

Parent/Guardian #1:

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Occupation: _____

Employer Name and Address:_____

Employer Phone Number:_____

Hours at Work:_____

Parent/Guardian #2:

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Occupation: _____

Employer Name and Address:_____

Employer Phone Number:_____

Hours at Work:_____

Additional Information

Special Diet?_____

Allergies: ☐ If yes, describe: _____

Epipen: ☐ If yes, describe _____

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._____

Medications and side effects: _____

Special limitations or concerns? _____

_____

I acknowledge that this care is being provided in a state of an emergency pursuant to Governor Baker's Executive Order. EEC's Emergency Child Care Program is not subject to EEC licensure and does not require that the program meet all requirements in EEC regulations. I recognize that this child care is being offered on a temporary basis.

_____ _____

Parent/Guardian Signature Date

Emergency Card Information

Reminder: This emergency card information is for the educator's first aid kit. The educator must take this first aid kit when leaving the child care premises to ensure child safety.

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

Child's Home Address: _____

_____ **Phone:** _____

Instructions to Reach 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. _____
(Physician's Name, Address, Phone #)

2. _____
(Physician's Name, Address, Phone #)

Emergency Medical Treatment

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

Administer bsic first aid/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 Name_____

Type of Insurance_____

Policy Number: _____

[ ] Copy of Insurance Card

Other Pertinent Medical Information:

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: _____

The Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION ADMINISTRATION RECORD

(This record must be maintained in the children's file when completed)
606 CMR 7.11 (1-3)

FOR STAFF USE:
Who trained the staff? _____
Has the Medication Consent form been completed? ____
Have the "5 rights" been addressed? ____
Is the medication in a safety cap container? ___
Is the original prescription label on the medication container? ___
Is the name of the child given below on the container? ___
Is the date on the prescription current (within the month for antibiotics and within the expiration date for medications which are so labeled; within the year otherwise? ___
Is the dose, name of drugs, frequency of administration given on the label consistent with parental instructions?___

Medication can be administered only if the answers to all questions above are "Yes"

CHILD'S NAME_____**MEDICATION**_____

DATE	TIME	MEDICATION	DOSE	ROUTE	STAFF SIGNATURE	MISDOSES ERRORS	CHILD REFUSAL ☑

Did you check the label 3 times?_____

If child refused medication explain why?_____

[redacted]