

FACE SHEET — ENROLLMENT FORM

Child's Name _____

Date of Birth _____

Time of Arrival _____ Time of Departure _____

- Office use -

Date of Admission _____

Age at Admission _____

Primary Language _____

Place of Birth _____

Household Contacts

Parent or Guardian _____

Home Address _____

Primary Phone _____

Additional Phone _____

Business Name _____

Business Address _____

Business Phone _____

Additional Phone _____

Parent or Guardian _____

Home Address _____

Primary Phone _____

Additional Phone _____

Business Name _____

Business Address _____

Business Phone _____

Additional Phone _____

Others in Household / Relationship to Child

_____/_____
_____/_____

_____/_____
_____/_____

Emergency Contacts

Name _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Name _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Medical Contact

Child's Physician _____

Clinic _____

Telephone _____

Address _____

Identifying Information

Eye color _____

Hair Color _____

Sex _____

Height _____

Weight _____

Race _____

Identifying Marks _____

Parent or Guardian Signature _____ Date _____

FIRST AID AND EMERGENCY MEDICAL FORM

Check to use previously entered information:

Child's Name _____

Melrose YMCA Child Care Center

Date of Birth _____

106 Main Street

Melrose, MA 02176

I authorize the staff of Melrose YMCA Child Care Center, who are trained in the basics of first aid and CPR, to give my child first aid or 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 Melrose YMCA Child Care Center staff to transport my child to Melrose Wakefield Hospital or below listed hospital, and to secure necessary medical treatment for my child.

Secondary Hospital _____

Child's Physician _____

Telephone _____

Clinic _____

Address _____

Child's Allergies _____

Chronic Health Conditions _____

Health Insurance Coverage _____ Policy # _____

Emergency Contacts

Contact Name 1 _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Do you give permission for child to be released to this person? _____

Contact Name 2 _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Do you give permission for child to be released to this person? _____

Contact Name 3 _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Do you give permission for child to be released to this person? _____

Household Contacts

Parent or Guardian _____

Primary Phone _____

Additional Phone _____

Parent or Guardian _____

Primary Phone _____

Additional Phone _____

Parent or Guardian Signature _____

Date _____

COMMUNITY OUTING AUTHORIZATION

Check to use previously entered information:

Child's Name _____

Melrose YMCA Child Care Center

Date of Birth _____

106 Main Street

Melrose, MA 02176

I give permission for my child to walk or ride in a carriage to local parks, playgrounds and places of interest.

All children will be supervised and the appropriate staff to child ratio will be met.

Parent or Guardian Name _____

Parent or Guardian Signature _____ **Date** _____

TRANSPORTATION PLAN AND AUTHORIZATION

Check to use previously entered information:

Child's Name _____

Melrose YMCA Child Care Center

Date of Birth _____

106 Main Street

Melrose, MA 02176

My Child Will Arrive To The Program:

Supervised Walk

Unsupervised Walk

Public/Private Van

Program Bus/Van

Contract Bus/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 Bus/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. ***

Persons Authorized to Take Custody

Contact Name 1 _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Contact Name 2 _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Contact Name 3 _____

Relationship _____

Home Address _____

Primary Phone _____

Additional Phone _____

Parent or Guardian Signature

Date

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Check to use previously entered information:

Child's Name _____

Melrose YMCA Child Care Center

Date of Birth _____

106 Main Street

Melrose, MA 02176

Please provide information as appropriate to the age of your child.

*Details particular to Infants and Toddlers are marked **

Developmental History

Age began

sitting?

crawling?

walking?

Age began

talking?

Any speech difficulties?

Special words to describe needs

Language spoken

at home

*Any history

of colic?

Does your child

**pull up?*

**crawl?*

**Walk with*

support?

*Does your child use pacifier

or suck their thumb? When?

*Is there a fussy time? When?

*How do you handle this time?

Health

Any complications at birth?

Serious illnesses / hospitalizations

Special physical conditions / disabilities

Allergies

(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

*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 frequent diaper rash?	_____
*Regularly used skin protection	_____	*how often applied?	_____
(oil, powder, lotion, other)		How many per day?	_____
*Are bowel movements regular?	_____		
*Is there a problem with diarrhea or constipation?	_____		
*Has toilet training been attempted?	_____	*Special seat used at home	_____
		(Potty Chair / Child Seat / regular seat)	
*Please describe any particular procedure to be used for your child	_____		
*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

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.

*Does your child sleep in a <i>crib</i> ?	_____	<i>Bed?</i>	_____
* Does your child become tired or nap?	_____	When and for how long	_____
When does your child go to bed at night?	_____	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.

Is there anything else we should know about your child?

Parent or Guardian Signature

Date
