The Salvation Army Children's Learning Center
Pre-School Program
26 Wales Street, Dorchester, MA 02124
Phone 617-436-2480 Fax 617-822-9015

ALL DOCUMENTATION MUST BE IN BEFORE YOUR CHILD CAN START

1) **Proof of Income (private and contract slot only)**

- 4 pay stubs (if paid weekly)
- 2 pay stubs (if paid by weekly)

2) **An original or certified copy of your child's birth certificate**

(a copy will be made for you and the original returned)

3) **Complete physical**

- Physical must be signed and dated by physician within a year
- All immunizations must be up to date
- Lead test must be done yearly until age 6

4) **One of the following utility bills within the past 60 days**

- Gas bill
- Oil bill
- Electric bill
- Home telephone bill

5) **Valid Mass. driver's license or Mass. Photo identification card**

6) **Please beware that children must go through a one-day transition period as follows**:

- Day 1: Parent stays with the child in the classroom for a short period of time before leaving. Parent will pick child up after lunch at 12:30pm
- Day 2: Full-day if child is ready, otherwise more transition is required
- This schedule may be altered to meet the needs of your child

7) **Complete set of clothing for your child's clothing box on the first day**

- Pants/dress/skirt
- Shirt
- Underwear/socks

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For Center Use
Date of Admission _____
Age at Admission _____

CHILD'S ENROLLMENT FORM

Child Information

Child's Name: _____ Date of Birth: _____

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: _____

Reachable Phone Number: _____ Email address: _____

Business Name: _____ Business Address: _____

Business Phone Number: _____ Hours at Work: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Reachable Phone Number: _____ Email address: _____

Business Name: _____ Business Address: _____

Business Phone Number: _____ Hours at Work: _____

Additional Information

Child's Physician: _____

Phone Number: _____ Address: _____

Allergies/Special Diets: _____

Special limitations or concerns? _____

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.

Parent 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: _____

Language spoken at home: _____

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: _____

Favorite foods: _____ Foods refused: _____

TOILET HABITS

Has toilet training been attempted? _____

Are bowel movements regular? _____ How many per day? _____

Is there a problem with diarrhea? _____ Constipation? _____

Please describe any particular procedure to be used for your child at the center: _____

_____

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

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 experiences with other children/day are: _____

_____

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, napping, toilet habits, fussy time, night bedtime, and etc. _____

_____

Is there anything else we should know about your child? _____

_____

Parent Signature: _____ Date: _____

TRANSPORTATION PLAN AND AUTHORIZATION

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE PROGRAM:	MY CHILD WILL DEPART FROM THE PROGRAM:
___PARENT DROP OFF	___PARENT PICK UP
___SUPERVISED WALK	___SUPERVISED WALK
___UNSUPERVISED WALK	___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN	___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN	____PROGRAM BUS/VAN
___CONTRACT/VAN	___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT	___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER	___OTHER

Parent Signature: _____ Date: _____

PARENT RELEASE FORM

Child's Name _____ Date _____

1. I give permission for my child to accompany the class, under the supervision of the teachers, on walk to places of interest in the neighborhood or on a day trips.

Parent Signature _____

2. I give permission to have my child's picture taken with a group, or individually, and used for publication if needed by The Salvation Army Children's Learning Center.

Parent Signature_____

3. I understanding that all information contained within the child's records is privileged information and is totally confidential. No part of this information will be distributed or released without the written consent of the parent

Parent Signature: _____

You will be notified of any request for information by any other party. You will have access to the child's and copies may be obtained.

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program that is 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: _____

Health Insurance Coverage_____ Policy #_____

Parent/Guardian Name: _____ Phone # _____

Parent/Guardian Name: _____ Phone # _____

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_____

Parent Signature: _____ Date: _____

Pick Up List

Child's Name: _____

Name_____Address_____

Relationship to child_____ Home Phone _____Cell Phone_____

Name_____Address_____

Relationship to child_____ Home Phone _____Cell Phone_____

Name_____Address_____

Relationship to child_____ Home Phone _____Cell Phone_____

Name_____Address_____

Relationship to child_____ Home Phone _____Cell Phone_____

Name_____Address_____

Relationship to child_____ Home Phone _____Cell Phone_____

Name_____Address_____

Relationship to child_____ Home Phone _____Cell Phone_____

Name_____Address_____

Relationship to child_____ Home Phone _____Cell Phone_____

Parent Signature: _____ Date: _____

TERMS AND AGREEMENT OF SERVICES OF CARE

The Salvation Army Children's Learning Center agrees to provide child care for you child(ren) twelve (12) months a year except upon identified holidays. The Center will be open from 7:30 a.m. until 5:30 p.m. five days per week, unless there is an emergency in which the CLC must be closed. As a parent, I agree to transport, or arrange transportation for my child to and from the Center on the days that the Center is open. If my child is sick or otherwise unable to attend the Center, I will call the Center before 9:00 a.m. A call before 4:00 p.m. must be made to inform the Center of any changes in escort.

I agree that I will have my child in the classroom no later than 9:30 a.m. If I am unavoidably late and have not called, I will stop by the Parent Coordinator or Director's office where a decision will be made as to whether or not my child may attend the Center for that day. No child is allowed into the center after 9:30 a.m. without a written Doctor note for the particular day. Although the Center will be open from 7:30 a.m. to 5:30 p.m., I understand the Center's policy that no child should be in care for a full ten hours of programming time.

I understand that if my child is left at the Center after 5:30 p.m., I will be responsible for payment of the late fee: $1.00 per minute up to 6:00 p.m. If I have not contacted the Center by 6:00pm my child will be considered "abandoned," and it may be necessary to call the Department of Children and Families (DCF). After 6:30pm, the Center is required by law to contact DCF.

I agree to pay The Salvation Army Children's Learning Center $_____ per week for my child/children. This fee is to be paid every Monday, in advance of the coming week, unless special arrangements are made. All parents are required to pay one-week tuition in advance of and not providing service for my child. The full fee will be paid whether or not my child is absent on certain days.

If your child deliberately hits either a staff member or another child, the child will be given 2 verbal warnings, allowing the child to have the opportunity to change the behavior. If the behavior has not stopped after 2 verbal warnings, the parent will be called immediately and informed of the incident. After 3 written incident reports, the parent and child will meet with program staff to investigate options for behavior modification and the need for an assessment/referral. The parent will receive a written EEC incident report within 24 hours after incident occur. If there are any future complications or violent incidents, the Director will determine the appropriateness of the placement in the program. If it is determined that this is not the appropriate placement, the CLC will allow a reasonable amount of time for the parent to locate another program.

Parent Signature: _____ Date: _____

Child's Name_____

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

THE SALVATION ARMY CHILDREN'S LEARNING CENTER

CHILD'S NAME: _____

PARENT NAME: _____

SIGNATURE: _____

DATE: _____