



GROUP DAY CARE AND SCHOOL AGE CHILD CARE
CHILD'S FACE SHEET -- ENROLLMENT FORM

How did you hear about us? _____

Child's Name _____ Eye Color _____ Skin Color _____

Home Address _____ Hair Color _____ Height _____

_____ Sex _____ Weight _____

Home Phone _____ Date of Birth _____

Primary Language _____ Identifying Marks _____

Allergies/special diets _____

DATE OF ADMISSION _____ AGE AT ADMISSION _____

PARENT/GUARDIAN INFORMATION

Name _____ **Name** _____

Relationship to Child _____ Relationship to Child _____

Home Address _____ Home Address _____

Home Phone _____ Home Phone _____

Business Name _____ Business Name _____

Address _____ Address _____

Business Phone _____ Business Phone _____

Hours at Work _____ Hours at Work _____

ADDITIONAL INFORMATION

Child's Physician/Clinic _____ E-mail address _____

Name Address Phone

Chronic Health conditions _____

Special limitations or concerns _____

School Age only: Current School & Address _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements is on file at my child's school.

Parent/Guardian signature _____ Date _____

Group Day Care and School age child care
First aid and Emergency Medical Care
Consent Form
102CMR 7.09(3)

Child's name _____ Date of birth _____

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that every effort will be made to contact me in the event of an emergency necessitating medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the Mt. Auburn Hospital in Cambridge and to secure necessary medical treatment for my child.

Child's physician's name: _____

Address: _____

Phone number: _____

Child's allergies: _____

Chronic health conditions: _____

EMERGENCY CONTACTS (IN ORDER TO BE CONTACTED)

Name: _____

Address: _____

Relationship to child: _____

Phone # _____

Do you give permission for your child to be released to this person? Yes _____ No _____

Name: _____

Address: _____

Relationship to child: _____

Phone #: _____

Do you give permission for your child to be released to this person? Yes _____ No _____

Name: _____

Address: _____

Relationship to child: _____

Phone #: _____

Do you give permission for your child to be released to this person? Yes _____ No _____

Health insurance coverage: _____ Policy #: _____

Parent(s) name _____ Phone(w) _____

Phone(h) _____

Parent(s) name _____ Phone(w) _____

Phone(h) _____

Parent signature _____ Date _____

Emergency Card Information

Child's name _____

Date of birth _____

Child's home address _____

Phone _____

INSTRUCTIONS TO REACH PARENT / GUARDIAN

1. _____
(name, address, phone #)

2. _____
(name, address, phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's name, address, phone #)

EMERGENCY CONTACT PERSON(S)

1. _____
(name, address, phone #)

2. _____
(name, address, phone #)

MEDICAL EMERGENCY TREATMENT

I hereby give _____ permission to administer
Basic first aid and / or CPR to my child _____
And /or take my child _____ to the Mt. Auburn
Hospital in Cambridge for medical treatment when I cannot be reached or when
delay would be dangerous to my child's health.

(Date and parent signature)

Insurance information (optional)

Company name _____ Policy # _____

Participating hospital _____

Special instructions _____

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Registration for licensed child care facilities require this information to be on file so 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? _____

SPECIAL WORDS TO DESCRIBE NEEDS _____

HEALTH

ANY KNOWN COMPLICATIONS AT BIRTH? _____

SERIOUS ILLNESSES AND/OR HOSPITALIZATIONS: _____

SPECIAL PHYSICAL CONDITIONS , DISABILITIES: _____

ALLERGIES i.e. asthma, hay fever, insect bites, medication, food reactions:

REGULAR MEDICATIONS: _____

EATING HABITS

SPECIAL CHARACTERISTICS OR DIFFICULTIES: _____

FAVORITE FOODS _____ CHILD EATS WITH HANDS _____ SPOON _____ FORK _____

FOODS REFUSED _____

TOILET HABITS

HOW DOES YOUR CHILD INDICATE TOILET NEEDS (INCLUDE SPECIAL WORDS) _____

IS CHILD EVER RELUCTANT TO USE THE BATHROOM? _____

DOES CHILD HAVE ACCIDENTS? _____

SLEEPING HABITS

DOES CHILD BECOME TIRED OR NAP DURING THE DAY (INCLUDE WHEN AND HOW LONG)? _____

WHEN DOES 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 CHILD? _____

WHAT IS THE METHOD OF BEHAVIOR MANAGEMENT/DISCIPLINE AT HOME? _____

DESCRIBE YOUR CHILD'S SCHEDULE ON A TYPICAL DAY: _____

WHAT WOULD YOU LIKE YOUR CHILD TO GAIN FROM THIS CHILD CARE EXPERIENCE?

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD?

PARENT'S/ GUARDIAN SIGNATURE _____

DATE _____



97 UNION STREET, WATERTOWN, MA 02472

TEL: 617-923-0930

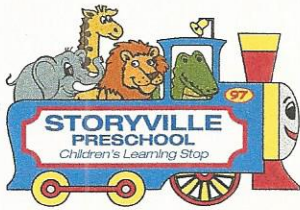
FAX: 617-923-2015

I give permission for my son/daughter, _____,
to go on walking trips with his/her classmates and Teachers.

I understand that my child's class may walk to local playgrounds
or on nature walks as part of the daily curriculum. I do not hold
Storyville Preschool or any of its staff responsible for any injury
that may occur to my child while on a walking trip.

Signed _____

Date _____



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FAX: 617-923-2015

Transportation Plan

My child _____ is a student at Storyville Preschool and his/her transportation back and forth to school is my responsibility.

The following people may possibly drive him/her to school or pick him/her up each day:

In the event of an emergency necessitating evacuation of the building I give Storyville Preschool staff permission to walk with my child to the Stop & Shop in Watertown. If wider spread evacuation is necessary I give permission for my child to be transported via a bus provided by the Local Motion Bus Company. In the event of an extreme emergency that requires widespread evacuation I give permission for my child to be transported by private staff vehicles if we are unable to hire a bus in time. Parents will be notified of these plans as they are occurring.

Parent(s) _____
signature _____

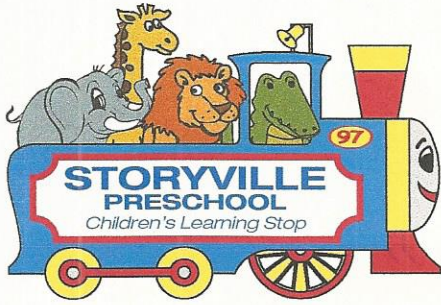
Date _____

Waiver

I give my child _____ permission to participate in the "Imagine and Move" class taught by Brenda Callahan. I release Ms. Callahan and Storyville Preschool from liability for any accidental injury caused by participation in this class. The class will take place on alternating Tuesdays, beginning on March 17th, 2015.

Parent signature _____

Date _____



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Storyville Preschool is now on Facebook, and would like to post pictures of our Storyville children involved in great projects and activities at our school. Please indicate below whether you give permission for your child to be on our Facebook page. No identifying information will be included with any child's photo.

My child's name is:

I do _____ give my permission for my child to be on Storyville's facebook page

I do not _____ give permission for my child to be on Storyville's facebook page

Parent signature _____

Date _____

**Please return this form to the office at your earliest convenience. Thanks!