

**FOR CENTER USE:**

Date of Admission: \_\_\_\_\_ Age: \_\_\_\_\_

**CHILD'S FACE SHEET ENROLLMENT FORM**

**CHILD INFORMATION:**

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

Date of Birth: \_\_\_\_\_

Place Of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

(City/Town)

Telephone #: \_\_\_\_\_

Primary Language \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

**CHILD'S IDENTIFYING INFORMATION:** (Required by Department of Early Education & Care)

EYE COLOR: \_\_\_\_\_

HAIR COLOR: \_\_\_\_\_

SEX: \_\_\_\_\_

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

SKIN COLOR: \_\_\_\_\_

IDENTIFYING MARKS: \_\_\_\_\_

**\*ALLERGIES/CHRONIC HEALTH CONDITIONS:** \_\_\_\_\_

Individual Health Care Plan for child with chronic health condition? If yes, please attach. \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

PARENT/GUARDIAN NAME \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

REACHABLE PHONE NUMBER # \_\_\_\_\_

REACHABLE PHONE NUMBER # \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

BUSINESS NAME \_\_\_\_\_

BUSINESS NAME \_\_\_\_\_

BUSINESS NUMBER \_\_\_\_\_

BUSINESS NUMBER \_\_\_\_\_

HOURS AT WORK \_\_\_\_\_

HOURS AT WORK \_\_\_\_\_

**IF PARENTS CANNOT BE CONTACTED, NOTIFY:** (Include Names on Emergency Release Form)

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Telephone #(Daytime) \_\_\_\_\_

Telephone #(Daytime) \_\_\_\_\_

**OTHERS IN FAMILY: SIBLINGS/AGE** \_\_\_\_\_

**CHILD'S PHYSICIANS/CLINIC** \_\_\_\_\_ **TELEPHONE #** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**AUTHORIZATION AND CONSENT FORM**

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child\_\_\_\_\_.  
(NAME)

However, if I cannot be reached I hereby authorize **LITTLE ANGELS** to transport my child to \_\_\_\_\_Hospital (or nearest Hospital) and to secure for my child the necessary medical treatment. I understand the staff members at Little Angels are trained in the basics for First Aid and CPR and I authorize them to give my child First Aid and CPR when appropriate.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_DATE:\_\_\_\_\_

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**EMERGENCY RELEASE FORM**

I give my permission for my child to be released from Little Angels and/or be received at the end of the program by the following people:

Name:\_\_\_\_\_ Relationship to Child:\_\_\_\_\_

Address:\_\_\_\_\_ Telephone#\_\_\_\_\_

Name:\_\_\_\_\_ Relationship to Child:\_\_\_\_\_

Address:\_\_\_\_\_ Telephone#\_\_\_\_\_

Name:\_\_\_\_\_ Relationship to Child:\_\_\_\_\_

Address:\_\_\_\_\_ Telephone#\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE:\_\_\_\_\_DATE:\_\_\_\_\_

**DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION**

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

**CHILD'S NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Age began sitting \_\_\_\_\_ crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

Any speech difficulties? \_\_\_\_\_

Special words to describe needs \_\_\_\_\_

**HEALTH**

Any known complication 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: \_\_\_\_\_

Favorite foods: \_\_\_\_\_ child eats with hands\_\_ spoon\_\_ fork \_\_

Foods refused: \_\_\_\_\_

**TOILET HABITS**

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

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

Does child have accidents? \_\_\_\_\_

**SLEEPING HABITS**

Does child become tired or nap during the day (include when and how long)?

\_\_\_\_\_

When does 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.): \_\_\_\_\_

What is the method of behavior management/discipline at home

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your child's schedule on a typical day: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like your child to gain from this child care experience? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like us to know about your child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parents/Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_

THE COMMONWEALTH OF MASSACHUSETTS  
Department of Early Education and Care

**Sample Group and Large Group Transportation Plan and Authorization**

CHILD'S NAME: \_\_\_\_\_

**MY CHILD WILL ARRIVE AT THE PROGRAM:**

- PARENT DROP OFF
- SUPERVISED WALK
- UNSUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

**MY CHILD WILL DEPART FROM THE PROGRAM:**

- PARENT PICK UP
- SUPERVISED WALK
- UNSUPERVISED WALK
- PUBLIC/PRIVATE/VAN
- PROGRAM BUS/VAN
- CONTRACT/VAN
- PRIVATE TRANS. ARRANGED BY PARENT
- OTHER

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_

**REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION**

SG/LGTransportationAuthorization20100326

Dear Parents,

With concerns about the increase in tooth decay (cavities) among young children, the 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.**

\*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.

\*Children will be brushing with the direct supervision of our child care staff.

\*Children will be using toothpaste with fluoride and approved by the American Dental Association.

Little Angels will be responsible for purchasing toothbrushes, toothpaste, and providing safe storage of all toothbrushes. Please note that your child's toothbrush will be disposed of after three months or if your child is sick.

Please sign and return to acknowledge that you have read this note regarding the tooth brushing program. If you have any questions or concerns, please do not hesitate to call.

**~ FULL DAY CHILDREN ONLY ~**

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

**PLEASE CHECK ONE BELOW**

\_\_\_\_\_ **I do want** my child to participate in the tooth brushing program

\_\_\_\_\_ **I do not want** my child to participate in the tooth brushing program

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### **Sunscreen Permission Slip**

I, \_\_\_\_\_, give Little Angels permission to reapply sunscreen to my child \_\_\_\_\_ in the afternoon. It is our expectation that you apply sunscreen before your child arrives.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

## **STATEMENT OF AGREEMENT**

We, at **LITTLE ANGELS ACADEMY**, agree to meet certain responsibilities concerning our child. These include, but are not necessarily limited to the following:

- a) To provide qualified supervision of your child at all times.
- b) To provide a readiness curriculum to help prepare your child for public school.
- c) To provide as "SAFE" an environment as possible, including First Aid & CPR trained personnel.
- d) To provide a twice yearly written report on your child's progress.
- e) To provide a warm, loving atmosphere where your child can enjoy that most important first experience with education.

As the parent of a child enrolled at **LITTLE ANGELS ACADEMY**, I agree to meet the responsibilities listed below:

- a) To provide **LITTLE ANGELS ACADEMY** with information regarding any special problems or circumstances that would affect my child's emotional, social or educational growth.
- b) To provide prompt transportation for my child to and from **LITTLE ANGELS ACADEMY**
- c) To provide **LITTLE ANGELS ACADEMY** with Two Week's Notice in the event of withdrawal or change in schedule.
- d) To pay my child's tuition one week in advance, regardless of my child's illness or vacation days. (Exclusive of two week's vacation per school year when notified in advance.

Owner's Signature

*Jennifer Dolan*

Parent/Guardian's Signature & Date

\_\_\_\_\_

## **Little Angels Academy Parent Waiver and Consent to the Use of Student Images on the Little Angels Academy Website**

From time to time, we record digital images of students participating in the classroom and desire to post these on our social websites to provide information to the community about our programs and services.

Given the global nature of the Internet, Little Angels Academy prohibits the posting of any student images or identifying information on our website without expressed written permission from the parent.

It is our intent to protect student and family rights to privacy, and endeavor to publish student photos on our site only as a means of promoting the preschool.

***No identifying information (name, class, year of enrollment, etc.) will be included with any child's picture.***

### **Consent to the use of student image on Little Angels Academy Social Websites**

Yes, the undersigned parent or legal guardian of (student name)

\_\_\_\_\_ a student or former student of Little Angels Preschool, agrees and consents to the posting of photographs of the student in connection with regular activities on the Little Angels website.

No, the undersigned parent or legal guardian of (student name)

\_\_\_\_\_ a student or former student of Little Angels Preschool, agrees and consents to the posting of photographs of the student in connection with regular activities on the Little Angels website.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date



Little Angels Academy  
Emergency Card Information

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS & PHONE: \_\_\_\_\_

Street Town State Phone #

**ALLERGIES/HEALTH CONDITION** \_\_\_\_\_

**INSTRUCTIONS TO REACH PARENT/GUARDIAN**

1. \_\_\_\_\_  
Name Cell Phone Work Phone

2. \_\_\_\_\_  
Name Cell Phone Work Phone

**EMERGENCY CONTACT & RELEASE IF PARENT'S CANNOT BE CONTACTED**

1. \_\_\_\_\_  
Name Address Phone #'s  
Relationship to Child

2. \_\_\_\_\_  
Name Address Phone #'s  
Relationship to Child

**PEDIATRICIAN/HEALTHCARE & INSURANCE**

\_\_\_\_\_  
Doctors Name Address/Phone # Insurance Name

**\*MEDICAL EMERGENCY TREATMENT\***

I hereby give Little Angels permission to administer first aid and CPR to my child  
\_\_\_\_\_ and/or take my child \_\_\_\_\_  
(Name) (Name)

to a hospital and secure medical treatment when I cannot be reached or when delay  
would be dangerous to my child's health.

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(Date)

**SCHOOL YEAR 2020-2021**

**Little Angels Academy**

**90 Arlington Street**

**Dracutinfo@littleangelsacademy-ma.com**

**NEWSFLASH!**

We are requesting your e-mail address so that we will be able to better communicate important information to you via e-mail blasts. E-mails such as reminders of your monthly newsletter and special events will be forwarded to you. Your e-mail address will be used for this purpose only.

PLEASE PRINT CLEARLY

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

Class: \_\_\_\_\_

Parents Name : \_\_\_\_\_

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

**I would prefer not to share my e-mail address at this time.**

\_\_\_\_\_

Parent signature

\_\_\_\_\_

Date