Family ACCESS
Early Learning Center

FOR CENTER USE
Date of Admission: _____
Age at Admission: _____

CHILD'S FACE SHEET/ENROLLMENT FORM
INFANT/TODDLER

CHILD INFORMATION:

Child's Name: _____ Date of Birth_____

Home Address: _____ Place of Birth:(city/town)_____

Telephone: _____ Primary Language: _____

Child's Identifying Information (required by the Department of Early Education and Care regulations):

Eye Color:_____ Hair Color:_____ Sex:_____

Height: _____ Weight:_____ Ethnicity:_____

Skin Color(optional): _____Identifying Marks: _____

Allergies/Special Diets: _____

Special limitations or concerns: _____

Is your child on an Individualized Health Plan for a chronic medical condition? Yes _____ No _____ if yes, please attach.

Please enclose copies of any custody agreements, court orders, and restraining orders pertaining to your child. Yes _____ No _____, if yes please attach

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name _____ Parent/Guardian Name _____

Relationship to child _____ Relationship to child _____

Home address _____Home address _____

Business/School Name _____ Business/School Name_____

Address _____Address _____

Work Phone # _____Work Phone #_____

Occupation _____Occupation _____

Parent/Guardian Signature _____ Date _____

Parent or Guardian must take responsibility for updating this information valid for one year

Family ACCESS
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IDENTIFICATION AND EMERGENCY INFORMATION

Name of Child: _____ D.O.B.: _____ Age: _____
Last First Nickname

Address: _____ City: _____Zip: _____ Phone: _____

Primary Parent/Guardian: _____

Employment/School: _____ Phone: _____ Hours: _____

Cell/Beeper #: _____ e-mail address: _____

Parent/Guardian: _____

Employment/School:_____ Phone: _____ Hours: _____

Cell/Beeper #: _____ e-mail address: _____

Child's Physician:_____ Phone: _____

Child's Dentist: _____ Phone: _____

Local contacts to be called in case of emergency if parent/guardian cannot be reached.
Under no circumstances will your child be released to anyone not listed without authorization of parent/guardian. List in the order to be called.

I give permission for my child to be released to the following:

1) Name _____ Relationship to child _____

Address _____ Phone _____

2) Name _____ Relationship to child _____

Address _____ Phone _____

3) Name _____ Relationship to child _____

Address _____ Phone _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian is responsible for updating information

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Family ACCESS
Early Learning Center

Medical Release Form

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 give permission to the staff of Family ACCESS of Newton to provide/or secure medical care for my child. I also give permission to have my child transported to Newton-Wellesley Hospital or _____ in the event of a medical emergency.

I understand that the staff members and providers are trained in the basics of first aid/CPR and I authorize them to give my child first aid/CPR when appropriate.

Physician's Name_____

Address _____Phone_____

*Child's Allergies/Medication(s)

_____

**Chronic Health Conditions

_____

*** An allergy/asthma plan must be on file in the Early Learning Center office.**
**** An individual health plan must be on file in the Early Learning Center office.**

Health Insurance Co: _____Policy# _____

Parent/Guardian Name: _____Phone: _____ Cell: _____

Parent/Guardian Name: _____ Phone: _____Cell: _____

_____ _____
Parent/Guardian Signature Date

Parent or Guardian must take responsibility for updating this information valid for one year

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Office Copy

Family ACCESS
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Medical Release Form

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 give permission to the staff of Family ACCESS of Newton to provide/or secure medical care for my child. I also give permission to have my child transported to Newton-Wellesley Hospital or _____ in the event of a medical emergency.

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Health Insurance Co: _____Policy# _____

Parent/Guardian Name: _____Phone: _____ Cell: _____

Parent/Guardian Name: _____ Phone: _____Cell: _____

_____ _____
Parent/Guardian Signature Date

Parent or Guardian must take responsibility for updating this information valid for one year

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Classroom Copy

Family ACCESS
Early Learning Center

GENERAL PERMISSIONS

By initialing the following statements, I, _____ give permission for my child, _____ to participate in the specifically noted activities.

FIELD TRIPS: I give permission for my child to go on local community field trips with the Infant/Toddler Program. These trips may include: Newton Police Station, walks around West Newton Square, Webster Park, Albemarle Park, West Newton Post Office, CVS, and other West Newton businesses.

_____ _____ _____
YES NO INITIALS

SUN SCREEN: I hereby authorize the Family ACCESS of Newton, Early Learning Center to apply Rocky Mountain Oxybenzone Free or equivalent sun screen, SPF 30, to my child.
I will supply my own sun screen: _____ Product Name: _____
To be applied when going outdoors, or as directed _____
_____

_____ _____ _____
YES NO INITIALS

POOL ACTIVITIES:I hereby give permission for my child to participate in water play inclusive of sprinklers, wading pools, etc.

_____ _____ _____
YES NO INITIALS

PHOTOGRAPHS: I hereby give permission for Family ACCESS of Newton, Early Learning Center to use any pictures, videos, or slides of my child, taken in the course of his/her participation in Family ACCESS Early Learning Center, for newsletters and mounted on bulletin boards at Family ACCESS.

_____ _____ _____
YES NO INITIALS

PHOTOGRAPHS: I hereby give permission for Family ACCESS to use any pictures, videos, or slides of my child, taken in the course of his/her participation in Family ACCESS of Newton Early Learning Center, for general marketing or publicity purposes for the agency.

_____ _____ _____
YES NO INITIALS

STUDENT DIRECTORY: I hereby give permission for Family ACCESS of Newton to use my email, phone number and address in the Family ACCESS student directory.

_____ _____ _____
YES NO INITIALS

REFERENCE: I hereby give permission for Family ACCESS to give my name, email address and phone number out to families of potential students.

_____ _____ _____
YES NO INITIALS

_____ _____

Parent Signature Date

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TRANSPORTATION PLAN

Child's Name: _____

Please name who is responsible for your child prior to their arrival at the program: (ex. School or Parent)
_____.

My child will arrive at the program by:
_____ Parent or authorized person dropping off
_____ Newton Schools
_____ Other (Please specify) _____

My child will depart from the program by:

_____ Parent or authorized person picking up
_____ Newton Schools
_____ Other (Please specify) _____

If your child is enrolled in Newton Early Childhood Program please specify their schedule (days and arrival time to Family ACCESS):
_____

I give permission for my child to be released from the program at the end of the day as stated above. Any other transportation requests must be stated in writing and maintained in the child's file or the above plan must be implemented. This permission is valid for one program year from the date of the signature.

Parent/Guardian Signature _____ Date _____

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DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION
INFANT AND TODDLER PROGRAM

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME: _____ DATE OF BIRTH: _____

FAMILY:
List all family members (include names, ages, and how your child addresses each member)
Name Relationship Age In/Out of Home Child's Name for

_____
_____
_____
_____
_____
_____
_____

DEVELOPMENTAL HISTORY:

Age began sitting _____ crawling _____ walking _____ talking _____

Does child pull up? _____ crawl? _____ walk with support? _____

Any speech difficulties? (describe) _____

Special words to describe need? _____

Language spoken at home? _____ Any history of colic? _____

Does child use pacifier or suck thumb? _____ When? _____

Does child have a fussy time? _____ When? _____

How do you handle this time? _____

HEALTH:

Any known complication 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: _____

Favorite foods: _____ Foods refused: _____

If infant is on a special formula, describe its preparation in detail: _____

_____

Child eats with hands ____ spoon ____ fork ____ Child fed on lap? ____ in high chair? ____

TOILET HABITS:

Are disposable or cloth diapers used? _____Is there frequent occurrence of diaper rash? _____ Do you use: oil ____ powder _____ lotion ____ other ____

Are bowel movements regular? _____ How often? _____

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 center: _____

What is used at home? Potty chair _____ special seat _____ regular seat _____

How does child indicate bathroom needs (include special words)? _____

_____

Is child ever reluctant to use the bathroom? _____ Does child have accidents?

_____

SLEEPING HABITS:

Does your child sleep in a crib? _____ bed _____

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.)

_____

_____

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 pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

SOCIAL RELATIONSHIPS:

How would you describe your child:

_____

Previous experience with other children/child care _____

Reaction to strangers: _____ Ability 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, by approximate time, your child's current daily activities, i.e., awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.

A.M.	P.M.

Is there anything else you would like us to know about your child?

_____

_____

_____

Parent/Guardian Signature_____ Date_____

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Oral Health Non-Participation Form

EEC has issued new regulations for child care programs that include a requirement that educators assist children with brushing their teeth if children are in care for more than four hours or if children have a meal while in care [606 CMR 7.11(11)(d]. This regulation is intended to:

- Help children learn about the importance of good oral health
- Provide information and resources regarding good oral health to child care programs and families
- Help address the high incidence of tooth decay among young children in Massachusetts, which is associated with numerous health risks.

EEC licensed programs must comply with this regulation. However, parents may choose that their child (ren) not participate in tooth brushing while present at the child care program.
You do not need to fill out this form to have your child (ren) participate in tooth brushing while they are in child care. However, if you do not want your child to brush his or her teeth while s/he is attending the child care program, please fill out the information found below. A separate form must be filled out for each child in care. This form must be renewed annually and will be kept in your child's record at the program. Should you change your mind and wish for your child to participate in tooth brushing, this form may be withdrawn at any time by requesting in writing that it be removed from your child's file. Thank you.

I do not wish to have my child participate in tooth brushing while in care at

Family ACCESS of Newton, Early Learning Center

Child's Name:_____

Parent/Guardian's Name: _____

Signature:_____

Date:_____
If you have any questions or concerns, please call or email:

Linda Miller at lmiller@familyaccess.org or (617) 969-5906 ext 121

Family ACCESS Early Learning Center

Dear Parent/Guardian,

We are pleased to announce that we will begin implementing our annual screening again this fall to all children 5 years and under in our Early Learning Center programs. We will use the Denver II Developmental Screening Test, as we have now done for the past couple of years.

This screening tool looks at four areas of child development - social-emotional, fine motor, language, and gross motor. The Denver II is the most internationally recognized and used developmental screening test. It is used in a variety of settings including: pediatric offices, public health clinics, early intervention programs, home visitation programs, Early Start and Head Start programs, childcare centers, and preschools. The Denver II may be used to monitor a child's development as well as a screen for any areas of concern.

Developmental screening is considered a "best practice" for early education and child care settings. Measuring your children's skills early in their EEC experience and then several months later will assist us in addressing any specific developmental concerns and also help us determine the effectiveness of our programming.

The screen is quick, simple and usually fun for children. It typically takes less than 20 minutes. Your child will be screened by the clinician from the Parents Program, who regularly visits your child's class and is familiar with your child. We will share screening results once completed

Please complete and return the form below to your child's teacher. Please contact Susan Sklan, Director of the Parents Program (ssklan@familyaccess.org, ext. 125) or Suzy Blevins, Early Childhood Specialist (sblevins@familyaccess.org, ext. 133) with any questions.

Thank you,

Lonnie Schroeder
Senior Director, ELC

- -

I, _______________________________, parent of ____________________ give permission for my child to be screened using the Denver II Developmental Screening Test. I will be contacted prior to the screening. I understand that information regarding screening results will be shared upon completion and scoring of the test.

___________________________ ________________

Signature Date

If your child was born more than 2 weeks before the expected date of delivery and is less than 2 years of age, please indicate how many weeks your child was premature. This information will allow for more accurate screening results.

Premature: Yes No

Number of weeks premature: _________________________

Family ACCESS
Early Learning Center

Dear Physician: _____
(Child's Name)
is enrolled in an early childhood program 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, updated immunizations and lead screening in accordance with Department of Public Health's recommended schedules.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter. A copy of a health form signed by physician is acceptable.

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 _____
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 child care provider? If so, please detail below:
_____
_____
Is this child on an Individualized Health Plan for a chronic medical Condition? ____Yes if yes, please enclose.

Physician's Signature: _____

Date: _____ Comments: _____

Please return to Parent/Guardian or Program:
Family ACCESS of Newton, Early Learning Center
492 Waltham Street
West Newton, Massachusetts 02465-1920
(617) 969-5906 or (617) 964-3975 Fax