



**New Student**

***For Staff Use***

Classroom: \_\_\_\_\_  
Updated by: \_\_\_\_\_  
Date: \_\_\_\_\_

**Enrollment Information**

**Child's Information**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Nickname (if applicable): \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Home Address: \_\_\_\_\_

**Parent/Legal Guardian #1:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Driver License Number: \_\_\_\_\_ License Plate Number: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Days/Hours of Employment: \_\_\_\_\_

Address of Employment: \_\_\_\_\_

**Parent/Legal Guardian #2:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Driver License Number: \_\_\_\_\_ License Plate Number: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Days/Hours of Employment: \_\_\_\_\_

Address of Employment: \_\_\_\_\_

**Emergency Information**

**Transport Arrangement in an Emergency Situation:**

Hospital Preference: \_\_\_\_\_

*\*If one is not specified, Windham Hospital will be utilized. \**

**Emergency Contacts** (to whom child may be released to if legal guardian is unavailable):

**Emergency Contacts must bring a photo ID.** If you have more than two emergency contacts attach additional sheet.

**Name #1:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**Name #2:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Other:** \_\_\_\_\_

Name of any other individuals who may access your child's CFDRRC health records:

\_\_\_\_\_

I give consent for trained CFDRRC staff to provide my child with first aid and/or transport them via ambulance to a hospital as needed. I understand that when my child is ill or needs to be picked up for other unexpected reasons that I (or another designated adult) must arrive within thirty minutes of being called. I agree to review and update this information whenever a change occurs or every six months.

I understand that if I am not available, I authorize the above people to act for my child.

**Parent/Guardian #1 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian #2 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health**

**Asthma:** Yes  / No       **Allergies:** Yes  / No       **Epi-Pen Needed:** Yes  / No

*If answered yes to any, please explain:*

**My Child has or has had:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Stomach or intestinal concerns                        | <input type="checkbox"/> ADD, ADHD, Hyperactivity      |
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Heart concerns  | <input type="checkbox"/> Depression                    |
| <input type="checkbox"/> Brain or neurologic concerns                           | <input type="checkbox"/> Bone or joint concern                                 | <input type="checkbox"/> Other psychological concern   |
| <input type="checkbox"/> Head injury or concussion                              | <input type="checkbox"/> Glasses   | <input type="checkbox"/> Frequent absences from school |
| <input type="checkbox"/> Bleeding disorder or bleeding that's very hard to stop | <input type="checkbox"/> Hearing Aid(s)  | <input type="checkbox"/> Concerns in school            |
| <input type="checkbox"/> Problem with under eating or weight loss               | <input type="checkbox"/> Activity or gym restrictions (requires doctor's note) | <input type="checkbox"/> Concerns at home              |
|   | <input type="checkbox"/> Problem with overeating or weight gain                | <input type="checkbox"/> Other medical concern(s)      |

Please provide more information if any are checked off:

Are there special requirements or limitations for your child's diet while in childcare? Yes  No

If yes, are they family preference? Yes  No

If yes, are they doctor's requirement? Yes  No

Please specify requirements or limitations:

*I give permission for the CFDRRC nurse to contact my child's health care provider for purposes of care planning and medication administration.*

*I understand that all records, documentation, and discussion between the CFDRRC nurse and health care providers will be confidential and I will be consulted before any changes are made in the care of my child.*

Yes, CFDRRC may contact my child's provider

No, CFDRRC may not contact my child's provider

**Child's Pediatrician:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Child's Dentist:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Child's Health Insurance:**

**Is your child covered by medical insurance? Yes / No**

Name of Insurance Plan: \_\_\_\_\_ ID #: \_\_\_\_\_

Subscriber's Name (on insurance card): \_\_\_\_\_

<b>Consent and Release</b>
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- I give permission for my child to participate in center sponsored field trips and excursions whether transportation is by foot or vehicle. I also understand that I will be notified prior to any field trips taken by vehicle. Yes  / No
- I understand my child will be observed by non-center personnel for teaching or training purposes. I give permission for my child to participate in the observation projects conducted by those authorized by the CFDRRC Director. Confidentiality will always be maintained. Yes  / No
- I give permission for my child to participate in research or testing as approved by the CFDRRC Director. A separate consent form will be supplied prior to research. Yes  / No

- In the event of an emergency (illness or accident) involving my child, I give my consent to the Child and Family Development Resource Center to provide emergency care for my child through an emergency medical technician, clinic, hospital, private physician or dentist. Yes  / No

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

**Development**

Any concerns about your child's:

Mental  Visual  Auditory  Physical  Emotional  Behavioral

Please provide more information if any are checked off:

Does your child require specialized treatment or medication? Yes  / No

If yes, please specify:

Will treatment or medication need to be administered at the center? Yes  / No

Does your child use specialized equipment for health or mobility? Yes  / No

If yes, please specify:

**Child's Personal History**

If applicable, name step-parents in your child's life or other significant caregivers:

1. Name: \_\_\_\_\_

2. Name: \_\_\_\_\_

Are there pets in the home? Yes  / No

If yes, specify:

How has childcare been provided in the past? (*check any that apply*)

Parent  Grandparent  Other Relative  Day Care Home  Day Care Center  Nanny  Other

Is English your child's primary language? Yes  / No

If no, what is?

Describe your child's style of communicating (e.g. uses a few words, gestures and points, uses full sentences, etc.):

Describe your child's activity level at home:

Describe your child's preferred play activities (e.g., toys, games, books):

Please describe the type of discipline for behavior you use at home:

Are there religious or family/cultural traditions your child observes? Yes  / No

If yes, please specify:

Please describe any unique circumstances in your family or child's life that may affect your child's current behavior? (For instance: child's imaginary playmate, new sibling, a recent move, problems with childcare arrangement, family death, illness or hospitalization, parent separation or divorce, etc.)

Please take a moment to describe your child's personality and temperament:

What do you hope your child gains from enrollment in our program?

**Parent Survey**

Monthly parent-teacher meetings are held during the fall and spring semesters. Are there specific topics you would like addressed? Yes  / No

If yes, specify:

Do you have any personal talents/skills you would enjoy sharing with classroom children (e.g. musical talent, craft skill, etc.)? Yes  / No

If yes, specify:

How did you hear about the Child and Family Development Resource Center?

What influenced your decision to apply to our Center? (check any that apply)

Location  Price  Reputation  Educational Program  Head Teacher  Director  Facility

**Bill Payment**

I, \_\_\_\_\_, understand that I will be held solely responsible for payment of child care charges accrued during my child's enrollment at the Child and Family Development Resource Center. I understand that the determination of my charges will be based on the child care rates in effect during my child's enrollment, and that I will be expected to pay charges by the posted due dates in order to maintain my child's enrollment status.

Print name of person responsible for payment: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of person responsible for payment: \_\_\_\_\_

*For Office Use Only*

Submission Date: \_\_\_\_\_ Date Enrolled: \_\_\_\_\_ Withdrawal Date: \_\_\_\_\_