Please Print Clearly

Child's Name: _____

Parents Name: _____

DOB: _____

Day's you want your child to attend the Barnyard School: _____

Deposit/Check #: _____

- Please send back a copy of your child's last physical and updated immunizations.

The Commonwealth of Massachusetts Department of Early Education and Care

Child's Enrollment Form

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 Name: _____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____
Email Address:_____
Business Name:_____
Business Address:_____
Business Phone Number:_____
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 request the forms.**

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:_____

EMERGENCY CARD INFORMATION

Child's Name:_____
Date of Birth: _____
Child's Home Address:_____
Home Phone #: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1.

_____

Name Relationship Phone #

_____

Address

2.

_____

Name Relationship Phone #

_____

Address

PEDITRICIAN OR SOURCE OF HEALTHE CARE

_____

Doctor's Name Address Phone #

EMERGENCY CONTACT PERSONS

(People okay to pick up incase of emergency or illness and you can use the back of this page to write more people if needed)

1.

_____

Name Relationship Address Phone #

2.

_____

_Name Relationship Address Phone #

MEDICAL EMERGENCY TREATMENT

I hereby give THE BARNAYRD SCHOOL OF MANSFIELD permission to administer basic first aid/CPR to my child _____ and /or take my child _____,

Name Name

to a hospital for medial treatment when I cannot be reached or when delay would be dangerous to my child's health.

Insurance Information (optional)

Company Name:_____Policy #_____

Participating Hospital: _____Special Instructions:_____

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:
_____

Medications Taken on are regular
basis_____

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)? _____ _____ _____

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 their experience at school?

_____

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) _____

SG/LG/SADevelopmentalHistory20100122

THE COMMONWEALTH OF MASSACHUSETTS Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____DATE: _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___PARENT DROP OFF
___SUPERVISED WALK
___UNSUPERVISED WALK (School age only, 8-years and up)

___PUBLIC/PRIVATE/VAN

- NAME OF BUS/VAN COMPANY_____
- PHONE # OF COMPANY_____

****

MY CHILD WILL DEPART FROM THE PROGRAM:

___PARENT PICK UP
___SUPERVISED WALK
___UNSUPERVISED WALK (School age only, 8-years and up)

___PUBLIC/PRIVATE/VAN

- NAME OF BUS/VAN COMPANY_____
- PHONE # OF COMPANY_____

PRIVATE & PUBLIC TRANS WILL BE ARRANGED BY PARENT