PARKWAY PRESCHOOL CENTER, INC.
146 SPRING STREET
WEST ROXBURY, MA (617) 469-4909

CHILD'S FACE SHEET/ ENROLLMENT/APPLICATION FORM **Registration Fee $25.00 (Y / N)**

CHILD INFORMATION:

Child's Name: ______________________________

Date of Birth: ______________________________

Place of Birth ______________________________

Home Address: ____

Home Telephone: ______________________________

Primary Language: ______________________________

CHILD'S IDENTIFYING INFORMATION (required by the O.F.C. regulations)

Eye Color:_______ Hair Color:_______ Skin Color:_______ Height: _______ Weight: ______Sex: M / F

PARENT/GUARDIAN INFORMATION:

Father

Parent/Guardian Name: ____________________

Relationship to child: ____________________

Home Address: ____________________

Home Telephone #____________________

Cellular Telephone #____________________

Home Email Address: ____________________

Work Email Address: ____________________

Business Name: ____________________

Business Address: ____________________

Business Telephone # ____________________

Hours at Work: ____________________

Mother

Parent/Guardian Name: ____________________

Relationship to Child: ____________________

Home Address: ____________________

Home Telephone #____________________

Cellular Telephone # ____________________

Home Email Address: ____________________

Work Email Address: ____________________

Business Name: ____________________

Business Address: ____________________

Business Telephone # ____________________

Hours at Work: ____________________

If parents cannot be contacted......please Notify (include names on emergency release form)

Name: ____________________

Address: ____________________

Relationship to Child: ____________________

Telephone (day time): ____________________

Name: ____________________

Address: ____________________

Relationship to Child: ____________________

Telephone (day time): ____________________

Other Family Members (living with child):

____

Child's Physician/ Clinic: ____________________ Telephone #____________________

How did you learn of Parkway Preschool Center Inc.?______________________________

Program Request (**please state a.m.'s , p.m.'s, half days, full days, which days, preferred starting date**)

____

Signatures:

______________________________ Current Date: ____________________

Parent/Guardian

For center use only:

Date of admission: ____________________ Age at Admission: ____________________

PARKWAY PRESCHOOL CENTER, INC - PARENT/SCHOOL AGREEMENT

Child's Name______________________ Date of Birth______ Enrollment Date______

I/We ____,on this date, place my/our child, ____, in the Parkway Preschool Center, Inc. (hereinafter referred to as "PPSCI") and hereby agree to the following terms:

1. Payment for specified program (ages 2.9 yrs. and up) is to be paid in full on each Monday (or the first day of your child's scheduled week) of the Preschool/Kindergarten week.
2. A deposit in the amount of $___________(one week of tuition) will be paid on this date. This deposit will be applied to the last week's tuition of the Preschool/Kindergarten program. Should the child, for any reason, not attend the Center, the deposit is **NON-REFUNDABLE**.
3. Payment must be made for any child/parent sick or snow days falling within the Preschool/Kindergarten week. No make up hours are allowed.
4. Payment must be made for all PPSCI honored holidays (State and Federal) falling within the Preschool/Kindergarten week.
5. A two week written notice MUST be given, or a two week payment MUST be made, at the time the child leaves PPSCI.
6. A brochure and tour of PPSCI has been given and the school's policies have been discussed.
7. PPSCI operates Monday through Friday from 7:30 a.m. to 6:00 p.m.
8. PPSCI closes promptly at 6:00 p.m. which means that you should be at the school to pick up your child by 5:55 p.m. In the event the last child should leave the school prior to 6:00 p.m. PPSCI retains the right to close early if there are no children present.
9. Any parent arriving at the PPSCI after 6:00 p.m. to pick up a child will incur a charge of $10.00 for every 15 minutes late. Payment will be made directly to the teacher who stays with child - not to the school.
10. There will be at least two scheduled parent/teacher conferences per year. However, you may request a conference art any time.
11. You are entitled to copies of all progress reports written for your child. Please request a copy at any time.
12. PPSCI must be notified when your child is out sick. Also, inform the school as to the illness as it is necessary to post contagious illnesses (ie: chicken pox, measles, etc.) for the health and well being of all our children and staff.
13. PPSCI does not provide transportation unless emergency medical help is necessary.
14. Parents must indicate, at the beginning of each day, who will drop-off or pick up your child. Please be sure that your child is signed in by a staff member each day.

I/We , ____, have read and fully understand this Parent/School Agreement. **Date**______________________

The Commonwealth of Massachusetts
Department of Early Education and Care

Child's Enrollment Form

Child Information

Child's Name:______________________ Date of Birth:______________

Age at Admission:______________________ Date of Admission:__________

Child's Home Address:______________________________________

Home Phone Number:______________________________________

Primary Language:______________ Identifying Marks:______________

Eye Color:________ Hair Color:________ Skin Color:______________

Sex:____________ Height:__________ Weight:______________

Parent/Guardian Information

Parent/Guardian Name:______________________________________

Relationship to Child:______________________________________

Home Address:______________________________________

Reachable Phone Number:______________________________________

Email Address:______________________________________

Business Name:______________________________________

Business Address:______________________________________

Business Phone Number:______________________________________

Hours at Work:______________________________________

Parent/Guardian Name:______________________________________

Relationship to Child:______________________________________

Home Address:______________________________________

Reachable Phone Number:____

Email Address:____

Business Name:____

Business Address:____

Business Phone Number:_______________________________________

Hours at Work:____

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? ____________________________________

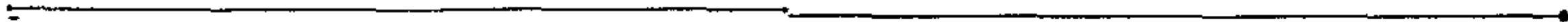
____

School Age Only

Current School:____

School Address:________________________ School Phone Number:__________

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:***



__________________________________ ____________________

Parent/Guardian Signature **Date**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

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:** ______________

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: 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? ____

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? _________________

____

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)

✳ Physical Notation Sheet

Child's Name_______________________________________

Parent's Name_______________________________________

Child's Date of Birth_________________________________

____

Child's Doctor____

Doctor's Address____

Doctor's Telephone Number_______________________________

Child's next physical examination date:_________________________

Parent Signature____

Current Date____

✳ This sheet need only be filled out and returned only if there is no Private Physician's Examination Form being completed.

Dear Physician: ____

(Child's Name)

is enrolled in an early childhood program 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 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 ________

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 provider? If so, please detail below:

____

____

____

Physician's Signature: ______________________________

Date: ____________ Comments: ______________________________

____

____

Please return to Program: ______________________

____

____

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name:

Date of Birth: / / **Sex:** ☐ female ☐ male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* Date: / /

Signature:

Facility name:

EMERGENCY CARD INFORMATION

Child's Name:______________________________
Date of Birth:______________________________

Child's Home Address:____

____ Phone: ____________________________

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1.____
(Name, Address, Phone #)

2.____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

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

EMERGENCY CONTACT PERSON(S)

1. ____
(Name, Address, Phone #)

2. ____
(Name, Address, Phone #)

MEDICAL EMERGENCY TREATMENT
I hereby give ____
(Name of program)
permission to administer basic first aid and/or CPR to my child ________________________
(Name)
and/or take my child ______________________________, to a hospital for medical
(Name)
treatment when I cannot be reached or when delay would be dangerous to my child's health.

____ ____________________________
(Parent Signature) (Date)

INSURANCE INFORMATION (OPTIONAL)
Company Name:__________________________________ Policy #______________________________
Participating Hospital:____
Special Instructions:____

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 Number: ______________________

Child's Allergies: ____
Chronic Health Conditions: ____

Emergency Contacts (*In order to be contacted*)
Name____
Address____
Relationship to child____
Home Phone_________________________ Cell Phone____________________
Do you give permission for child to be released to this person? Yes_____ No______

Name____
Address____
Relationship to child____
Home Phone_________________________ Cell Phone____________________
Do you give permission for child to be released to this person? Yes_____ No_____

Name____
Address____
Relationship to child____
Home Phone_________________________ Cell'Phone____________________
Do you give permission for child to be released to this person? Yes_____ No___

Health Insurance Coverage______________________________ Policy #______________

Parent/Guardian Name: ____________________________ Phone__________ Cell__________

Parent/Guardian Name: ____________________________ Phone__________ Cell__________

______________________________ ______________________
Parent /Guardian Signature Date (valid for one year)

Student Teacher/ Observer Consent Form

I, _________________________, hereby agree to allow various Student
(Parent/Guardian Name)

teachers (from local participating High Schools and Colleges) to assist the Parkway Preschool Teachers in all activities and observation involving my child.

Parent Signature______________________________________

Date___________________________

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME________________________________

MY CHILD WILL ARRIVE AT THE PROGRAM:

___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:

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PROGRAM BUS/VAN

___CONTRACT/VAN

___PRIVATE TRANS. ARRANGED BY PARENT

___OTHER

I give permission for my child to be released from the program at the end of the program day as stated above and /or I give permission to the following people to receive my child at the end of the day. (If no one is authorized other than the parent/legal guardian please indicate below "NO ONE".)

*IF A CHILD IS PROTECTED BY A RESTRAINING ORDER PLEASE SUBMIT ORDER TO THE PROVIDER.

NAME__________________________

RELATIONSHIP__________________

ADDRESS_______________________

PHONE__________________________CELL______________________

NAME__________________________

RELATIONSHIP__________________

ADDRESS_______________________

PHONE__________________________CELL______________________

NAME__________________________

RELATIONSHIP__________________

ADDRESS_______________________

PHONE__________________________CELL______________________

PARENT/GUARDIAN SIGNATURE___________________________________DATE____________________

PARKWAY PRESCHOOL CENTER, INC.

Oral Health Non-Participation Form

In January 2010, EEC issued new regulations for child care programs that include a requirement that educators assist children with brushing their teeth if children are in care for more than four hours or if children have a meal while in care [606 CMR 7.11(11)(d]. This regulation is intended to:

- Help children learn about the importance of good oral health
- Provide information and resources regarding good oral health to child care programs and families
- Help address the high incidence of tooth decay among young children in Massachusetts, which is associated with numerous health risks.

EEC licensed programs must comply with this regulation. However, parents may choose that their child(ren) not participate in tooth brushing while present at the child care program.

You do not need to fill out this form to have your child (ren) participate in tooth brushing while they are in child care. However, if you do not want your child to brush his or her teeth while s/he is attending the child care program, please fill out the information found below. A separate form must be filled out for each child in care. This form must be renewed annually and will be kept in your child's record at the program. Should you change your mind and wish for your child to participate in tooth brushing, this form may be withdrawn at any time by requesting in writing that it be removed from your child's file.

Thank you.

I do not wish to have my child participate in tooth brushing while in care at Parkway Preschool Center, Inc.

Child's Name: ______________________________

Parent/Guardian's Name: ______________________________

Signature: ______________________________

Date: ______________________________

If you have any questions or concerns, please call:

______________________________ **at** ______________________________
(Contact Person at Program) (Phone Number)