

FIDELITY HOUSE PRESCHOOL

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 Name: _____ Parent/Guardian Name _____

Relationship to Child: _____ Relationship to Child: _____

Home Address: _____ Home Address: _____

Reachable Phone Number: _____ Reachable Phone Number: _____

Email Address: _____ Email Address: _____

Business Name: _____ Business Name: _____

Business Address: _____ Business Address: _____

Business Phone Number: _____ Business Phone Number _____

Hours at Work: _____ 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:***

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Parent/Guardian Signature

Date

FIDELITY HOUSE PRESCHOOL

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: _____

DEVELOPMENTAL HISTORY

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____

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: _____

Favorite foods: _____

Foods refused: _____

Does your child eat with spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

*Are bowel movements regular? _____ How many per day? _____

*Is there a problem with diarrhea? _____ Constipation? _____

*Has toilet training been attempted? _____

*How does your child indicate bathroom needs (include special words): _____

Is your child ever reluctant to use the bathroom? _____

Does your child have accidents? _____

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SOCIAL RELATIONSHIPS

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)

FIDELIT HOUSE PRESCHOOL

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 Signature

Date (valid for one year)

FIDELITY HOUSE PRESCHOOL

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

MY CHILD WILL DEPART FROM THE PROGRAM:

PARENT DROP OFF

PARENT PICK UP

SUPERVISED WALK

SUPERVISED WALK

UNSUPERVISED WALK

UNSUPERVISED WALK

PUBLIC/PRIVATE/VAN

PUBLIC/PRIVATE/VAN

PROGRAM BUS/VAN

PROGRAM BUS/VAN

CONTRACT/VAN

CONTRACT/VAN

PRIVATE TRANS. ARRANGED BY PARENT

PRIVATE TRANS. ARRANGED BY PARENT

OTHER

OTHER

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

MY CHILD WILL DEPART FROM THE PROGRAM:

PARENT DROP OFF

PARENT PICK UP

SUPERVISED WALK

SUPERVISED WALK

UNSUPERVISED WALK

UNSUPERVISED WALK

PUBLIC/PRIVATE/VAN

PUBLIC/PRIVATE/VAN

PROGRAM BUS/VAN

PROGRAM BUS/VAN

CONTRACT/VAN

CONTRACT/VAN

PRIVATE TRANS. ARRANGED BY PARENT

PRIVATE TRANS. ARRANGED BY PARENT

OTHER

OTHER

PARENT /GUARDIAN SIGNATURE _____ DATE _____

REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION

WALKING PERMISSION SLIP

_____ has my permission to leave Fidelity House Preschool to go on special school walking trips with the Preschool Teachers. This includes trips to the library, police station, post office, Parallel Park, Spy Pond, Fire Station or any other trip which might be planned.

Date

Signature-parent /guardian

MEDIA/PHOTO RELEASE

I hereby affirm that I am the parent (or guardian) of _____ and

I give my consent: Yes _____ No _____ for photographs of this child, by or for

Fidelity House, to be used and or reproduced for the purpose, illustration, publication,

education, i.e. future brochures, newspaper release in-service training to volunteer groups.

Date

Signature-parent /guardian

EMERGENCY CARD INFORMATION

Child's Name: _____

Date of Birth: _____

Child's Home Address: _____

Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

PEDIATRICIAN 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 _____
(Name of program)

permission to administer basic first aid and/or CPR to my child _____
(Name)

and/or take my child _____, to a hospital for medical
(Name)

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

(Parent Signature)

(Date)

INSURANCE INFORMATION (OPTIONAL)

Company Name: _____ Policy # _____

Participating Hospital: _____

Special Instructions: _____

**Massachusetts Department of Public Health
CERTIFICATE OF IMMUNIZATION**

Name _____

Date of Birth _____ Sex (check off) Female _____ Male _____

VACCINE			DATE	VACCINE			DATE	
Hepatitis B			1		Hib		1	
			2				2	
			3				3	
DTaP	DT	Td	1				4	
			2		MMR		1	
			3				2	
			4				1	
			5				2	
6			1					
IPV			7		Hepatitis A		2	
			1				1	
			2			PPV23 <i>(Pneumococcal Polysaccharide 23-valent)</i>		2
			3					1
PCV7 <i>(Pneumococcal conjugate 7-valent)</i>			4		Influenza		2	
			1				3	
			2			Other		
			3				<i>Date & Results</i>	
		4		<i>Of Lead Test</i>				

Serologic Proof Of Immunity	Date of Test	Check One		Check Off for	Chickenpox History
		Positive	Negative		
Test (if done)					CHECK IN THE COLUMN TO THE LEFT IF THIS PERSON HAS A PHYSICIAN-CERTIFIED RELIABLE HISTORY OF CHICKENPOX.
Measles					Reliable history may be based on: <ul style="list-style-type: none"> Physician interpretation of parent/guardian description of chickenpox Physical diagnosis of chickenpox, or Serologic proof of immunity
Mumps					
Rubella					
Varicella*					
Hepatitis B					
	*Must History box	also check off in column	Chickenpox to the right		

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print) _____ Date: _____

Signature: _____

Facility name: _____

Name _____

MEDICAL HISTORY (give dates)

Accidents	Ear Infections	Measles	Scarlet Fever
Allergy	Encephalitis	Meningitis	Strep Throat
Chicken Pox	German Measles	Mumps	Tonsillitis
Congenital Anomaly	Heart Disease	Operations	Tuberculosis
Convulsions	Hernia	Poliomyelitis	Whooping Cough
Diabetes	Kidney Disease	Rheumatic Fever	Other

PERTINENT FAMILY MEDICAL HISTORY

PRIVATE PHYSICIAN'S EXAMINATION

DATE _____ (o) normal (x) (Abnormal- Comment, Specify, Consultation requested)

Age _____ BP _____ / _____ Pulse _____ Hgt. _____ Wgt. _____

Physical Development _____

Nutritional Status _____

Skin _____

Eye _____ Sclera _____ Pupils _____ Light & Distance: R _____ L _____ Glasses _____

Ears _____ Canals: R _____ L _____ Drums: R _____ L _____

Nose _____ Septum _____ Turbinates _____

Mouth _____ Lips _____ Tongue _____ Pharynx _____

Teeth _____ Gingiva _____

Neck _____ Mobility _____ Lymph nodes _____ Thyroid _____

Throat _____ Shape _____ Symmetry _____

Lungs _____

Heart _____ Rate _____ Rhythm _____ Murmur _____

Abdomen _____ Liver _____ Spleen _____ Hernias _____

Ano-Genital _____ Anus _____ Penis _____ Labia _____

Spine _____

Lower Extremities _____ Range of motion _____ Development _____ Strength _____

Upper Extremities _____ Range of motion _____ Development _____ Strength _____

Cranial Nerve _____ I-XII _____

Gait _____

Coordination _____

Signature _____ Date _____ Phone _____