



Central Massachusetts

## Early Education & Child Care Enrollment Form

Program: \_\_\_\_\_

### Child Information

Full Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_  
Eye Color \_\_\_\_\_ Skin Color \_\_\_\_\_ Hair Color \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex: M / F  
Date of Admission \_\_\_\_\_ Age at Admission \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Primary Language \_\_\_\_\_ Identifying Marks \_\_\_\_\_  
Allergies / special diets \_\_\_\_\_

### Parent/Guardian Information

#### Parent/Guardian 1

Full Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone (home) \_\_\_\_\_ (cell) \_\_\_\_\_  
Email \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone (work) \_\_\_\_\_ Hours at Work \_\_\_\_\_

#### Parent/Guardian 2

Full Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone (home) \_\_\_\_\_ (cell) \_\_\_\_\_  
Email \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone (work) \_\_\_\_\_ Hours at Work \_\_\_\_\_

### Additional Information

Physician's Name \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_  
Address \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Medical Insurance Provider \_\_\_\_\_ Policy and/or Group # \_\_\_\_\_  
Chronic health conditions \_\_\_\_\_  
Special limitations or concern \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



# Early Education & Child Care First Aid and Emergency Medical Care Consent Form

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I authorize staff in the child care program that is trained in the basics of first aid to give my child first aid 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.

## Medical Information

Physician's Name \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_  
Address \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Child's Allergies: \_\_\_\_\_  
Chronic Health Conditions: \_\_\_\_\_

Medical Insurance Provider \_\_\_\_\_ Policy and/or Group # \_\_\_\_\_  
Parent(s) Name \_\_\_\_\_ Phone(work) \_\_\_\_\_ (home) \_\_\_\_\_  
Parent(s) Name \_\_\_\_\_ Phone(work) \_\_\_\_\_ (home) \_\_\_\_\_

## Emergency Contacts (In order to be contacted)

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

Do you give permission for child to be released to this person? Yes No  
Do you give permission to YWCA Staff to release health/medical information regarding this child? Yes No

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

Do you give permission for child to be released to this person? Yes No  
Do you give permission to YWCA Staff to release health/medical information regarding this child? Yes No

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

Do you give permission for child to be released to this person? Yes No  
Do you give permission to YWCA Staff to release health/medical information regarding this child? Yes No

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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Central Massachusetts

## Early Education & Child Care Emergency Card

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
Home Address \_\_\_\_\_ Phone \_\_\_\_\_

### Instructions to Reach Parent/Guardian

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

### Pediatrician or Source of Health Care

1. Name \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

### Emergency Contact Person(s)

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

Do you give permission for child to be released to this person? Yes No

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_

Do you give permission for child to be released to this person? Yes No

### Insurance Information (Optional)

Company Name \_\_\_\_\_ Policy # \_\_\_\_\_

Participating Hospital: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

### Medical Emergency Treatment

I hereby give \_\_\_\_\_ permission to administer basic first aid and/or CPR to my  
child \_\_\_\_\_  
Name of program

and/or take my child \_\_\_\_\_ to a hospital for medical  
Name Name  
treatment when I cannot be reached or when delay would be dangerous to my child's health.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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**Early Education & Child Care Consent Form**

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Insect Repellant**

I understand that it is my responsibility to provide insect repellant containing DEET, which has not expired and is labeled with my child's name.

I give the YWCA staff permission to apply insect repellant to my child no more than once per day and only if it is recommended by public health authorities due to a high of insect-borne disease.

\_\_\_\_\_  
Initial

**Photographs**

I give permission for photograph to be taken of my child for use by the YWCA in program brochures, annual report, website, and other promotional materials and for release to local newspapers.

\_\_\_\_\_  
Initial

**Sunscreen**

I understand that I will apply sunscreen to my child prior to arriving to the center. I will provide to the center sunscreen with SPF 15 or higher and is labeled with my child's name.

I give the YWCA staff permission to apply sunscreen on my child.

\_\_\_\_\_  
Initial

**Activities, Play & Observation**

I give permission for my child to:

- Use play equipment.
- Participate in ALL activities
- Leave the center under the supervision of an authorized staff
- Be observed by students

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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Central Massachusetts

## **Early Education & Child Care Parent Volunteer Opportunities**

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

The YWCA Early Education & Care staff encourages parents to be an integral part of their child's growth and development. Please indicate any activities that are of interest to you.

- Spend time in my child's classroom assisting with activities/conducting your own.
- Chaperone a fieldtrip
- Share my profession with children
- Assist as a interpreter for another family
- Participate in a parent group
- Participate in planning/executing family events
- Participate in planning/executing teacher appreciation events
- Become a Classroom Parent Representative
- Other: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**TUITION**

**Hop aboard the Tuition Express  
and never write a check again!**

*Express*

# Early Education & Child Care Tuition Express

ProCare Software

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time. It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express. Tuition Express is a program that allows your child care tuition balance to be automatically deducted from your checking, savings or credit card account. Not only can you choose the account from which the payments are made, you can also choose from 3 timing options: monthly, biweekly (you choose which week is the off week) or weekly. Because this automated billing process has enabled us to save administrative time, we are able to pass along a \$1 per day reduction in fees if you chose this method of payment.

### For Bank Account Authorization, complete and return to center management

This payment method is required for Westborough families; optional for Worcester families

**ELECTRONIC FUNDS TRANSFER AUTHORIZATION**

I (we) authorize \_\_\_\_\_ (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express\* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Parent Name: \_\_\_\_\_

Daytime Telephone: \_\_\_\_\_

**Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.**

Weekly Deductions (deductions will be taken every Friday)

Your Name \_\_\_\_\_ Phone # \_\_\_\_\_ DEPOSITORY - Bank or Credit Union Name \_\_\_\_\_

Biweekly Deductions (deductions will be taken every other Friday)

Please specify which Friday you want deductions to start: \_\_\_\_\_ Bank or Credit Union Address \_\_\_\_\_

Monthly Deductions (deductions will be taken every month on the 5<sup>th</sup> of the month) State \_\_\_\_\_ Zip \_\_\_\_\_

Type:  Checking  Savings

Routing Transit Number (see sample below)

Account Number (see sample below)

This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

\*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Routing Transit Account Check  
Number Number Number

**Please attach a copy of a voided check here. Deposit slips not accepted.**



**For Credit Card Authorization, complete and return to center management.**

### CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize \_\_\_\_\_ (called "CENTER" in this Authorization) to initiate recurring credit card charges to the below referenced credit card account for the purpose of collecting childcare related payments. I (we) understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction. I (we) understand that this agreement is between myself (us) and the below referenced "CENTER". I (we) authorize CENTER to utilize Tuition Express\* to capture, create, and transmit all credit card information. I (we) indemnify and hold harmless, Tuition Express from any and all liability resulting from any and all transactions. All disputes will be directed to and addressed by and between CENTER and the below signed cardholder. **I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give CENTER written notice of revocation. A minimum of 5 business days is required to affect revocation.**

**PLEASE CONTACT CENTER REPRESENTATIVES FOR CREDIT CARD TYPES ACCEPTED BY CENTER.**

_____	_____
Cardholder Name	Phone #
_____	_____
Cardholder Billing Address	Account Number
_____	_____
City                                  State                                  Zip	Expiration Date
_____	_____
Cardholder Signature	Date

\*Tuition Express is an assumed business name of Blum Investment Group, Inc.

For Official Use Only:

Date Received: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

**Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.**

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Central Massachusetts



Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To Whom It May Concern:

\_\_\_\_\_ is enrolled in the YWCA Early Education & Care program.

We have been informed that he is allergic to \_\_\_\_\_.

On the enclosed form, please provide us with any special instruction that maybe relevant to this child's allergy reaction and care.

Thank you for your assistance.

Sincerely,

YWCA Early Education & Care Staff.

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**Parental Consent**

I \_\_\_\_\_ give my child's health care provider permission to release the information requested above to the YWCA Central Massachusetts.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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Early Education & Child Care **Severe Allergy Plan**  
**ywca**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Central Massachusetts

Severe Allergy To: \_\_\_\_\_

**Mild Reaction**

Mild symptoms consist of: hives; itchy skin; swelling

Treatment Procedure

1. Contact parent or persons listed on the Emergency Card.
2. Stay with child until parent arrives.
3. Watch child for more serious symptoms.

Special Instruction (To be completed by health care provider)

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**Severe Reaction**

Severe symptoms consist of: hives all over the body; swelling of the face/neck/tongue; tingling of the tongue; wheezing, difficulty swallowing/breathing; vomiting; signs of shock; loss of consciousness.

Treatment Procedure

1. Use premeasured EpiPen/EpiPen Jr.
2. Call 911. Anytime the EpiPen is given to a child, 911 will be contacted.
3. Contact parent or persons listed on the Emergency Card. Staff will accompany child if parent is unavailable.

Special Instruction (To be completed by health care provider)

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\_\_\_\_\_  
Prescribing Practitioner Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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# Early Education & Child Care Developmental History & Background Information

Regular child care facilities require this information to be on file to address the needs of children while in care.

\*Note: Please provide information for Infants and Toddlers (marked \*) as appropriate to the age of your child.

Central Massachusetts

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

## Developmental History

Age began: sitting \_\_\_\_\_ crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

\*Does your child: pull up \_\_\_\_\_ crawl \_\_\_\_\_ walk with support \_\_\_\_\_

Does your child have any speech difficulties? \_\_\_\_\_

Does your child use special words to describe needs? \_\_\_\_\_

Language spoken at home: \_\_\_\_\_ \*Any history of colic? \_\_\_\_\_

\*Does your child use pacifier/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)? \_\_\_\_\_



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.


Is there anything else we should know about your child?

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Date: \_\_\_\_\_



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	4	
	1	<b>Measles, Mumps,</b>
	2	
	4	<b>Varicella</b> (Var)
	5	
	6	<b>Hepatitis A</b> (HepA)
7		
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1	<b>Pneumococcal Polysaccharide</b> (PPV23)
	2	
	3	<b>Influenza</b> Inactivated Intramuscular or Live (Intranasal)
	4	
<b>Pneumococcal Conjugate</b> (PCV7)	1	<b>Other:</b>
	2	
	3	
	4	

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

\* Must also check Chickenpox History box.

Chickenpox History	
<input type="checkbox"/>	Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on: <ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>	

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: **YWCA Central Massachusetts**

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Date of Birth \_\_\_\_\_

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This pre-evaluation will hopefully help parents and staff build common goals. The YWCA offers a variety of parent trainings, parent meetings and an opportunity for parents/staff to communicate daily. Please fill out this survey so we can begin to support you with a better understanding with child development.



Do you feel you have a clear understanding of your child's development? \_\_\_\_\_

How can the YWCA Staff support you? \_\_\_\_\_

Do you read to your child? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

How often do you play with your child? \_\_\_\_\_

Would you be interested in attending parent training? \_\_\_\_\_

**Circle your interests**

- |                                   |  |                       |
|-----------------------------------|--|-----------------------|
| Importance of Reading to my Child | Toilet Training                          | Stages of Development |
| Discipline                        | How can I Juggle all my Responsibilities | Home Activities       |
| Importance of Routines            | Ways to Play                             | Nutrition             |

Would you feel comfortable speaking to your child's teacher about specific concern regarding your child, that they might be able to support you with? \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

# Early Education & Child Care Parent/Family Evaluation

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent Name: \_\_\_\_\_

What does your child call you: \_\_\_\_\_

Please list and siblings with their names & ages:

\_\_\_\_\_  
\_\_\_\_\_

Please list any other significant people in your child's life:

\_\_\_\_\_  
\_\_\_\_\_

Please list any family pets and their names:

\_\_\_\_\_  
\_\_\_\_\_

Does your child spend significant time in more than one household? \_\_\_\_\_

What types of activities do you enjoy at home with your child? \_\_\_\_\_

What special days do you celebrate in your family and how do you celebrate them? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you like our childcare program to support/reflect the special days you celebrate? \_\_\_\_\_

\_\_\_\_\_

If you do not celebrate special days, how would you prefer the program to work with you and your child when we celebrate special days, like holidays? \_\_\_\_\_

\_\_\_\_\_

What concerns do you have regarding holidays? \_\_\_\_\_

\_\_\_\_\_

How do you feel about your child learning or participating in holiday activities that are not celebrated by your family's tradition?

\_\_\_\_\_

Are there any holidays that you object to? \_\_\_\_\_

\_\_\_\_\_

What languages, other than English, are spoken at home? \_\_\_\_\_

Does your child understand and speak the languages listed above?

Please help us learn some key words and phrases that may help us help your child feel more comfortable as (s)he adjusts to the center.

**Key Words/ Phrases**

Mom: \_\_\_\_\_

Dad: \_\_\_\_\_

Are you hungry? \_\_\_\_\_

I am hungry? \_\_\_\_\_

Needs the potty: \_\_\_\_\_

I am tired. \_\_\_\_\_

Express feeling

Happy \_\_\_\_\_

Sad \_\_\_\_\_



Angry \_\_\_\_\_

Afraid \_\_\_\_\_

Mom/dad will be back later: \_\_\_\_\_

Where do you want to play: \_\_\_\_\_

Blocks \_\_\_\_\_

Puzzles \_\_\_\_\_

Playdough \_\_\_\_\_

Paint \_\_\_\_\_

Sand Table \_\_\_\_\_

Water Table \_\_\_\_\_

Books \_\_\_\_\_

Cars \_\_\_\_\_

Other words you think would be helpful for staff to know: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_