Child Development and Education

UPDATE / CHANGE FORM

(Please complete Registration Packet for the Provider.) Please fill out form completely - N/A in areas not applicable.

GENERAL INFORMATION

Date of Admission: _____ Date of Birth: _____ Date of Discharge: _____

Child's Full Name: _____ Nickname: _____

Address: _____ City: _____

Telephone Number: _____ Primary Language: _____

Eye Color: _____ Hair Color: _____ Sex: _____ Height: _____ Weight: _____

Allergies/Special Diets: _____

PARENT'S / GUARDIAN'S INFORMATION (Both):

Parent/Guardian #1: _____ Parent/Guardian #2: _____

Address #1 (if different): _____ Address #2: _____

Telephone #1: _____ Telephone #2: _____

Cell phone #1: _____ Cell phone #2: _____

Work #1: _____ Work #2: _____

Parent's / Guardian's location/s during child care (give address) Specify at work or school, or other:

Guardian #1: _____ Guardian #2: _____

Special Instructions: _____

EMERGENCY CONTACTS / AUTHORIZED & NON-AUTHORIZED PICK-UP PERSON:

#1 Name: _____ Address: _____

Telephone: _____ Cell phone: _____ Work: _____

#2 Name: _____ Address: _____

Telephone: _____ Cell phone: _____ Work: _____

☐ YES, I additionally authorize the following individual to take my child: (name) _____ from the child care premises.
(Notify the Provider at the beginning of the day when your child will be picked up by one of the authorized individuals.)

#1 Name: _____ Address: _____

Telephone: _____ Cell phone: _____ Work: _____

Non-Authorized Person/s: _____

CHILD CARE NEED - SCHEDULE

DAY	IN / OUT	IN / OUT	DAY	IN / OUT	IN / OUT	DAY	IN / OUT	IN / OUT
Monday Thursday Sunday			Tuesday Friday			Wednesday Saturday		

ACKNOWLEDGEMENT OF PARENT FACT SHEET AND PARENTAL VISIT NOTICE (First two pages of the Registration Packet.)

☐ YES, I acknowledge that I have read and received the first two pages; Parent Fact Sheet developed by EEC and I understand that I may visit my Family Child Care Provider, _____ unannounced at any time during the hours that my child is in care.

SIGNATURE REQUIRED: _____ **DATE REQUIRED:** _____

PEDIATRICIAN OR SOURCE OF HEALTH CARE

Name: _____ Telephone: _____

Address: _____ City: _____

MEDICAL INSURANCE INFORMATION (Optional)

Subscriber's Name: _____ Insurance/Policy: _____

LIST ANY MEDICAL CONCERNS, MEDICATIONS OR DISABILITIES: (ASTHMA, ALLERGIES, OR ANY HEALTH CONDITIONS)

_____

SPECIAL INSTRUCTIONS: _____

☐ YES *I authorize my provider and/or her assistant to move my children from the home in the event of an emergency.*

SIGNATURE REQUIRED: _____

☐ YES I authorize Child Development and my provider to do an Educational and Developmental Assessment of my child and to provide me with the information.

_____ _____

PARENT/GUARDIAN'S SIGNATURE **CDE STAFF SIGNATURE**

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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 child care premises.

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

my child _____ 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:

Signature of Parent/Guardian: _____ **Date:** _____

☐ ***I do not want my child to be taken off the child care premises.***

Signature of Parent/Guardian: _____ **Date:** _____

Permission for 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 _____ (educator/assistant)

permission to administer basic first aid and/or 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.

Signature of Parent/Guardian: _____ **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.

Signature of Parent/Guardian: _____ **Date:** _____

Annual Update Form

The regulations require that all children's records be reviewed and updated as necessary, but at least once a year. All written permission forms are valid for one year from the date it is signed unless the consent is withdrawn in writing prior to that time.

Please review the information contained in this record and make any corrections. By signing this form, you are stating that you give the educator(s) permission to:

1. Transport your child to a medical facility and receive emergency medical treatment***
2. Administer basic first aid and/or CPR on your child.
3. Take your child off the premises of the family child care home for the specified excursions.
4. Apply the topical medications listed on the applicable permission form.
5. Use the on-site swimming pool (if applicable).

*** The actual permission forms on the Emergency Card/Form that the educator must take with her when she leaves the premises must be signed again.

SIGNATURE REQUIRED: _____ **DATE REQUIRED:** _____

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10 Cabot Road, Suite 201, Medford, MA 02155 Tel: (781) 393-5100 / Fax: (781) 393-5120 | www.cdedu.us

ENROLLMENT PACKET HEALTH CARE FORM

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

(PLEASE CHECK ALL THAT APPLY)

Child's Photo

PLAN WAS CREATED BY:

- ☐ Parent
- ☐ Doctor or Licensed Practitioner
- ☐ Program's Health Care Consultant
- ☐ Older school age child (9+ yrs. of age)
- ☐ Other: _____

PLAN IS MAINTAINED BY:

- ☐ Director
- ☐ Assistant Director
- ☐ Child's Educator
- ☐ Other: _____

Child's Name: _____ Date: _____

Any change to the child's Health Care Plan? Yes ☐ (**indicate changes below**) No ☐ (**updated physician/parental signatures required**)

Name of chronic health care condition:

Description of chronic health care condition:

Symptoms:

Medical treatment necessary while at the program:

Potential side effects of treatment:

Potential consequences if treatment is not administered:

Name of educators that received training addressing the medical condition:

Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Signature of Parent/Guardian Consent: _____ **Date:** _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of Child: _____ Date of Birth: _____ Back-up medication received? Yes ☐ No ☐

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Administrator: _____ **Date:** _____

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UPDATE / CHANGE FORM

Complete Only For Children Under 2 Years Old

Development 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.
(*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(s) 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 for toileting:

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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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.

Parent/Guardian initials: _____

When does your child go to bed at night? _____ When does your child 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: _____

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?

Signature of Pare nt/Guardian: _____ **Date :** _____

RESET FORM

SUBMIT FORM