

The Commonwealth of Massachusetts
Department of Early Education and Care

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: _____

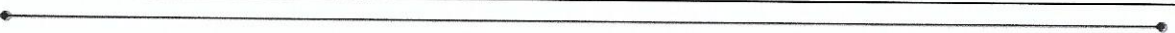
Address: _____ Phone Number: _____

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? _____



School Age Only

Current School: _____

School Address: _____ School Phone Number: _____

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 are on file at my child's school. ***Parent/Guardian initials:***



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: _____

Child's Allergies: _____
Chronic Health Conditions: _____

Emergency Contacts (In order to be contacted)

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

Name _____
Address _____
Relationship to child _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

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 _____ Cell _____
Parent/Guardian Name: _____	Phone _____ Cell _____

Parent /Guardian Signature

Date (valid for one year)

PERMISSION SLIP - TRANSITIONS

A plan has been developed to assist your child's transition between the classroom and the Program. In the past, we may have had conversation with a classroom teacher when and if a child came to the Program clearly agitated, upset, distressed or troubled. We found that sharing this information was most helpful when welcoming your child to the Program. Please sign and return the form below giving us permission to share pertinent information to allow for a smooth transition between the classroom and the Program.

I, _____ give permission for educators to share pertinent information with other education professionals, issues that concern my child's _____ welfare and being.

(child's name)

date _____

SG/LGTransportationAuthorization20100326
THE COMMONWEALTH OF MASSACHUSETTS
All Day Program Form

Department of Early Education and Care
Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE
ALL DAY PROGRAM :

- PARENT DROP OFF
- SUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

MY CHILD WILL DEPART FROM THE
ALL DAY PROGRAM (to Dawson Recreation Area) :

- PARENT PICK UP
- SUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE
ALL DAY PROGRAM
(From Dawson Recreation Area):

- PARENT DROP OFF
- SUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

MY CHILD WILL DEPART FROM THE
ALL DAY PROGRAM (or Dawson Recreation Area):

- PARENT PICK UP
- SUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

PARENT /GUARDIAN SIGNATURE _____
DATE _____

**REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR
RELEASE INFORMATION**

REVISED 3/28/12

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

OFF SITE ACTIVITIES PERMISSION FORM

Section 1 - Program completes prior to parental consent

Program: Before/After School Program - Dawson - 155 Salisbury St.
Mayo - 351 Bullard St.
Davis Hill - 80 Jamieson Rd.
All Day Summer Program - Dawson Rec. Area - 200 Salisbury St.

Name of Educator(s) responsible for child: varies

Name of off-site location and address: Field, gym, playground, library, pods, art room
SUMMER ONLY: Dawson Recreation Area: basketball courts, tennis courts, playground, field and pools.

Date of off-site activity: Monday - Friday
Time Leaving Program: varies Time Returning to Program: varies
Method of Transportation: walk Fee associated with activity (if any): \$0.00

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 #: _____

(Parent/Guardian Signature)

(Date)

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