Child Care of the Berkshires, Inc.

Monument Square Early Childhood Center

Child's Face Sheet/ Enrollment Form

Child's Name____ Date of Birth ___________________

Place of Birth____ Primary Language ______________

Home Address_______________________________________ Telephone # ___________________

Age at Admission_____________________________________ Date of Admission______________

Child's Identifying Information (required by DEEC):

Eye Color____________________ Hair Color __________________ Sex _____________________

Height ________________________ Weight ____________________ Skin Color ________________

Identifying Marks ____

Other in Family (siblings)____

Parent/Guardian Information:

Parent/Guardian_______________________________________Relationship to Child ____________

Home Address ____

Home Phone ____Cell Phone ____________________

Bus. Name ____Occupation ____________________

Hours at Work _______________________________________Bus. Phone ___________________

E-Mail Address ____

Parent/Guardian Information:

Parent/Guardian______________________________________Relationship to Child ____________

Home Address ____

Home Phone ____Cell Phone ____________________

Bus. Name ____ Occupation ____________________

Hours at Work _______________________________________Bus. Phone ___________________

E-Mail Address ____

Additional Information:

Child's Physician _____________________________________Tel #_________________________

Address ____

Allergies/Special Diet ____

Chronic Health Conditions ____

Special Limitations or Concerns ____

____ _________________________________

Parent/ Guardian Signature Date

Child Care of the Berkshires, Inc.
Monument Square Early Childhood Center

AUTHORIZATION TO RELEASE FORM

Parent's Name: ____

Child's Name: ____

I hereby authorize Monument Square Early Childhood Center to release my child to the following persons (other than parents):

Name: ______________________________ Relationship: _________________

Address: ____________________________ Phone: ______________________

Name: ______________________________ Relationship: _________________

Address: ____________________________ Phone: ______________________

Name: ______________________________ Relationship: _________________

Address: ____________________________ Phone: ______________________

Parent Signature: _______________________________ Date:__________________

Please Note:

- CHILD WILL NOT BE RELEASED TO ANYONE UNLESS PARENT NOTIFIES THE CENTER.
- No one under the age of 16 may be an authorized contact person unless pre-approved by CCB/MSQ EEC.
- A copy of any court orders that restricts to whom the child can be released must be on file with Child Care of the Berkshires, Inc.

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** _____________

*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: ____

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 the 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)? ______________

____

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 walking 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.

____

____

____

Is there anything else we should know about your child?

____

____

____

Parent/Guardian Signature: ___________________________ Date: ______________________

EMERGENCY CARD INFORMATION

Child's Name: ____________________________________ DOB: __________________

Child's Home Address: ____

Home Phone Number: ____

INSTRUCTIONS TO REACH PARENT/ GUARDIAN

1. ____

Name, Address, Phone #

2. ____

Name, Address, Phone #

PEDIATRICIANS OR SOURCE OF HEALTH CARE

1. ____

Doctor's Name, Address, Phone #

EMERGENCY CONTACT PERSON(S)

1. ____

Name, Address, Phone #

2. ____

Name, Address, Phone #

MEDICAL EMERGENCY TREATMENT

I hereby give MONUMENT SQUARE EARLY CHILDHOOD CENTER permission to

administer basic first aid and/or CPR to my child ________________________________
Child's Name

and/or take my child ______________________________, to a hospital for medical
Child's Name

treatment when I cannot be reached or when delay would be dangerous to my child's

health.

Parent/ Guardian Signature: ______________________________ Date: _____________

INSURANCE INFORMATION (OPTIONAL)

Company Name: _____________________________ Policy #: ____________________
Participating Hospital: ____
Special Instructions: ____

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)

CHILD CARE OF THE BERKSHRIES, INC.
MONUMENT SQUARE EARLY CHILDHOOD CENTER
210 STATE STREET
NORTH ADAMS, MA 01247
413-664-4657

Permission Form for Topical Non-Prescription Medications

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I do hereby give permission to the staff of Monument Square Early Childhood Center to apply topical non-prescription medications (i.e.- Vaseline, A&D, Desitin, sunscreen, etc.) on my child ____________________________ as needed.

Medication(s): ___________________________________
____
____

Instructions: We must follow the directions on the original container, unless otherwise authorized by a written order from the child's physicians.

Parent's Signature: _______________________________

Date: ____

Note: This form is valid for one year.

Transportation Plan and Authorization
7.09(3) and 7.12(1)

Child's Name ____

My child will arrive at the program by:

_____ Unsupervised Walk
_____ Supervised Walk (who will walk the child ____________________)
_____ School Bus Drop Off
_____ Program Bus
_____ Program Van
_____ Parent Drop Off
_____ Other (describe ____)

My child will depart from the program by:

_____ Unsupervised Walk
_____ Supervised Walk (who will walk the child ____________________)
_____ School Bus Pick Up
_____ Program Bus
_____ Program Van
_____ Parent Pick Up
_____ Other (describe ____)

I give permission for my child to be released from the program at the end of the 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, please indicate below by writing "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_______________

CHILD CARE OF THE BERKSHIRES, INC.
Monument Square Early Childhood Center Program

RELEASE FORM

(RESOURCE TEACHER/STUDENT TEACHER/INTERNS)

MSQ has a Resource Teacher/students and or/interns from MSQ, MCLA,BCC, Early Intervention and Williams College.

You (the parents) are being informed that these people will be in the classrooms as part of their learning experience and also as a support for our teachers.

They will have direct contact with the children and the teachers.

They will be supervised by the teachers and are obligated to adhere to the same guidelines concerning confidentiality, as are the teachers.

Guardian Signature: ________________________________ Date: __________

Guardian Signature (Print):____________________________