

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:_____

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: _____

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 weeks' 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

262 Middlesex Road Tyngsboro

Tyngsboroinfo@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