Ms. London's Bilingual Academy

# Child Enrollment Form

## Child Information

Date of Admission:_____ School Year of Enrollment: _____ Age at Admission: _____

Child's full name: _____Date of Birth: _____

Address:_____ City:_____ Zip:_____

Nickname _____ Sex: _____ Height: _____ Weight: _____

Primary Language of Child _____ Primary Language of Parents_____

Allergies/Special Diets _____

## Parent/Guardian Information

Name of Parent/Guardian_____ Relationship to Child_____

Home address (if different) _____

Telephone Number: _____ Email Address: _____

Name of Parent/Guardian_____ Relationship to Child_____

Home address (if different) _____

Telephone Number: _____ Email Address: _____

## Parent(s)/guardian(s) business address/location during childcare:

Parent/Guardian: _____ Parent/Guardian: _____

Where: _____ Where: _____

Telephone: _____ Telephone: _____

Cell Phone: _____ Cell Phone: _____

Instructions: _____ Instructions:_____

_____ _____

## Emergency Contact/Authorized pick-up person

(1) Name: _____ Address _____

Telephone _____Cell Phone _____

(2) Name: _____ Address _____

Telephone _____ Cell Phone _____

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## TRANSPORTATION PLAN / AUTHORIZED PICK- UP

| My child will arrive to the program by: | My child will depart the program by: |
|---|---|
| __Parent Drop Off<br>__Supervised Walk<br>__Unsupervised Walk<br>__Public/Private Van<br>__Program Bus/Van<br>__Private Transportation Provided by Parent | __Parent Pick Up<br>__Supervised Walk<br>__Unsupervised Walk<br>__Public/Private Van<br>__Program Bus/Van<br>__Private Transportation Provided by Parent |

In the space below, please note any important information regarding transportation of your child to and from the program (i.e.--indicate who will be supervising children during transport or prior to their arrival at the program, who supervises the walk from a bus stop, etc.)

_____

_____

I additionally authorize the following individual to take my child from the childcare premises. (Please let me know at the beginning of the day when your child will be picked up by one of the authorized individuals.)

Name _____ Address _____

Telephone _____ Cell Phone _____

Name _____ Address _____

Telephone _____ Cell Phone _____

## Child's Physician or Health Care Professional

Name: _____ Telephone: _____

Address: _____

Information on allergies, special diets, chronic health conditions, special limitations, concerns including medications child is taking at home/school and possible side effects:

_____

_____

_____

_____ _____

**Parent/Guardian Signature** **Date**

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# Developmental History and Background Information

Regulations for licensed childcare 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:

_____


## Developmental History and Background Information

### 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? _____ Highchair? _____

* 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? _____

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## Developmental History and Background Information

### 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/childcare:

_____

_____

_____

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## Developmental History and Background Information

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.
*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**

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# Emergency Care Consent Form

Child's Name:_____ Date of Birth:_____
Child's Home Address:_____
Phone: _____

Instructions to Reach Parent 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. _____
(Name, Address, Home and Cell Phone #)

2. _____
(Name, Address, Home and Cell Phone #)

Emergency Medical Treatment

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

administer basic first aid and/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

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# Permissions & Autherizations

## Permissions (for each child enrolled)

General Permission- (Basic Transport) (Parents should not sign this permission unless specific places where your child is allowed to go are listed by your educator.) By signing this form, I am allowing my child to be taken off the childcare premises.

I, hereby give _____ permission to take my child _____
(educator/assistant)

off the premises of the family child care home for the following excursions: (specific places your child is allowed to go): _____
_____
_____
using the following forms of transportation: _____
_____

_____ _____
Parent/Guardian Signature Date

I do not want my child to be taken off the childcare premises.

_____ _____
Parent/Guardian Signature Date

## Permission - (Transport to Medical Facility and Receive Emergency Medical Treatment)

Medical Emergency Treatment (Department of Early Education and Care recommends checking with your local hospital about the acceptability of this statement)

I, hereby give _____ permission to administer basic first aid and/or
(educator/assistant)

CPR to my child _____, and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____
Parent/Guardian Signature Date

Topical Medication/Ointments (Please list only those medications/ointments which you will allow the educator(s) to administer to your child's skin): Ex: sunscreen, insect repellent (bug spray), diapering ointment.
_____
_____

_____ _____
Parent/Guardian Signature Date

# Permissions & Autherizations

## Written Acknowledgement of Receipt of Parent Handbook

I acknowledge that I have received a copy of the provider's parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook).

_____ _____
Parent/Guardian Signature Date

Photo Release Permission Slip
____ YES, I give Ms. London's Bilingual Academy permission to take pictures/videos of my child. Photographs and videos are only used for center purposes including website and promotion.

____ NO, I do not authorize Ms. London's Bilingual Academy to take pictures/videos of my child for any event.

Student's Name: _____
_____ _____
Parent/Guardian Signature Date

## Child Release Permission

I authorize the following persons to pick up my child from Ms. London's Bilingual Academy. I also understand that these persons will also be called if the Center staff is unable to reach either parent in case of accident or illness. Please include both parents if applicable.

Name _____Relationship _____Phone _____

Signature _____ Date_____

Name _____Relationship _____Phone _____

Signature _____ Date_____

Name _____Relationship _____Phone _____

Signature _____ Date_____

Name _____Relationship _____Phone _____

Signature _____ Date_____

Name _____Relationship _____Phone _____

Signature _____ Date_____

Ms. London's Bilingual Academy

# Physician Letter & Immunization Record

Dear Physician: _____
(Child's Name)

is enrolled in a family childcare home which is licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one (1) year from the date the child was examined and must be renewed annually thereafter.

## IDENTIFICATION

Name of Child: _____ Date of Birth: _____
Address: _____ Phone # _____
Name of Parents: _____
Address: _____
Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance:
_____
_____

Has this child been screened for lead poisoning? Yes _____ No _____

(*At least one (1) time between ages 9-12 months; Annually-Ages 2 & 3; at Age 4 if High Risk for Lead Poisoning)

If Yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the childcare educator? If so, please detail below:
_____
_____
_____

Physician's Signature: _____Date: _____

Comments: _____
_____
_____
_____

**Please return this form and the child's immunization record to:**

_____

_____

_____

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## Medical Form

Dear Physician/Health Care Professional:

The Department of Early Education and Care requires that all persons who will be caring for children in their homes or working as an assistant in a licensed family child care home be examined by a physician/health care professional. EEC allows a licensee or a certified assistant to care for up to eight children under the age of fourteen without any assistance provided two of the children are school age.

Your patient, _____, is required to submit this medical form as part of his/her licensing or certification requirement. Please fill out the form in its entirety and return it to your patient.

Name of patient: _____ Date of birth: _____
Address: _____

Date of Examination: _____

In your professional opinion what is the status of your patient's general physical and mental health?

_____

_____

_____

_____

In your professional opinion does your patient have any limitations (for example side effects of medication, inability to lift, etc.) that would affect his/her ability to work with young children? If yes, please provide details of any of these limitations.

_____

_____

_____

Are you the patient's treating physician/health care professional? _____ If so, how long have you been treating this patient?

_____

If not, how many times have you seen this patient?

_____

Comments:

_____

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## Medical Form

Has this person been immunized in accordance with the requirements of the Department of Public Health (Mumps, Measles and Rubella)?

_____ Yes _____ No

Family childcare educators may be granted a medical exemption if they are able to provide documentation signed by a physician stating the specific medical exemption. Please indicate whether your patient should be medically exempted from proving immunity to these diseases based on the fact that re-vaccination may be medically contraindicated.

_____

_____

_____

_____
Signature of Physician/Health Care Professional

_____
Date

_____
Please print your name, address, telephone number, and license number -

_____

_____

_____