

**Kid Connection Preschool Vacation Week  
Child Enrollment Form**

**EEC Regulations require this information to be on file to address the needs of children while in care. This form must be submitted with a current physical/school form, listing immunizations, before your child can attend.**

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

Primary Language of child: \_\_\_\_\_ Primary Language of parents: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_ Gender: \_\_\_\_\_ Skin Color: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_

Does your child have any special concerns or limitations? (dietary, speech, physical, etc.) \_\_\_\_\_

If so, please describe \_\_\_\_\_

Please describe any previous group experiences (ie: play groups, daycare) \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_ **Primary phone number:** \_\_\_\_\_

Email Address: \_\_\_\_\_

Employment/location during child care: \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_ **Primary Phone number:** \_\_\_\_\_

Email Address: \_\_\_\_\_

Employment/location during child care: \_\_\_\_\_

☐ Copies of any custody agreements, court orders, restraining orders (if applicable)

**Transportation Plan**

My child will arrive at the program by:

\_\_\_\_ Supervised walk

\_\_\_\_ Parent drop-off

\_\_\_\_ Other (describe \_\_\_\_\_)

My child will depart from the program by:

\_\_\_\_ Supervised walk

\_\_\_\_ Parent pick-up

\_\_\_\_ Other (describe \_\_\_\_\_)

I additionally authorize the following individual(s) to take my child from the child care premises.

1. Name: \_\_\_\_\_ relationship: \_\_\_\_\_

Address: \_\_\_\_\_ phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ relationship: \_\_\_\_\_

Address: \_\_\_\_\_ phone: \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

At what age did your child begin sitting: \_\_\_\_\_ crawling: \_\_\_\_\_ walking: \_\_\_\_\_ talking: \_\_\_\_\_

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

Please describe your child's schedule on a typical day. \_\_\_\_\_

\_\_\_\_\_

## HEALTH

Any known complications/health issues during birth or infancy? \_\_\_\_\_

Any serious illnesses and/or hospitalizations? \_\_\_\_\_

If yes to any of the above questions, please list/comment: \_\_\_\_\_

\_\_\_\_\_  
Please list any regular medications administered to your child:

**Note:** If your child requires an epipen, inhaler, or other lifesaving medication, an Individual Health Care Plan must be submitted. Medication must be provided in original package with prescription.

**Hand Sanitizer:** Staff will supervise use of hand sanitizer when soap and water is not readily available.  
\_\_\_\_\_ I give \_\_\_\_\_ I do not give \_\_\_\_\_ permission for my child to use hand sanitizer at school.

## EATING HABITS / TOILET HABITS

Is your child toilet trained? \_\_\_\_\_ Does your child have accidents? \_\_\_\_\_

How does your child indicate bathroom needs (include special words): \_\_\_\_\_

Is your child ever reluctant to use the bathroom? \_\_\_\_\_

## SOCIAL RELATIONSHIPS

Please describe any previous group experiences (ie: play groups, daycare) \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_

How does your child relate to other children? \_\_\_\_\_

What are your child's favorite toys and activities? \_\_\_\_\_

Does your child have any worries or fears? \_\_\_\_\_

How do you comfort your child? \_\_\_\_\_

What is the method of behavior management/discipline at home? \_\_\_\_\_

Is there anything else we should know about your child or family that will help us provide the most positive experience for your child? \_\_\_\_\_

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

\_\_\_\_\_  
**Date** (*valid for one year*)

THE COMMONWEALTH OF MASSACHUSETTS  
Department of Early Education and Care  
**FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM**

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

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to \_\_\_\_\_, and to secure necessary medical treatment for my child.

Child's Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_

Chronic Health Conditions: \_\_\_\_\_

**Emergency Contacts (*In order to be contacted*)**

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Cell phone: \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

Health Insurance Coverage \_\_\_\_\_ Policy # \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  
*Signature* *date*