scalliwags
INFANT TODDLER CHILDCARE

The Commonwealth of Massachusetts Department of Early Education and Care

Child's Enrollment Form

Child's Name:_____ Date of Birth:_____

Age at Admission:_____ Date of Admission:_____

Child's Home Address:_____

Home Phone Number:_____

Primary Language:_____ Identifying Marks:_____

Eye Color:_____ Hair Color:_____ Skin Color:_____

Sex:_____ Height:_____ Weight:_____

Enrollment M T W TH F Please circle your choice

○ Half Day 8am-12pm ○ Full Day 7:30am-3:30pm

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

Child's Physician:_____

Address:_____ Phone Number:_____

Allergies/Special Diets?_____

Individual Health Plan for a child with a chronic health condition?

If yes, please attach._____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If yes, please
attach._____

Special limitations or concerns? _____
_____

Parent/Guardian Signature

_____

Date _____