



OPEN ARMS
Christian Preschool

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

FOR CENTER USE

Date of Admission: _____
Age at Admission: _____

REGISTRATION FACE SHEET

CHILD INFORMATION:

Child's Name: _____
Date of Birth: _____ Place of Birth: _____
Home Address: _____ (city/town/country)
Primary Language: _____
Telephone: _____ Child's Nickname: _____

Child's Identifying Information (required by the Department of Early Education and Care regulations):

Eye Color: _____ Hair Color: _____ Sex: _____
Height: _____ Weight: _____ Skin Color: _____
Identifying Marks: _____
Allergies: _____

PARENT/GUARDIAN INFORMATION:

Name _____	Name _____
Relationship to child _____	Relationship to child _____
Home Address _____	Home Address _____
Home Phone # _____	Home Phone # _____
Cell Phone # _____	Cell Phone # _____
Business Name _____	Business Name _____
Business Address _____	Business Address _____
Business Phone # _____	Business Phone # _____
Hours at Work _____	Hours at Work _____

If parents cannot be contacted, Notify: (include names on emergency release form)

Name _____	Name _____
Address _____	Address _____
Relationship to child _____	Relationship to child _____
Day time phone # _____	Day time phone # _____
Siblings: (names and ages) _____	/ _____
	/ _____
Child's Physician/Clinic _____	Phone # _____

Parent/Guardian Signature _____ Date _____
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.

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

DEVELOPMENTAL HISTORY

Any speech difficulties? _____
Special words to describe needs _____

HEALTH

Any known complication 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: _____
Favorite foods: _____ child eats with hands ___ spoon ___ fork ___
Foods refused: _____

TOILET HABITS

How does child indicate bathroom needs (include special words): _____
Is child ever reluctant to use the bathroom? _____
Does child have accidents? _____

SLEEPING HABITS

Does child become tired or nap during the day (include when and how long)? _____

When does child go to bed at night? _____ and get up in the morning? _____

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 child: _____

**GROUP CHILD CARE AND SCHOOL AGE CHILD CARE
FIRST AID AND EMERGENCY MEDICAL CARE
CONSENT FORM
102 CMR 7.09(3)**

Child's Name: _____ Date of Birth: _____

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid 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)

1. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	
2. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	
3. Name: _____	Address: _____
Relationship to Child: _____	Phone #: _____
Do you give permission for child to be released to this person? Yes No	

Health Insurance Coverage: _____	Policy #: _____
Parent(s) Name: _____	Phone(w) Phone (h)
Parent(s) Name: _____	Phone(w) Phone (h)

Parent/Guardian Signature

Date

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

What would you like your child to gain from this child care experience?

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

Parent's/Guardian Signature _____

Date _____

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 _____ |
| PreKindergarten - 5 days _____ | |