



**OPEN ARMS**  
**Christian Preschool**

426 Davis Rd, Bedford, MA 01730  
781-271-1148

**CHILD'S ENROLLMENT FORM**

**CHILD INFORMATION:**

Child's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age at Admission: \_\_\_\_\_ Date of Admission: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Child's Nickname: \_\_\_\_\_  
Primary Language: \_\_\_\_\_

Child's Identifying Information:

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Skin Color \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_  
Identifying Marks: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION:**

|                             |                             |
|-----------------------------|-----------------------------|
| Name _____                  | Name _____                  |
| Relationship to child _____ | Relationship to child _____ |
| Home Address _____          | Home Address _____          |
| Reachable Phone # _____     | Reachable Phone # _____     |
| Cell Phone # _____          | Cell Phone # _____          |
| Email address: _____        | Email address _____         |
| Business Name _____         | Business Name _____         |
| Business Address _____      | Business Address _____      |
| Business Phone # _____      | Business Phone # _____      |
| Hours at Work _____         | Hours at Work _____         |

**ADDITIONAL INFORMATION:**

Siblings: (names and ages):  
\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Individual Health Plan for 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?\_\_\_\_\_

Please check the program option(s) you are choosing for your child's enrollment:

Preschool 3's - Tue/Thurs\_\_\_\_ Additional Day(s) - Mon\_\_\_\_ Wed\_\_\_\_ Fri\_\_\_\_

Preschool 4's - Mon/Wed/Fri \_\_\_\_ Additional Day(s) - Tue \_\_\_\_ Thurs\_\_\_\_

(additional days are subject to availability, please mark your 1<sup>st</sup> and 2<sup>nd</sup> choice)  
5 day enrollment is available for all 3's and 4's

PreKindergarten - 5 days \_\_\_\_

Early Drop Off - Mon\_\_\_\_ Tues\_\_\_\_ Wed\_\_\_\_ Thurs\_\_\_\_ Fri\_\_\_\_

Stay & Play - Mon\_\_ Tues\_\_ Wed\_\_ Thurs\_\_\_\_

Are you a registered member of the Lutheran Church of the Savior? Yes\_\_\_\_\_ No\_\_\_\_\_

### **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:

#### **DEVELOPMENTAL HISTORY**

Any speech difficulties?\_\_\_\_\_

Special words to describe needs\_\_\_\_\_

Language(s) spoken at home\_\_\_\_\_

#### **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 etc.**

Regular medications \_\_\_\_\_

Special Diet Requirements \_\_\_\_\_

**EATING HABITS**

Special characteristics or difficulties \_\_\_\_\_

Favorite Foods \_\_\_\_\_

Foods Refused \_\_\_\_\_

**TOILET HABITS**

How does your child indicate bathroom needs (include special words) \_\_\_\_\_

Is your child ever reluctant to use the bathroom? \_\_\_\_\_

Does your child have accidents? \_\_\_\_\_

**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 discipline used at home? \_\_\_\_\_

What would you like your child to gain from this preschool experience? \_\_\_\_\_

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

Parent/Guardian Signature

Date

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 \_\_\_\_\_

|                                 |                        |
|---------------------------------|------------------------|
| Health Insurance Coverage _____ | Policy # _____         |
| Parent/Guardian Name: _____     | Phone _____ Cell _____ |
| Parent/Guardian Name: _____     | Phone _____ Cell _____ |

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date (valid for one year)