Children's Records must be maintained for at least five (5) years after a child has left the program

FAMILY CHILD CARE ENROLLMENT PACKET FACE SHEET

*PHOTO OF CHILD (*Optional) PLUS PHYSICAL DESCRIPTION

Eye Color _______
Hair Color ______ Sex_____
Height _____ Weight _______
Other:____________________
____
____

Please fill out these forms completely. If a question does not apply to your child, write N/A (not applicable). The forms must be in the educator's possession on or before the first day your child begins care. Please notify your educator if any of the information changes.

General Information

Date of Admission ________________ Age at Admission: ______

Date of Discharge ______________

Reason for Discharge: ____

____

Child's full name ______________________________Date of Birth ______________________________

Address:________________________________ City:___________________ Zip:________________

Telephone Number: ______________________________ Nickname __________________

Primary Language of Child _____________ Primary Language of Parents_________________

Allergies/Special Diets ____

Name of Parent(s)/Guardian(s)____

Home address (if different) ____

Telephone Number:____

Email Address: ____

Parent(s)/guardian(s) business address/location during child care:

Parent/Guardian: ______________________________
Where: ______________________________
Telephone: ______________________________
Cell Phone: ______________________________
Instructions: ______________________________
____

Parent/Guardian ______________________________
Where: ______________________________
Telephone:______________________________
Cell Phone:______________________________
Instructions:______________________________
____

Emergency Contact/Authorized pick-up person

In the event of an emergency when I may not be reached, the Educator may contact the following individuals (in the order given) whom I authorize to take my child from the child care premises.

(1) Name: ______________________________ Address ______________________________

Telephone ______________Cell Phone __________

(2) Name: ______________________________ Address ______________________________

Telephone _____________ Cell Phone __________

Child's Name ______________________

TRANSPORTATION PLAN / AUTHORIZED PICK- UP

My child will arrive to the program by:	My child will depart the program by:
__Parent Drop-Off	__Parent Pick Up
__Supervised Walk	__Supervised Walk
__Unsupervised Walk	__Unsupervised Walk
__Public/Private Van	__Public/Private Van
__Bus	__Program Bus/Van
__Private Transportation Provided by Parent	__Private Transportation Provided by Parent

In the space below, please note any important information regarding transportation of your child to and from the program (i.e.--indicate who will be supervising children during transport or prior to their arrival at the program, who supervises the walk from a bus stop, etc.)

____

____

____

____

I additionally authorize the following individual to take my child from the child care premises. (Please let me know at the beginning of the day when your child will be picked up by one of the authorized individuals.)

Name ______________________ Address ______________________

Telephone __________ Cell Phone ______________

Name ______________________ Address ______________________

Telephone __________ Cell Phone ______________

Anticipated Days/Time of Attendance

Day	Arrival Time	Departure Time	Day	Arrival Time	Departure Time
Monday	______	______	Friday	______	______
Tuesday	______	______	Saturday	______	______
Wednesday	______	______	Sunday	______	______
Thursday	______	______			

If applicable: Name of School Child Attends: ______________________

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

Notes:

____

____

____

Child's Name ______________

Parental Signatures

Written Acknowledgement of Receipt of Parent Handbook

I acknowledge that I have received a copy of the provider's parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook).

______________________________ ______________
Parent/Guardian Date

Parental Visit Notice

I understand that I may visit this family child care home unannounced at any time during the hours that my child is in care.

______________________________ ______________
Parent/Guardian Date

Child's Physician or Health Care Professional

Name: ______________________________ Telephone: ______________

Address: ______________________________

Information on allergies, special diets, chronic health conditions, special limitations, concerns including medications child is taking at home/school and possible side effects:

____
____
____
____
____

Medical Insurance Information (OPTIONAL)

Subscriber's Name: ______________________ Policy #: ______________

Type of Insurance: ______________________

[ ] Copy of Insurance Card

SCHOOL AGE ONLY

Current School: ______________________ School Address: ______________________
____

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/Guardian initials: ______________

Child's Name ______________________

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

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

CHILD'S NAME ______________________ **DATE OF BIRTH** __________

*Note: 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: ______________________

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: baby 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 program

____
What is used at home? Potty chair? _______ 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 the child have accidents? ______________________

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 physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your educator. Your educator will place your infant on his/her back unless there is a written physician's order that specifies otherwise.**

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 walking etc) ______________
____

SOCIAL RELATIONSHIPS

How would you describe your child:____
____

Previous experience with other children/child 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 child care 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: ________________

Permissions (for each child enrolled)

General Permission-(Basic Transport)

(Parents should not sign this permission unless specific places where your child is allowed to go are listed by your educator.) By signing this form, I am allowing my child to be taken off the child care premises.

I, hereby give ________________________________ permission to take my child ________________
(educator/assistant)

off the premises of the family child care home for the following excursions: (specific places your child is allowed to go): ____
____
____

using the following forms of transportation: ____
____

______________________________ ______________________________
Parent/Guardian Signature Date

I do not want my child to be taken off the child care premises.

______________________________ ______________________________
Parent/Guardian Signature Date

Permission - (Transport to Medical Facility and Receive Emergency Medical Treatment)

Medical Emergency Treatment (Department of Early Education and Care recommends checking with your local hospital about the acceptability of this statement)

I, hereby give ________________________________ permission to administer basic first aid and/or
(educator/assistant)

CPR to my child ______________________________, and/or take my child to a hospital for medical

treatment when I cannot be reached or when delay would be dangerous to my child's health.

______________________________ ______________________________
Parent/Guardian Signature Date

Topical Medication/Ointments (Please list only those medications/ointments which you will allow the educator(s) to administer to your child's skin): Ex: sunscreen, insect repellent (bug spray), diapering ointment.

____
____

______________________________ ______________________________
Parent/Guardian Signature Date

Child's Name ________________

Emergency Card Information

REMINDER : ***This emergency card information is for the educator's first aid kit. The educator(s) must take first aid materials when leaving the child care premises.***

Child's Name:______________________ Date of Birth:______________________

Child's Home Address:____

______________________________ Phone: ______________________

Instructions to Reach Parent or Guardian

1.____
(Name, Address, Home and Cell Phone #)

2.____
(Name, Address, Home and Cell Phone #)

Contact Information for Physician or Health Care Professional

1. ____
(Physician's Name, Address, Phone #)

Emergency Contact Person(s)

1. ____
(Name, Address, Home and Cell Phone #)

2. ____
(Name, Address, Home and Cell Phone #)

Emergency Medical Treatment

I hereby give ______________________________ permission to
(Name of educator/assistant)

administer basic first aid and/or CPR to my child ______________________
(Name)

and/or take my child ______________________, to a hospital for medical treatment
(Name)

when I cannot be reached or when delay would be dangerous to my child's health.

______________________ ______________________
Parent/Guardian Date

Medical Insurance Information (Optional)

Subscriber's Name:______________________________
Type of Insurance:______________________________
Policy Number:______________________________
[ ] Copy of insurance card______________________________
Other pertinent medical information:______________________________
____
____

Dear Physician: ____
(Child's Name)

is enrolled in a family child care home which is 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.

Evidence of a physical exam is valid for one (1) year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: ______________________ Date of Birth: ______________

Address: ______________________________ Phone # ______________

Name of Parents: ____

Address: ____

Date of Examination of Child: ______________________________

What is your opinion concerning the child's general health and appearance:

____

____

____

Has this child been screened for lead poisoning? Yes ________ No _________

(*At least one (1) time between ages 9-12 months; Annually-Ages 2 & 3; at Age 4 if High Risk for Lead Poisoning)

If Yes, date screened: ______________

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care educator? If so, please detail below:

____

____

____

Physician's Signature: ______________________ Date: ______________

Comments: ____

____

____

____

Please return this form and the child's immunization record to:

____

____

____

Children's Services of Roxbury Health Care Policy

Children's Services of Roxbury understands that it is difficult for parent/guardian to leave or miss work, therefore it is suggested that alternative arrangements be made in case of illness. If your child has any of the following symptoms, we will contact you to pick up your child from the center (within 1 hour) both to provide comfort to your child and to prevent contagion of the other children. Your child must be kept home for 24 hours (SYMPTOMS FREE) before returning to school. In case of contagious illness (or suspected contagious illness) a doctor's note will be required before your child can return to school.

- Temperature of 100 degrees (under arm/forehead)
- Vomiting (more than once)
- Diarrhea (more than once for Toddlers and Preschoolers & three times for infants)
- Any suspicious rash
- Colored nasal discharge (if transmission cannot be controlled)
- Any contagious illness
- Any symptoms requiring one-to-one care and/or causing severe discomfort
- Any illness accompanied by open, oozing bacterial infections and/or severe and bloody diarrhea
- Ringworm
- Hacking cough

When returning your child to Children's Services of Roxbury after illness, please remember

- Your child must be free from fever, vomiting, and diarrhea for 24 hours (without symptoms) prior to returning to school
- Any child prescribed an antibiotic must take it for 24 hours before returning to school
- Any contagious illness requires a doctor's statement that the child is not contagious prior to returning to school
- Your child must be able to participate in all activities upon returning (including outdoor times)

POLICY ON PRESCRIPTION MEDICATIONS

- Always require a note signed by the parent/guardian and written order of physician
- The note must specify both the dosage and the time to be administered
- A new note is needed each time a medication is prescribed
- The medication must have a current pharmacist label, in the original bottle. Label must include name of medication, child's name, dosage, frequency of intake, date prescription filled, expiration date along with the name and number of physicians

POLICY ON NON-PRSCRIPTION MEDICATIONS

- A note is required signed by both the parent/guardian and the pediatrician
- The note can cover an extended period no longer than 3 months
- The parent/guardian must request in writing specific instructions how the medication should be administered, specifying time and dosage
- Non-prescription ointment, diaper creams, and topical lotions require only a note signed by the parent/guardian, specifying time and dosage (not exceed 3 months).

Parent / Guardian Signature Date Director's Signature Date

Children's Services of Roxbury
Strengthening Families across Massachusetts

Roxbury • Tewksbury • Worcester • Northampton

Photography Consent Form

Dear Parent/Guardian,

As the parent of child/children at Children's Services of Roxbury Family Childcare Providers I agree to the following:

I understand that my child/children may be photographed/videotaped at my child's Provider during normal daycare hours, fieldtrips, or activities. I understand these photographs may be used in promoting childcare services or advertising within the childcare program or at Children's Services of Roxbury, either in print/Internet or social media outlets.

Parent/Guardian name: ______________________________

Child/childrens name/s: ______________________________

____

____

Address______________________________________

City________________ State____________ Zip__________________

Children's Services of Roxbury
Strengthening Families across Massachusetts

Roxbury • Tewksbury • Worcester • Northampton

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

PARENT NAME____
STREET ADDRESS____
CITY, STATE, ZIP CODE_____________________________________
SOCIAL SECURITY NUMBER: XXX-XX-__________________________

AUTHORIZATION TO OBTAIN INFORMATION:

I hearby, authorize **(Name of Entity)** ____ to release all relevant information, including documentation and other materials pertinent to my eligibility to Participate at Children's Services of Roxbury Family Childcare, Early Education and Care Program. all information is to be sent to 520A Dudley Street, Roxbury Ma. 02119

AUTHORIZATION TO RELEASE INFORMATION:

I **(parent name)** ____ also authorize Children's Services of Roxbury Family Childcare Program to release all relevevant information regarding me including documentation, and other materials pertinent to my participation to the Department of Transitional Assistance, and or any other entity that sends verifiable release of information on my behalf to the program.

Parent Name: ________________________________ **Date:** __________

Staff Name: ________________________________ **Date:** __________

United Way of Massachusetts Bay and Merrimack Valley

United Way of Massachusetts Bay & Merrimack Valley (United Way) and Children's Services of Roxbury Family Child Care invite you to participate in the developmental screening process by completing the Ages & Stages Questionnaires® (ASQ®) and/or Ages & Stages Questionnaires: Social Emotional® (ASQ:SE®) with your child. The ASQ®/ASQ:SE® are developmental screening tools that provide you with a **quick check of your child's development.** They are easy to use and typically take about ten minutes each to complete.

The ASQ®/ASQ:SE® provide a snapshot of your child's development and it focuses on what your child can do. It celebrates your child's strengths, highlights developmental milestones, and identifies any areas that may need more support. Regular screenings allow you to learn about your child's development and to address any questions or concerns you may have about what typical development looks like. It allows you to participate in the decision-making opportunities related to your child's early education and care programming, and it provides your program with invaluable knowledge about your child.

Children's Services of Roxbury Family Child Care and United Way collect ASQ®/ASQ:SE® screening data to identify trends and patterns in the early education and care settings in order to better support the programs with resources and professional development opportunities. United Way is only analyzing the combined scores of all the screening results. The specific names of children are not included in the analysis.

ASQ®/ASQ:SE® results are confidential. Both Children's Services of Roxbury Family Child Care and United Way follow the Massachusetts confidentiality laws to ensure that your and your child's personally identifiable information is protected.

This form requests your permission to participate in the developmental screening process with your child; to enter your child's screening data into an online database; and to share your child's de-identified screening data with the United Way and any of its designated agents, assigns, partners, research consultants, contractors, or subcontractors.

I acknowledge that I have read the information provided by Children's Services of Roxbury Family Child Care and United Way about the ASQ®/ASQ:SE® screening process and I agree to complete the ASQ®/ASQ:SE®, and Children Service's of Roxbury Family Child Care <u>may enter</u> my child's information into the online database to be shared with United Way.

____
Name of Child

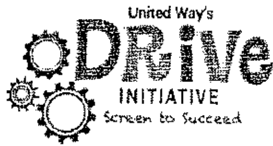
Circle screening tool to give consent: ASQ® ASQ:SE®

____
Signature of Parent or Guardian

____
Date

____
Name of Parent or Guardian

* The data summary reports will only compile combined scores from all children and will not include the specific names of children.



Child's name ______________________
Child's DOB _____/_____/_____

Child

1. **Child's ethnicity**

Is your child Latino/Hispanic? ☐ Yes ☐ No
Is your child Haitian or Caribbean? ☐ Yes ☐ No
Is your child Cape Verdean? ☐ Yes ☐ No

2. **Child's race (check all that apply):**

☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ Asian (which country?) ______________________
☐ Other (specify) ______________________________________

3. **Languages spoken at home (check all that apply):**

☐ English ☐ Spanish ☐ Portuguese ☐ Vietnamese ☐ Arabic
☐ Khmer ☐ Chinese Mandarin ☐ Chinese Cantonese ☐ Cape Verdean Creole ☐ Haitian Creole
☐ Other ____________________

4. **Who takes care of your child most of the time during the weekdays? (check all that apply):**

☐ Relative (mom, dad, sibling, grandparent)
☐ Other relative (aunt, uncle, cousin)
☐ Non-relative person (babysitter, nanny, friend)
☐ Licensed family child care provider (non-relative providing childcare for 2 or more children outside of child's home)
☐ Center-based child care provider (day care or child care center, preschool, Head Start program)

Parent/Caregiver

5. **Adult -- Last grade completed by parent/caregiver:**

☐ Less than high school diploma ☐ High School / GED ☐ Some College/Technical School ☐ College Degree or higher

6. **Adult's employment status (check all that apply):**

☐ Unemployed ☐ Working Part Time ☐ Working Full Time
☐ Student ☐ Stay at Home Parent/Guardian ☐ Retired

7. **Adult -- Which of the following resources are you currently receiving for you or your child (check all that apply):**

☐ DTA ☐ WIC ☐ DCF (DSS) ☐ SNAP (Food Stamps)
☐ Early Intervention ☐ Unemployment ☐ SSI for Child or Adult ☐ Mass Health
☐ Fuel Assistance ☐ Early Head Start or Head Start ☐ None of the services listed

8. **Number of adults (18 and older) living in household?** *(include yourself)* _____

9. **Number of children (under 18) living in household?** *(include the child being screened)* _____

Nombre del niño ____________
Fecha de nacimiento ____/____/____

Niño

1. Etnia del niño

¿Es su niño Latino/Hispano? ☐ Sí ☐ No
¿Es su niño Haitiano/Caribeño? ☐ Sí ☐ No
¿Es su niño Caboverdiano? ☐ Sí ☐ No

2. Raza del niño (marque todas las que se apliquen):

☐ Indio Americano o Nativo de Alaska ☐ Negro o Afroamericano ☐ Blanco
☐ Nativo de Hawaii o de otras Islas del Pacífico ☐ Asiático (¿Cual país?) ____________
☐ Otro (especifique) ____________

3. Idiomas hablados en el hogar (marque todas las que se apliquen):

☐ Inglés ☐ Español ☐ Portugués ☐ Vietnamita ☐ Árabe
☐ Khmer ☐ Mandarin Chino ☐ Cantonés Chino ☐ Criollo Caboverdiano ☐ Criollo Haitiano
☐ Other ____________

4. Quién cuida a su niño durante los dias de semana? (marque todas las que se apliquen):

☐ Familiar (madre, padre, hermano, abuelo)
☐ Otro Familiar (tia, tio, primo)
☐ Personas que no son familiares (niñera, amigo)
☐ Centro de cuidado de niños licenciado (provedor de cuidados infantiles que no sea un familiar y que cuide 2 o más niños fuera de la casa del niño)
☐ Centro de Cuidado Infantil (guardería, preescuela, Head Start)

Padre/Madre o Cuidador

5. Adulto – Nivel máximo de educación de padre/madre o cuidador:

☐ Diploma de Escuela Secundaria o menos ☐ Escuela Secundaria / GED ☐ Universidad Incompleta/Escuela Técnica ☐ Diploma Universitario o más

6. Estado de Empleo (Marque todos los que se apliquen):

☐ Desempleado ☐ Trabajando Medio Tiempo ☐ Trabajando Tiempo Completo
☐ Estudiante ☐ Padre o Guardián que Permanece en la Casa ☐ Retirado

7. Adulto-- ¿Cuáles de estos recursos usted recibe actualmente para usted o su niño?(marque todos los que se apliquen):

☐ DTA ☐ WIC ☐ DCF (DSS) ☐ SNAP (Cupones de Alimentos)
☐ Intervención Temprana ☐ Desempleo ☐ SSI para el niño o un adulto ☐ Mass Health
☐ Asististencia de combustible ☐ Head Start Temprano o Head Start ☐ Ninguno de estos servicios

8. ¿Número de adultos (mayores de 18 años) viviendo en el hogar? *(incluirte a ti mismo)* _____

9. ¿Número de niños (menores de 18 años) viviendo en el hogar? *(incluir al niño siendo examiado)* _____

Children's Services of Roxbury
Strengthening Families across Massachusetts
Roxbury • Tewksbury • Worcester • Northampton

2022-2023 Holiday Closing and Professional Development Schedule for Family Childcare Staff and Educators

#	Month/Day/Year	Day of the Week	Holiday Name, if applicable	State if Open or Closed
1	7/4/2022	Monday	Independence Day	Closed
PD1	8/12/2022	Friday	Essential Training	PD
PD2	9/2/2022	Friday	QRIS 1	PD
2	9/5/2022	Monday	Labor Day	Closed
PD3	10/7/2022	Friday	QRIS 2	PD
3	10/10/2022	Monday	Columbus Day	Closed
4	11/11/2022	Friday	Veteran's Day	Closed
5	11/24/2022	Thursday	Thanksgiving Day	Closed
6	11/25/2022	Friday	Day After Thanksgiving	Closed
7	12/26/2022	Monday	Christmas Day	Closed
8	1/2/2023	Monday	New Year's Day	Closed
9	1/16/2023	Monday	Martin Luther King Day	Closed
10	2/20/2023	Monday	Presidents' Day	Closed
PD4	3/17/2023	Friday	St. Patrick's Day	PD
11	4/17/2023	Monday	Patriots' Day	Closed
12	5/29/2023	Monday	Memorial Day	Closed
PD5	6/16/2023	Friday	Bunker Hill Day	PD