



ENROLLMENT FORM

THE COMMUNITY SCHOOL | PO Box 111, 82 Main Street, Maynard, MA 01754

| | | | |
|---------------------------|-------------------|---------------------------|------------|
| Child Name: | | Date of Birth: | |
| Age at Admission: | | Date of Admission: | |
| Address: | | | |
| Phone: | | | |
| Primary Language: | | | |
| Identifying Marks: | | | |
| Eye Color | Hair Color | Skin Color | Sex |
| | | | |

PARENT / GUARDIAN INFORMATION:

| | | | |
|------------------------|--|-------------------------------|--|
| Name (print): | | Relationship to child: | |
| Address: | | | |
| Phone: | | Email: | |
| Business Name: | | Business Address: | |
| Business Phone: | | Hours at Work: | |

PARENT / GUARDIAN INFORMATION:

| | | | |
|------------------------|--|-------------------------------|--|
| Name (print): | | Relationship to child: | |
| Address: | | | |
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| Business Name: | | Business Address: | |
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ENROLLMENT FORM

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?

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school.

PARENT SIGNATURE _____

DATE _____



EMERGENCY CARE

| FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM | | | |
|---|--|-----------------------|--|
| Child 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: _____

Address: _____ Phone Number: _____

Allergies/Special Diets: _____

Chronic Health Conditions: _____

| EMERGENCY CONTACTS (In order to be contacted): | | | |
|---|--|------------------------|--|
| Name (print): | | Relationship to child: | |
| Home Phone: | | Cell Phone: | |
| Do you give permission for child to be released to this person? (Y/N) | | | |
| Name (print): | | Relationship to child: | |
| Home Phone: | | Cell Phone: | |
| Do you give permission for child to be released to this person? (Y/N) | | | |
| Name (print): | | Relationship to child: | |
| Home Phone: | | Cell Phone: | |
| Do you give permission for child to be released to this person? (Y/N) | | | |

PARENT SIGNATURE _____ **DATE** _____



DEVELOPMENT & BACKGROUND

| DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION | | | |
|--|--|----------------|--|
| Child Name: | | Date of Birth: | |

Regulations for licensed childcare facilities require this information to be on file to address the needs of children while in care. Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting: _____ crawling: _____ walking: _____ talking: _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or 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: _____



DEVELOPMENT & BACKGROUND

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 your child have accidents? _____



DEVELOPMENT & BACKGROUND

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)?

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.

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? _____



DEVELOPMENT & BACKGROUND

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 SIGNATURE _____

DATE _____



PERMISSION FORM

| | | | |
|--------------------|--|-----------------------|--|
| Child Name: | | Date of Birth: | |
|--------------------|--|-----------------------|--|

EVALUATION PERMISSION

I give The Community School staff permission to observe and record my child's speech, language, cognitive, social, emotional, self-help, fine motor, gross motor, and developmental skills in order to help them identify my child's strengths and individual needs.

This information is used strictly for staff to share with parents during parent/teacher conferences and/or other parent/teacher/director. No standardized testing is done.

PARENT SIGNATURE _____ **DATE** _____

PHOTO PERMISSION

I give permission to The Community School staff to take and use photographs of my child for the following: (Please initial each purpose you accept)

1. _____ For use in the classroom or classroom hallways
2. _____ For distribution to other TCS families via Procure Daily Photos or Monthly Newsletters
3. For marketing purposes (no names will be used):
 - i. _____ Brochures, poster boards, newspaper articles
 - ii. _____ The Community School website
 - iii. _____ The Community School Social Media Sites (Facebook, Instagram)

PARENT SIGNATURE _____ **DATE** _____

TRANSPORTATION PLAN AND AUTHORIZATION

I represent that my child will:

ARRIVE AT THE PROGRAM BY:

- ___ Parent drop-off
- ___ Private transportation arranged by parent
- ___ Other | Describe _____

DEPART FROM THE PROGRAM BY:

- ___ Parent pick-up
- ___ Private transportation arranged by parent
- ___ Other | Describe _____

PARENT SIGNATURE _____ **DATE** _____



PERMISSION FORM

| CLASS LIST AUTHORIZATION | | | |
|--------------------------|--|----------------|--|
| Child Name: | | Date of Birth: | |

Every year The Community School compiles a class list for each classroom. These lists are available to all families at The Community School for the school year. These lists are helpful to families planning play dates, birthday parties, etc. We encourage all families to participate.

By completing each entry below as you want it to be included, parents are authorizing that this information to be on their child's class list at The Community School for the school year.

Child's Name: _____

Parent's Name(s): _____

Family Address: _____

Family Phone Number: _____

Email: _____

*Class lists are for private use only and not to be used for solicitation purposes.

PARENT SIGNATURE _____ **DATE** _____



PERMISSION FORM

| WALKING TRIPS | | | |
|--------------------|--|-----------------------|--|
| Child Name: | | Date of Birth: | |

I give permission for my child _____ to participate in walks around Maynard for the purpose of:

1. Visiting local businesses to learn more about our community.
2. Visiting the Post Office, the Fire Station, the Police Station, etc. to learn about our community's services.
3. Taking nature walks for the purpose of observing nature or collecting nature materials for classroom study and artwork.
4. Walking to the Maynard Public Library for a special Community School story hour.
5. Seeing things of interest in Maynard.

I understand that I will be notified, when possible, when these trips will occur.

PARENT SIGNATURE _____ **DATE** _____



AUTHORIZATION FORM

| Authorization Form | | | |
|--------------------|--|-----------------------|--|
| Child Name: | | Date of Birth: | |

I hereby give permission to the staff educators of The Community School to administer the over-the-counter preparations listed below in accordance with the directions for use listed on the container.

All items must be supplied by parents if use is requested. Items must be provided in the original container clearly labeled with the child's name.

| List of Preparations: |
|-----------------------|
| Ointment: |
| Ointment: |
| Sunscreen: |
| Insect Repellent: |
| Other: |
| Other: |

PARENT SIGNATURE _____

DATE _____



SUPPLEMENTAL INFORMATION

THE COMMUNITY SCHOOL | PO Box 111, 82 Main Street, Maynard, MA 01754

Child Name:

**Date
of Birth:**

1. What name would you like your child called and written on his/her papers (if different from what is on the enrollment form)? _____

2. Does your child have any special interests that would help us know him/her better?

Please explain: _____

3. List all family members in your home: _____

4. If your child has had previous day care or preschool experience, may we contact the provider with your written permission? Yes _____ No _____

Provider Contact Name and Number: _____

5. How did you hear about The Community School? _____

FAMILY CELEBRATIONS

What special days do you celebrate in your family? _____

How would you like our program to be involved in your celebration? _____

What are some of the myths or stereotypes about your culture that you would like us to understand so as not to perpetuate them? _____

How do you feel about celebrations at the center that are not part of your family's tradition? _____

Would you have time to read a favorite story in your native language or share a favorite family recipe? _____