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Early Education & Care
Enrollment Form

CHILD INFORMATION

Child's Name: _____ Date Of Birth: _____

Child's Age at Admission: _____ Date of Admission: _____

Child's Home Address: _____

Home Phone: _____ Cell Phone: _____

Primary Language: _____ Secondary Language: _____

Eye Color: _____ Hair Color: _____ Skin Color: _____

Sex: _____ Height: _____ Weight: _____

Identifying Marks: _____

ADDITIONAL INFORMATION

Child's Physician: _____

Address: _____ Phone: _____

Allergies/Special Diet (Please list): _____

Individual health plan for child with a chronic health condition (circle one)? Yes No (If yes, please attach)

Are there any custody agreements, court orders, or restraining orders pertaining to the child (circle one)? Yes No (If yes, please attach)

Special limitations or concerns? _____

_____ _____

Parent/Guardian Signature Date

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Early Education & Care
First Day Checklist

Below is a list of items/activities that must be completed before your child can start in the YWCA Central Massachusetts's Early Education and Care Program:

- ☐ Complete and return all enrollment forms
- ☐ Submit child's physical, immunization records and lead test forms
- ☐ Paid tuition deposit/registration fee/membership fee/1st week's tuition
- ☐ Center visit
- ☐ Extra clothes and supplies
- ☐ Nap blanket/sheet

Please contact the Center Director with any questions about the above list.

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Early Education & Care
Parent Volunteer Opportunities

Child's Name: _____ Date of Birth: _____

The YWCA Early Education and Care Program staff encourage 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 or conducting your own activities.
- ☐ Chaperone a field trip
- ☐ Share my profession with children
- ☐ Assist as an interpreter for another family
- ☐ Participate in a parent group or committee
- ☐ Participate in planning/executing family events
- ☐ Participate in planning/executing teacher appreciation events
- ☐ Become a Classroom Parent Representative
- ☐ Other: _____

_____ _____

Parent/Guardian Signature Date

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Early Education & Care
First Aid & Emergency Medical Care Consent

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 to my child.

Child's Physican Name: _____

Address: _____

Phone Number: _____

Child's Allergies: _____

Chronic Health Conditions: _____

Health Insurance Coverage: _____ Policy: _____

_____ _____
Parent/Guardian Signature Date

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Early Education & Care
Contact Information/ Authorization to Release

Child's Name: _____ Date of Birth: _____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/ Guardian Name: _____ Relationship to Child: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone Number: _____ Cell Phone Number: _____
Email Address: _____
EmployerName: _____
Employer Address: _____
Employer Phone Number: _____ Hours at Work: _____

Parent/ Guardian Name: _____ Relationship to Child: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone Number: _____ Cell Phone Number: _____
Email Address: _____
EmployerName: _____
Employer Address: _____
Employer Phone Number: _____ Hours at Work: _____

EMERGENCY CONTACTS (In order to be contacted)

Name: _____ Relationship to Child: _____
Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Do you give permission for your child to be released to this person? (circle one) Yes No

Name: _____ Relationship to Child: _____
Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Do you give permission for your child to be released to this person? (circle one) Yes No

Name: _____ Relationship to Child: _____
Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Do you give permission for your child to be released to this person? (circle one) Yes No

_____
Parent/Guardian Signature

_____
Date

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Early Education & Care
Consent Form

Child's Name: _____ Date of Birth: _____

INSECT REPELLENT

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

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

PHOTOGRAPHS

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

SUNSCREEN

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

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

ACTIVITIES, PLAY & OBSERVATION

_____ Initials I give permission for my child to use play equipment, participate in ALL activities, leave the center for walks under the supervision of authorized staff, be observed by students, and participate in weekly swim lessons.

_____
Parent/Guardian Signature

_____
Date

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Early Education & Care
Photography Consent Form

Child's Name: _____ Date of Birth: _____

PHOTOGRAPHS

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

☐ YES ☐ NO

Parent Signature: _____ Date: _____

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Early Education & Care
Transportation Plan & Daily Schedule

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

Method of Arrival:

___Supervised Walk

___Unsupervised Walk

___ Public / Private / Van

___ Program Bus Van

___ Contract Van

___ Private Trans. Arranged by Parent

___ Other: _____

Method of Departure:

___Supervised Walk

___Unsupervised Walk

___ Public / Private / Van

___ Program Bus Van

___ Contract Van

___ Private Trans. Arranged by Parent

___ Other: _____

Indicate your child's daily schedule. It will be expected that the schedule written below will be followed by the Parent.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
☐ 7:30 a.m.-5:30 p.m.	☐ 7:30 a.m.-5:30 p.m.	☐ 7:30 a.m.-5:30 p.m.	☐ 7:30 a.m.-5:30 p.m.	☐ 7:30 a.m.-5:30 p.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.

_____
Parent/Guardian Signature

_____
Date

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Early Education & 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 (circle yes or no): pull up? Y N crawl? Y N walk with support? Y N
Does your child have any speech difficulties? _____
Does your child use special words to describe needs? _____
Language(s) spoken at home: _____
*Any history of colic? Y N *Does your child use pacifier/suck thumb? Y N *When? _____
*Does your child have a fussy time? Y N *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? Y N *Is your child fed in a high chair? Y N
*Does your child eat with: (select all that apply) ☐ spoon ☐ fork ☐ hands

TOILET HABITS

*What kind of diapers does your child wear? ☐ disposable ☐ cloth
*Does your child frequently get diaper rash? Y N *What do you use to treat it? _____
*Are child's bowel movements regular? Y N *How many per day? _____
*Does your child frequently get diarrhea? Y N *Does your experience frequent constipation? Y N
*Have you attempted to toilet train your child? Y N
*Please describe any particular toilet training procedure to be used for your child while at the center:
_____
_____

What is used at home?(select all that apply) ☐ potty chair ☐ special child seat ☐ regular toilet seat
How does your child indicate bathroom needs? (include any special words) _____
Is your child ever reluctant to use the bathroom? Y N Does your child ever have accidents? Y N

SLEEPING HABITS

*Where does your child sleep? ☐ crib ☐ bed
Does your child become tired or nap during the day? If yes, when and how long? _____

What time does your child go to bed at night? _____
What time does your child wake up in the morning? _____
Describe any special sleep characteristics or needs (stuffed animal, story, mood on waking, etc.): _____

SOCIAL RELATIONSHIPS

How would you describe your child's personality? _____

Previous experience with other children/daycare: _____
How does your child react to strangers? _____
Is your child able to play alone? _____
Favorite toys and activities: _____
Fears (the dark, animals, loud noises, etc): _____
How do you comfort your child? _____
What method(s) of behavior management/discipline do you use at home? _____

What do you want 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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Early Education & Care
Dental Care Program

Dear Parent or Caregiver:

With concerns about the increase in tooth decay (cavities) among young children, the YWCA Central Massachusetts Department of Early Education and Care (EEC) recently adopted a new regulation for child care settings, number 606 CMR 7.11 (11)(d), to promote oral health and prevent tooth decay.

Effective January 2010, child care workers must assist children with brushing their teeth if:

1. The children are in care for more than 4 hours, or
2. They have a meal while in care.

Some quick facts about the program:

- This Program will be implemented safely by following the regulations for infection control set by the U.S. Centers for Disease Control and Prevention (CDC).
- It will be a great benefit for your child **at no cost to you.**
- Children will be using toothpaste with fluoride and approved by the American Dental Association.
- Children will receive new toothbrushes after three months of use, or after they are sick.

Please sign here to acknowledge that you have read this note regarding the new tooth-brushing program. If you have questions or concerns, please call Darlene Belliveau at 508-767-2505 ext. 3045 or Lucille Gallagher at 508-767-2505 ext. 3031.

Child's Name: _____

Parent/Caregiver's Name: _____

Signature: _____

Date: _____

Comments: _____

_____

_____

Please read the parent fact sheet attached.

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Early Education & Care
Parent Evaluation

Child's Name: _____ Date of Birth: _____

This pre-evaluation will help parents and staff build common goals. YWCA offers a variety of parent trainings, parent handouts 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 YWCA staff support you? _____

_____

_____

_____

Do you read with your child? Y N If yes, how often? _____
How often do you play with your child? _____
Would you be interested in attending parent training? Y N

Circle your interests

Importance of reading to my child	Toilet training	Stages of development
Discipline	Time management	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 she/he might be able to support you with? Y N
If yes, please describe your concern(s): _____

_____

_____

_____
Parent/Guardian Signature

_____
Date

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Early Education & Care
Home Language Survey

Please answer the following questions about your child and the family members who care for her/him. You will respond by using a scale ranging from "only English" to "only home language." Try to gather as much information as possible to help you answer the questions. If you are unable to answer a question because you do not know the answer or because the child is not yet speaking, circle N/A.

Child's Name: _____ Date of Birth: _____

A. What language do family members use when speaking to your child in the home?

N/A	1	2	3	4	5
Not Applicable	only English	mostly English	both equally	mostly home language but some English	only home language (not English)

Home Language 1: _____ From what Country? _____

Home Language 2: _____ From what Country? _____

B.What language does the child use when speaking to family members in the home?

N/A	1	2	3	4	5
Not Applicable	only English	mostly English	both equally	mostly home language but some English	only home language (not English)

C. What language does the child use when speaking to other children in the classroom?

N/A	1	2	3	4	5
Not Applicable	only English	mostly English	both equally	mostly home language but some English	only home language (not English)

D. What language does the child use when speaking to the teachers?

N/A	1	2	3	4	5
Not Applicable	only English	mostly English	both equally	mostly home language but some English	only home language (not English)

Race/Ethnicity (Optional)
Please check as many as apply:

____White/Caucasian
____Black
____Hispanic
____Asian
____Native American
____Other

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Early Education & Care
Family Evaluation

Child's Name: _____ Date of Birth: _____

Parent Name: _____

What does your child call you? _____

Please list any siblings, their names and 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? Y N

What types of activities do 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 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 in your home? _____

Does your child understand and speak the languages listed above? Y N

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

Mom: _____
Dad: _____
Are you hungry? _____
I am hungry: _____
Do you need to use the potty? _____
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: _____
_____
_____
_____
_____

_____
Parent/Guardian Signature

_____
Date

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1 Salem Square
Worcester _____

Westborough _____

Roosevelt School _____

Clark St. School _____

Camp Wind in the Pines _____

Early Education & Child Care **Tuition Express**

Child's Name: _____ Date of Birth: _____

Date of Enrollment: _____

Tuition Express is a program that allows your child care tuition balance to be automatically deducted from your checking or savings account or charged to your credit card. 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.

Please fill out the information requested below and on the reverse side of this form, and return form to the center Director in order to start using Tuition Express.

Parent Name: _____

Daytime Telephone Number: _____

Timing Options (selection one):

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

*Please note that we are required to send deduction information to the processing center on Thursdays before 4:00 p.m., for Friday processing. Processing maybe done as early as 12:01 am Friday, so please have funds available by the end of the day on Thursdays. Please check with your bank regarding processing times. Some banks may deduct funds as soon they are notified of the upcoming Friday withdrawal, primarily when a debit card is used.

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

A service of

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Date: _____

_____

_____

_____

To Whom It May Concern:

_____ is enrolled in the YWCA Early Education & Care Program. We have been informed that she/he is allergic to _____. On the enclosed form, please provide us with any special instruction that ma be 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

Department of Early Education and Care
THE COMMONWEALTH OF MASSACHUSETTS

Small Group, Large Group and School Age Child Care Licensing

POLICY STATEMENT: Individual Health Care Plans

All programs must maintain as part of a child's record, an Individual Health Care Plan (IHCP) for each child with a chronic medical condition which has been diagnosed by a licensed health care provider as required by 606 CMR 7.11(3)(a)-(c). An IHCP ensures that a child with a chronic medical condition receives health care services he or she may need while attending the program.

Programs must develop an IHCP in collaboration with the parents/guardians, school age child who is 9 years or older (when appropriate), program educators and the child's licensed health care practitioner, who must authorize the IHCP.

The IHCP must include the following:

* description of the chronic condition which has been diagnosed by a licensed health care practitioner
* description of the symptoms of the condition
* outline of any medical treatment that may be necessary while the child is in care
* description of the potential side effects of the treatment
* outline of the potential consequences to the child's health if the treatment is not administered

An educator must have successfully completed training relative to a child's ICHP. This training must be given by the child's health care practitioner or, with the child's health care practitioner's written consent, by the child's parent or the program's health care consultant. The training must specifically address the child's medical condition, medication and other treatment needs. Some examples of an ICHP would include children with asthmatic conditions, allergic reactions, ADHD, or diabetic conditions. IHCP's are *not* required for children *without* chronic conditions needing oral or topical medications.

In the event of an ***unanticipated***, non-life-threatening condition requiring treatment (as specified in the IHCP) the educator must make a reasonable attempt to contact the parents/guardians prior to administering the unanticipated medication or beginning the unanticipated treatment. If parent/ guardians cannot be reached immediately, they should be notified as soon as possible after the medication or treatment has been administered to the child.

Educators must ensure that they document the administration of all medications and medical treatments in the child's medication/treatment log.

Written parental and licensed health care practitioner authorization shall be valid for one year, unless withdrawn sooner and must be renewed annually, *or when the child's condition changes*, for administration of medication and/or treatment to continue.

Additional information regarding Individual Health Care Plans:

- Educators with written parental consent and authorization of a licensed health care practitioner may develop and implement an Individual Health Care Plan that permits older school age children *who are 9 years or older* to carry their own inhalers and epinephrine auto-injectors and use them as needed, without the direct supervision of an educator. All educators must be aware of how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an IHCP provides for a child to carry his or her own medication, the licensee must maintain an on-site back-up supply of the medication for use as needed.
- A copy of the IHCP must be maintained in the child's file. It is recommended that a copy of the IHCP also be located in the classroom.
- There must be one person trained in the implementation of a child's IHCP whenever the child is in the care of the program.
- In addition to a licensed health care practitioner, training to implement an IHCP may also be given by the child's parent or the program's health care consultant with the licensed health care practitioner's written consent.

Additional medication requirements to consider:

- Emergency medication such as Epipens must be immediately available for use. For example, Epipens must be brought with children for outdoor play or walks as required by 7.11(2)(f). Training by a licensed health care practitioner for the specific administration of an Epipen is ***highly*** recommended but not required.
- All staff who administer medication of any kind must be trained in medication administration as required by 7.11(1)(b)2.

Child's Photo

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply….

Plan was created by:

__ Parent
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Older school age child (9+ yrs. of age)
__ Other: _____

Plan is maintained by:

__ Director
__ Assistant Director
__ Child's Educator
__ Other: _____

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

Name of Licensed Health Care Practitioner (please print):_____

Licensed Health Care Practitioner authorization:_____ Date:_____

Parental/Guardian consent: _____ Date:_____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: _____ Date: _____

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Date: _____

_____

_____

_____

Dear Physician:

_____ is enrolled in the YWCA Early Education & Care 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.