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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

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Central Massachusetts
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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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
Name of program
child_____ 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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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 Express
ProCare Software

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

Early Education & Child Care **Tuition Express**

Child's Name _____ **Date of Birth** _____

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.

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

Attached are forms for you to fill out to get Tuition Express started. Below, we have listed the timing options available for your selection. Please return the appropriate Automatic Payment Authorization form (checking/savings or credit card) and this form to start using Tuition Express.

Parent Name: _____

Daytime Telephone: _____

Timing Options:

- ○ Weekly Deductions (deductions will be taken every Friday)
- ○ Biweekly Deductions (deductions will be taken every other Friday)
  Please specify which Friday you want deductions to start: _____
- ○ Monthly Deductions (deductions will be taken every month on the 5th of the month)

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.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

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

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.

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

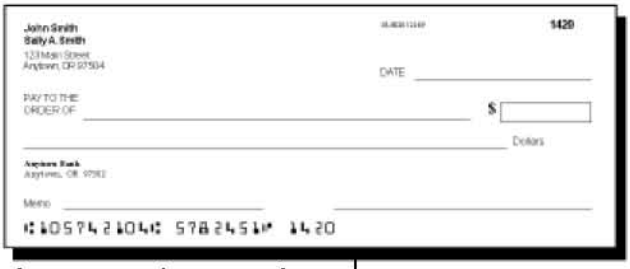
Your Name	Phone #	DEPOSITORY - Bank or Credit Union Name
Address		Bank or Credit Union Address
City	State Zip	City State Zip
		Type: ☐ Checking ☐ Savings
Routing Transit Number (see sample below)		**Account Number** (see sample below)

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 Number | Account Number | Check Number

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

TUITION Express
ProCare Software

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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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.

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**

Child's Name _____ **Date of Birth** _____

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)

_____

_____

_____

_____

_____

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)

_____

_____

_____

_____

_____

_____ _____
Prescribing Practitioner Signature Date

_____ _____
Parent/Guardian Signature Date

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Early Education & Child Care **Developmental History & Background Information**

Regulations for licensed 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.

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: _____

_____

_____

_____

Dear Physician:

_____ is enrolled in an early childhood program licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

Identification

Name of Child: _____Date of Birth:_____

Address: _____Phone: _____

Name of Parents: _____

Address: _____

Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance: _____

_____

Has this child been screened for lead poisoning? Yes _____No _____

If Yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:

_____

_____

_____

Physician's Signature: _____ Date: _____

Comments:_____

_____

Please return to Program: _____

_____

_____

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name:

Date of Birth: / / Sex: □female □male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B *(e.g., HepB, HepB-Hib,*	1		**Haemophilus influenzae**	1	
	2			2	

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				3	
				4	
Diphtheria Tetanus Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	3		***Measles, Mumps,***	1	
				2	
	4		***Varicella*** *(Var)*	1	
	5			2	
	6		***Hepatitis A*** *(HepA)*	1	
	7			2	
Polio *(e.g., IPV, DTaP-HepB-IPV)*	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		***Influenza*** *Inactivated Intramuscular) or Live (Intranasal)*	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	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

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

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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Child's Name _____ **Date of Birth** _____

This pre-evaluation will hopefully help parents and staff build common goals. The YWCA offers a variety of parent trainings, parent handbook and an opportunity for parents/staff to communication 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:_____

_____

_____

_____