Central Massachusetts

Early Education & Care **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:___________________________

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? ____

____

____ ___________________________

Parent/Guardian Signature **Date**

Central Massachusetts

Early Education & Care
Contact Information / Authorized to Release

Child's Name:____ Date of Birth:_____________________

PARENT / GUARDIAN CONTACT 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:______________________

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______

____ _________________________

Parent/Guardian Signature **Date**

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Central Massachusetts

Early Education & Care
First Aid and Emergency Medical Care Consent

102 CMR 7.09(3)

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: ____

Health Insurance Coverage____ Policy ___________________

____ __________________________

Parent/Guardian Signature **Date (Valid for one year)**

Central Massachusetts

Early Education & Care
Transportation Plan and Daily Schedule

Indicate how your child will arrive and depart from the center on a daily basis.

Method of Arrival

___Supervised Walk

___Unsupervised Walk

___ Parent Drop-off

___Public/Private/Van

___Program Bus/Van

___Contract/Van

___Other:______________________

Method of Departure

___Supervised Walk

___Unsupervised Walk

___ Parent Pick-up

___Public/Private/Van

___Program Bus/Van

___Contract/Van

___Other:______________________

Indicate your child's daily arrival and departure schedule. It will be expected that the schedule written below will followed by the parent.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
ARRIVAL					
DEPARTURE					

Early Moring Care
The YWCA provides an Early Morning Care (EMC) option for parents seeking care earlier than our normal hours of operation for an additional $6.50 per day. However, EMC has limited availability and a child must be signed up for EMC in order to arrive at the center prior to 7:30 a.m.

Late Pick-up
Children picked-up late are charged a late fee of $1.00 per minute. The fee will be assessed by the attending educators and classroom clock. There will be a late fee for any child picked up after 5:30 p.m. in Worcester or 6:00 p.m. in Westborough.

____ ____________________

Parent/Guardian Signature **Date**

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 ____ Relationship ______________________
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**

Central Massachusetts

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 for walks under the supervision of an authorized staff
Be observed by students
Participate in weekly swim lessons

____
Initial

____ ____________________

Parent/Guardian Signature **Date**

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**

Central Massachusetts

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.

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)

TUITION
Express
ProCare Software

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

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.

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**

Central Massachusetts

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

Use premeasured EpiPen/EpiPen Jr.

Call 911. Anytime the EpiPen is given to a child, 911 will be contacted.

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)

____
____
____
____
____

____ ________________________

Parent/Guardian Signature **Date**

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Central Massachusetts

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**

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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:

____

____

____

Comments: ______________________________

____

____

____

Physician's Signature: ______________________________ Date: ____________________

Please return to Program: ______________________________

____

____

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Child's 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, DTaP-HepB-IPV)*	1		**Haemophilus influenzae *type b*** *(e.g., Hib, HepB-Hib, DTaP-Hib)*	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		***Measles, Mumps,***	1	
	3			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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Early Education & Child Care **Parent Evaluation**

Child's Name ____ **Date of Birth** _____________________

This pre-evaluation will hopefully help parents and educators build common goals. The YWCA offers a variety of parent trainings, parent handouts 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	Ways to Play	Importance of Routines
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**

Central Massachusetts

Early Education & Child Care **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:_________________________
____
____
____