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Admissions Checklist

- ☐ Enrollment Application
- ☐ Enrollment Form
- ☐ First Aid/Emergency Medical Consent and Release
- ☐ Off Site Consent
- ☐ Transportation Plan
- ☐ Individual Health Care Plans (if applicable)
- ☐ Developmental History
- ☐ Annual Physical
- ☐ Immunizations
- ☐ Lead Screening
- ☐ Tooth Brushing Authorization

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First Day of School Checklist

We are so excited for your child to learn and grow at The Wonder School! Below you will find a list of supplies that your child will need for his/her first day of school.

Extra clothes

- ☐ Weather suitable shirt
- ☐ Weather suitable pants
- ☐ Shoes
- ☐ Underwear
- ☐ Socks

- ☐ Lunch stored in lunchbox with icepack or in thermos
- ☐ Water bottle
- ☐ Labeled package of diapers
- ☐ Labeled package of wipes
- ☐ Diaper cream with Topical Ointment authorization form completed
- ☐ Sleeping bag/fitted sheet and light blanket for nap time, small stuffed animal in bag
- ☐ Medication (if applicable) with Medication Authorization form completed

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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 #1: _____

Relationship to Child: _____

Home Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Occupation & Title: _____ Employers Name: _____

Business Address: _____ City: _____

Business Phone: _____ Email: _____

Hours at Work:_____

Parent/Guardian #2: _____

Relationship to Child: _____

Home Address: _____

City: _____ Zip: _____

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Home Phone: _____ Cell Phone: _____

Occupation & Title: _____ Employers Name: _____

Business Address: _____ City: _____

Business Phone: _____ Email: _____

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*

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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_____

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Health Insurance Coverage_____

Policy #_____

Parent/Guardian Name: _____

Phone_____ Cell_____

Parent/Guardian Name: _____

Phone_____ Cell_____

_____ _____

Parent /Guardian Signature *Date (valid for one year)*

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Medication Consent Form

606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please check one of the following: Prescription: ☐ Oral/Non-Prescription: ☐

Unanticipated Non-Prescription for mild symptoms ☐

Topical Non-Prescription ***(applied to open wound/ broken skin)*** ☐

My child has previously taken this medication ☐

☐ My child has **NOT** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan.

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____ Date_____

I, _____ (print name), (parent or guardian) gives permission to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date_____

*For topical, non-prescription **NOT** applied to open wound / broken skin (parent signature only)*

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Off Site Activities Permission Form

Children will always be accompanied with staff from The Wonder School and the teacher will always have a cell phone in case of an emergency.

I give permission for my child, _____ to leave The Wonder School property to go on walks or for activities in the surrounding area.

(Parent/Guardian Signature) _____ (Date)_____

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

Child's name_____

My child will arrive at the program

- ☐ Supervised walk
- ☐ Unsupervised walk
- ☐ Public/private/van
- ☐ Program bus/van
- ☐ Contract/van
- ☐ Private trans. *Arranged by parent*
- ☐ Other

My child will depart from the program:

- ☐ Supervised walk
- ☐ Unsupervised walk
- ☐ Public/private/van
- ☐ Program bus/van
- ☐ Contract/van
- ☐ Private trans. *Arranged by parent*
- ☐ Other

I give permission for my child to be released from the program at the end of the program day as stated above and /or I give permission to the following people to receive my child at the end of the day. (If no one is authorized other than the parent/legal guardian please indicate below "NO ONE".)

***IF A CHILD IS PROTECTED BY A RESTRAINING ORDER PLEASE SUBMIT ORDER TO THE PROVIDER.**

Name_____ Relationship_____

Address_____

Phone_____ Cell_____

Name_____ Relationship_____

Address_____

Phone_____ Cell_____

Name_____ Relationship_____

Address_____

Phone_____ Cell_____

Parent/Guardian Signature_____ **Date**_____

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Individual Health Care Plan Form

Child's Photo

Plan must be renewed annually or when child's condition changes Check all that apply….

Plan was created by:

Plan is maintained by:

__ Parent
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Older school age child (9+ yrs. of age)
__ Director
__ Assistant Director
__ Child's Educator
__ Other:____

Name of child: _____ 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:_____

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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:_____

Parental/Guardian consent: _____

Date:_____

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The Commonwealth of Massachusetts
Department of Early Education and Care
Developmental History and Background Information

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: _____

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: _____

_____

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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: 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 center:

_____

*What is used at home? Pottychair? _____ 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 your child have accidents? _____

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)?

_____

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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.

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 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 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.

_____

_____

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Is there anything else we should know about your child? _____

_____

_____

_____

_____

_____ _____

(Parent/Guardian Signature) *(Date)*

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Tooth Brushing Authorization

Dear Parent or Caregiver:

With concerns about the increase in tooth decay (cavities) among young children, the Massachusetts Department of Early Education and Care (EEC) recently adopted a new regulation for child care settings, number 606 CMR 7.11(11)(d), to promote oral health and prevent tooth decay.

Effective January 2010, child care workers must assist children with brushing their teeth if:

1. **The children are in care for more than 4 hours, or**
2. **They have a meal while in care.**

Some quick facts about the program:

- This program will be implemented safely by following the regulations for infection control set by the U.S. Centers for Disease Control and Prevention (CDC).
- It will be a great benefit for your child, their mouth health and general health
- Children will be brushing with the direct supervision of our child care staff
- Children will be using toothpaste with fluoride and approved by the American Dental Association
- Children will receive new toothbrushes after three months of use, or after they are sick

If you have any questions or concerns, please call 617-932-1175.

Child's Name: _____

Parent/Caregiver's Name: _____

Signature: _____

Date: _____

Comments: _____

_____

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Oral Health Non-Participation Form

In January 2010, EEC 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 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 completing a tooth brushing authorization form.

I do not wish to have my child participate in tooth brushing while in care at The Wonder School.

Child's Name: _____

Parent/Caregiver's Name: _____

Signature: _____

Date: _____

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

_____

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Photo and Observation authorization form

Child's full name: _____

Photographs and video's are taken on different occasions such as for documentation, birthdays, holidays, and special occasions. We use these pictures/videos in our school for teaching, arts & crafts, albums, newsletters, website and on our Facebook page.

Observations of students are done in the classroom as needed.

Please mark the appropriate box:

I give permission _____ I do not give permission _____

Date:_____

Parent Signature:_____