DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

CHILD'S NAME_____DATE OF BIRTH_____

PERSONAL HISTORY

Any speech difficulties?_____
Language spoken at home:_____
Special words to describe needs:_____

HEALTH

Special physical conditions and disabilities: _____
Allergies: _____
Regular medications: _____

EATING HABITS

Describe favorite foods, foods refused, and any special characteristics: _____

TOILET HABITS

How does child indicate bathroom needs include any special words): _____
_____

SLEEPING HABITS

When does child get up in the morning: _____and go to bed at night_____
Does child become tired or nap during the day?_____

SOCIAL RELATIONSHIPS

How would you describe your child: _____

Previous experience with other children:_____
Reaction to strangers:_____ Able to play alone: _____
Favorite toys and activities: _____
_____
Fears (the dark, animals etc.):_____
How do you comfort child: _____
How do you discipline child: _____
What would you like your child to gain from this experience?

Is there anything else you would like us to know about your child?

Parent's signature_____ Date: _____

EMERGENCY CARD INFORMATION

Child's Name: _____Date of Birth_____

Child's Home Address: _____

_____ Phone # _____

Mobile Phone #_____ E-mail_____

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 **TOTLAND COLLEGE PRESCHOOL**
(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 treatment
(Name)
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___

_____ _____
Parent /Guardian Signature Date (valid for one year)

Health Insurance Coverage_____ Policy #_____
Parent/Guardian Name: _____ Phone_____ Cell_____
Parent/Guardian Name: _____ Phone_____ Cell_____

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____ Phone Number _____

MY CHILD WILL ARRIVE AT THE PROGRAM

: ___PARENT DROP OFF

___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

___PARENT PICK UP

___SUPERVISED WALK

___UNSUPERVISED WALK

___PUBLIC/PRIVATE/VAN

___PUBLIC/PRIVATE/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 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_____