



46 Pleasant Street
Norton, MA 02766
Phone 508-222-3865
Fax 508-222-8010

DATE OF ADMISSION: _____
AGE AT ADMISSION: _____

CHILD'S NAME _____
DATE OF BIRTH _____ PLACE OF BIRTH _____
GENDER: _____ ETHNICITY: _____
EYE COLOR: _____ HAIR COLOR: _____
HEIGHT: _____ WEIGHT: _____
PRIMARY LANGUAGE: _____ IDENTIFYING MARKS: _____

PARENT CHILD LIVES WITH: _____
OTHERS IN FAMILY/RELATIONSHIP:
_____/_____
_____/_____

PARENTS' / GUARDIANS' NAMES:
MOTHER: _____ FATHER: _____
HOME ADDRESS: _____ HOME ADDRESS: _____
HOME TELEPHONE: _____ HOME TELEPHONE: _____
OTHER TELEPHONE: _____ OTHER TELEPHONE: _____
EMAIL ADDRESS: _____ EMAIL ADDRESS: _____
MOTHER'S PLACE OF WORK: _____ FATHER'S PLACE OF WORK: _____
ADDRESS: _____ ADDRESS: _____
WORK TELEPHONE & EXT. _____ WORK TELEPHONE & EXT. _____
HOURS AT WORK _____ HOURS AT WORK _____

HOURS YOUR CHILD WILL BE ATTENDING EXPANDING HORIZONS CHILDREN'S CENTER
Morning drop off time: _____ Afternoon pick up time: _____

If there are any custody agreements, court orders, and restraining orders pertaining to the child, that Expanding Horizons should be aware of, please provide copies.

Parent/Guardian Signature **Date**

Home Transportation Plan and Authorization

CHILD'S NAME _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

- EXPANDING HORIZONS VAN***
- PARENT DROP OFF
- OTHER _____

MY CHILD WILL DEPART FROM THE PROGRAM:

- EXPANDING HORIZONS VAN***
- PARENT PICK UP
- OTHER _____

Main pickup/drop off location for children transported by Expanding Horizons bus.

NAME: _____
ADDRESS: _____
PHONE: _____

Alternative emergency pick up/drop off location for children transported by Expanding Horizons bus.

NAME: _____
ADDRESS: _____
PHONE: _____

Public School Transportation Plan and Authorization

MY CHILD WILL DEPART FROM THE PROGRAM:

- EXPANDING HORIZONS BUS/ VAN (ATTLEBORO)
- PUBLIC SCHOOL BUS (NORTON)
- OTHER _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

- EXPANDING HORIZONS BUS/ VAN (ATTLEBORO)
- PUBLIC SCHOOL BUS (NORTON)
- OTHER _____

I give permission for my child to be released from Expanding Horizons 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".)

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
PHONE NUMBER: _____

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
PHONE NUMBER: _____

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
PHONE NUMBER: _____

Parent/Guardian Signature

Date

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: _____ Date of Birth: _____

I authorize the staff at Expanding Horizons Children's Center who has been 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 Expanding Horizons Children's Center 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: _____ Phone Number: _____
Address: _____

Child's Allergies: _____

Chronic Health Condition (MUST PROVIDE COMPLETED INDIVIDUAL HEALTH CARE PLAN): _____

Medications Taken Daily: _____

Emergency Contacts

INSTRUCTIONS TO REACH PARENTS/ GUARDIAN:

Mother: _____ Phone numbers: _____

Father: _____ Phone numbers: _____

If parents can not be contacted, notify the following people: (In order to be contacted)

Name: _____ Relationship to child: _____

Address: _____

Phone Numbers: _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name: _____ Relationship to child: _____

Address: _____

Phone Numbers: _____

Do you give permission for child to be released to this person? Yes _____ No _____

Name: _____ Relationship to child: _____

Address: _____

Phone Numbers: _____

Do you give permission for child to be released to this person? Yes _____ No _____

Health Insurance Coverage _____ Policy # _____

Parent/Guardian Signature

Date

ALLERGY INFORMATION

CHILD'S NAME: _____

Individual Health Plan for child with chronic health condition? Yes _____ No _____

(If yes, please see office for Individual Health Care Plan)

| ALLERGY | REACTION | TREATMENT REQUIRED (written instructions) (If none- write none) |
|----------|----------|--------------------------------------------------------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

DAILY MEDICATION INFORMATION

Medication: _____ Reason for medication: _____

Possible side effects: _____

Missed dose may result in: _____

Medication: _____ Reason for medication: _____

Possible side effects: _____

Missed dose may result in: _____

Special diets? _____

Special limitations and concerns? _____

Any Special needs or learning disabilities? _____

Tooth Brushing is a part of Expanding Horizons Children's Center daily program. If for any reason you **DO NOT** want your child to participate in brushing their teeth, please see the office for an opt-out form.

Parent/Guardian Signature

Date

School Age Children

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:** _____

EXPANDING HORIZONS CHILDREN'S CENTER

INFANT, TODDLER, PRESCHOOL PROGRAM

Dear Parents/Guardians,

Here at Expanding Horizons Children's Center we often enjoy taking pictures of children; for display, on field trips, special events etc...

_____ **YES**, My child _____ may be photographed at Expanding Horizons Children's Center.

_____ **NO**, I do not want my child _____ to be photographed at Expanding Horizons Children's Center.

Parent/Guardian Signature

Date

I give permission for my child _____ to leave Expanding Horizons Children's Center to attend walking excursions, or in the event of an emergency as decided by the director.

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)

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

HEALTH (changes over the past year)

Serious illnesses and/or hospitalization: _____

Special physical conditions, disabilities: _____

ALLERGIES i.e. asthma, hay fever, insect bites, medicine, food reactions: _____

Has your child started or stopped taken any daily medications: _____

If yes what medications: _____

EATING HABITS (changes over the past year)

Special characteristics or difficulties: _____

Favorite foods: _____

Foods refused: _____

TOILET HABITS

Please indicate in changes in your child's toileting habits over the past year: _____

HOME ENVIROMENT/SOCIAL RELATIONSHIPS

Have there been any significant changes to your child's home/ family environment? _____

How does your child react to new people? _____

What is the method of behavior management/discipline at home? _____

Please describe your child's schedule for a typical day: _____

PARENT'S SIGNATURE _____ **DATE** _____

BUS/ TRANSPORTATION RULES

In order to provide safe transportation for your children we ask that you review these rules with your child.

1. Parent/ Guardian must call as soon as possible to report an absence.
2. All Children must remain seated while the bus is moving. Use of a seat belt is mandatory.
3. There is no eating or drinking on the bus.
4. Respect of one another is a must.
5. Throwing anything out of the bus windows is forbidden.
6. Lunch boxes and book bags should not be opened nor should toys be taken out on the bus.
7. The bus driver's instructions are given to assure your safety. Please listen to and follow directions carefully.
8. Remember your inside voices and use them to talk to your friends. Yelling is not allowed.

I have read the bus rules and have reviewed them with my children. I understand that failure to follow these rules will result in suspension and or termination of transportation privileges.

Signature: _____

Date: _____

Expanding Horizons Children's Center Receipt of Parent Handbook/Health Care Policy

I have read and understand the policies and procedures of Expanding Horizons Children's Center regarding:

- Drop off and pick up policies
- Attendance / Transportation policies
- Tuition Policies
- Termination / Suspension of childcare policy
- Nutrition Requirements
- Fever / Illness Policy
- Personal Property Policy
- Statement of Limited Liability

Parent's / Guardian's Signature

Date