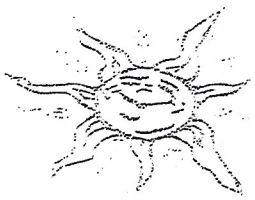

SUNSHINE'S PLACE, INC.

211 Acushnet Avenue
PO Box 2005
New Bedford, MA 02740
508-984-7373

Dear Family

Thank you for your interest in Sunshine's Place, Inc. We hope you and your child (ren) will enjoy our facility as much as we do! To enroll your child in the center, we will need to complete the following process:

_____ A complete application—all pages signed and dated
_____ The physical examination of your child within the year and record of immunizations
_____ A copy of the birth certificate or an abstract
_____ A completed program eligibility form for the food program
_____ A " voucher , " if applicable
_____ At least one change of clothes to be kept at the center in case of accidents
_____ 2-3 days advance notice required to arrange transportation , if applicable
_____ Car seat for children weighing less than eighty pounds (80lbs)
_____ A conference with the Director/Lead Teacher prior to enrolling

Once the application process is underway, we invite you to visit our classrooms with your child during program hours to see our school at work before your child is enrolled.

We look forward to the opportunity to work with you and your family.

Sincerely,

Jacquelyn M. Ramos, Director

PHOTO OF CHILD
or
PHYSICAL DESCRIPTION

Eye Color _____
Hair Color_____Sex: M / F
Height_____Weight ____
Skin Color:_____
Identifying marks:_____
Other:_____

Department of Early Education and Care
The Commonwealth of Massachusetts

Group and School Age Child Enrollment Packet

Please fill out these forms completely. If a question does not apply to your child, write N/A. The forms must be returned to the program on or before the first day your child begins care. Please notify the Administrator if any of the information changes. You will be asked to review this packet and update it annually.

CHILD INFORMATION:

Child's Name:_____ Date of Birth:_____

Age at Admission:_____ Date of Admission:_____

Child's Home Address:_____

Home Phone Number:_____

Primary Language:_____

Allergies, special diets or chronic health conditions?_____

Special limitations or concerns? _____

PARENT/ GUARDIAN INFORMATION:

- Parent/Guardian Name:_____

Relationship to Child:_____

Home Address:_____

Reachable Phone Number:_____

Email Address:_____

Business Name:_____

Business Address:_____

Business Phone Number:_____

Hours at Work:_____

- Parent/Guardian Name:_____

  Relationship to Child:_____

  Home Address:_____

  Reachable Phone Number:_____

  Email Address:_____

  Business Name:_____

  Business Address:_____

  Business Phone Number:_____

  Hours at Work:_____

ADDITIONAL INFORMATION:

- Are there any custody agreements, court orders, and restraining orders pertaining to this child?

  YES / NO

  (If yes, please attach. **The program can not legally restrict either parents involvement, information sharing or pick up without a copy of any relevant legal documentation.**)

SCHOOL INFORMATION:

- Current School:_____

  School Address:_____ School Phone Number:_____

TRANSPORTATION:

MY CHILD WILL ARRIVE AT THE PROGRAM BY	AM	PM	MY CHILD WILL DEPART FROM PROGRAM BY	AM	PM
Parent / Guardian Drop off			Parent / Guardian Pick up		
Supervised Walk			Supervised Walk		
Unsupervised Walk			Unsupervised Walk		
Public or private van			Public or private van		
Program bus or van			Program bus or van		
Contracted bus or van			Contracted bus or van		
Private Transportation			Private Transportation		
Other:			Other:		

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT:

- 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:_____

  Address:_____ Phone Number:_____

- Allergies/Special Diets?_____

- Chronic health condition? (If yes, please attach **Individual Health Care Plan**)_____

  _____

- Regular Medication:_____

  _____

EMERGENCY CONTACTS: ***(In addition to parents/guardians listed on page 1 and 2, the following can be contacted in the event of an emergency)***

- 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 #_____

Subscriber Name: _____ Phone_____ Cell_____

By signing this form I acknowledge that:

AGREE	DIS-AGREE	N/A	
			I have completed the Group and School Age Enrollment Packet.
			I have received a copy of the Program Handbook.
			I am aware that I can visit the program unannounced anytime while my child is in care.
			For School Age children only: I certify that documentation of my child's physical examination, immunizations and lead poisoning screening, in accordance with public health requirements, are on file at my child's school.
			I certify that I have provided any custody agreements, court orders, and restraining orders pertaining to the child. (If applicable)
			I have provided an Individual Health Care Plan, signed by my child's physician, for any chronic medical condition. (If applicable)
			I have provided any medication that my child may require while at the program and have signed a Medication Consent form for any medication provided. (If applicable)

Parent/Guardian Signature **Date**

SUNSHINE'S PLACE, INC.

211 Acushnet Avenue
PO Box 2005
New Bedford, MA 02740
508-984-7373

Child's Name: _____ DOB: _____

Home Address: _____

I, _____Give permission for my child _____

To go on any walking field trips planned by Sunshine's Place within the neighborhood. I do not require any notice, verbal or written for such trips. For example, the children might walk to the New Bedford Public Library, or Kenny's Tot Lot up the street.

I understand that I will receive at least two-days notice prior to any off-site field trips.

_____ _____
Parent signature Date

****

We like
king pictures

We want to make memories that include your child. Would you please give us permission to take pictures of your child while s/he is at Sunshine's Place and when we go on field trips? Some of the will be sent home to you, from time to time, as keepsakes. We will also hang some on our walls for the children to see.

_____

___ Yes, I give permission to Sunshine's Place to take pictures of my child as part of the ongoing program of activities.

___ No, I do not give my permission for pictures to be taken of my child.

_____ _____
Parent Signature Date

Teach a child. Change a life forever.

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) (Date)