

## CHILD'S ENROLLMENT FORM

### Child Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age at Admission: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_ Date of Admission: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
Sex: \_\_\_\_\_ Identifying Marks: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Hair Color: \_\_\_\_\_ Skin Color: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### Parent/Guardian Information

Parent/Guardian Name: _____	Parent/Guardian Name: _____
Relationship to Child: _____	Relationship to Child: _____
Home Address: _____	Home Address: _____
Home Phone Number: _____	Home Phone Number: _____
Cell Phone Number: _____	Cell Phone Number: _____
Email Address: _____	Email Address: _____
Business Name: _____	Business Name: _____
Business Address: _____	Business Address: _____
Business Phone Number: _____	Business Phone Number: _____
Hours at Work: _____	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, restraining orders pertaining to the child? If Yes please attach: \_\_\_\_\_  
Special limitations or concerns? \_\_\_\_\_

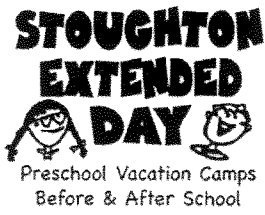
### School Age Only

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: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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 \_\_\_\_\_

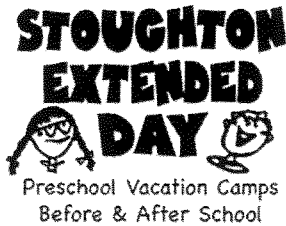
Name \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

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)



P.O. Box 257, 137 Walnut Street, Stoughton, MA 02072-0257 781-344-5512 Fax 781-341-0885

**Child(ren)'s Name:** \_\_\_\_\_

### **Photo Permission**

**I do / do not (circle one)** give permission for the above stated child(ren) to be photographed as part of the Stoughton Extended Day program which may be used for promotional material, web page displays, and any other materials associated with Stoughton Extended Day Program, Inc.

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Swimming Permission**

**I do / do not (circle one)** give permission for the above stated child(ren) to go swimming with any Stoughton Extended Day programs.

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Sunscreen and Bug Repellent Release**

**I do / do not (circle one)** give permission for the above stated child(ren) to have sunscreen and/or bug repellent applied by SED staff. You, the parent or guardian, must supply the sunscreen/bug repellent in the original container(s) labeled with you child's name. SED will make every effort to apply the sunscreen and /or bug repellent as directed. However, SED has no control over which products or brands are provided and their effectiveness. You must understand that if your child does get burned or bitten, neither SED nor its staff may be held responsible. You should also apply the sunscreen/bug repellent to your child before arriving at camp.

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*We also need a copy of your child(ren)'s immunizations from your child's Physician. Please include that in your registration packet.**



THE COMMONWEALTH OF MASSACHUSETTS  
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**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

\_\_\_ PARENT DROP OFF

\_\_\_ 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

\_\_\_ PARENT PICK UP

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

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ CELL \_\_\_\_\_

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