

CHILD ENROLLMENT FORM

Date of Application: _____ **Date of Enrollment:** _____ **Last Day of Enrollment:** _____
 Child's Name: _____ Child's Date of Birth: _____
 Child's Address: _____ City: _____ Zip Code: _____
 Mother's Name: _____ Address: _____
 City: _____ Zip Code: _____ e-mail address: _____
 Home Telephone #: (____) _____ Cell #: (____) _____
 Mother's Employer: _____ Work #: (____) _____
 Mother's Employer Address: _____ City: _____ Zip Code: _____
 Father's Name: _____ Address: (if different) _____
 City: _____ Zip Code: _____ e-mail address: _____
 Home Telephone #: (if different)(____) _____ Cell #: (____) _____
 Father's Employer: _____ Work #: (____) _____
 Father's Employer Address: _____ City: _____ Zip Code: _____

<p>Weekly Care Schedule: (please include the child's hours in care for each day)</p> <p>Sunday: _____</p> <p>Monday: _____</p> <p>Tuesday: _____</p> <p>Wednesday: _____</p> <p>Thursday: _____</p> <p>Friday: _____</p> <p>Saturday: _____</p>	<p>Persons to <u>Call in an Emergency or Release Child to</u> (if parent(s) can not be reached)</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone #: _____ Relationship: _____</p> <p style="text-align: center;">—◆—</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone #: _____ Relationship: _____</p> <p style="text-align: center;">—◆—</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone #: _____ Relationship: _____</p>
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<p>(Provider's name) _____, my child care provider, has my permission to transport my child, if necessary, when my child is in care.</p> <p style="text-align: center;">—◆—</p> <p>Physician's Name: _____</p> <p>Address: _____</p> <p>Phone #: (____) _____</p>	<p>Additional Emergency/Release names:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone #: (____) _____ Relationship: _____</p> <p style="text-align: center;">—◆—</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone #: (____) _____ Relationship: _____</p>
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The provisions outlined on this form have been worked out in consultation with me and have my approval.

Signature of Parent or Guardian _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Is your child related to the person providing his/her child care? Yes No **If Yes, what is the relationship?** (Relationship= grandchild, niece, nephew, sibling, son or daughter by blood, adoption or marriage)

(This form must be kept on file for one year after the child is no longer enrolled in the child care home.)



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Community Based Regulation Section

EMERGENCY MEDICAL CARE Family Day Care Licensing

Attention Provider: *This information must be kept current at all times. Carry a copy of this form and the Child Health Record during any off-premises child care activity. Please verify with the emergency medical care facility to assure that this form is acceptable.*

Child's name: _____ Birthdate: _____

Parent's name: _____ Emergency Tel: _____

Parent's name: _____ Emergency Tel: _____

Address: _____ Town: _____ Zip Code: _____

Allergies: _____ Last Tetanus _____

Medical Facility: _____ Phone #: _____

Insurance Carrier and _____

Insurance ID: _____

Physician to be called in an emergency:

Name: _____ Phone #: _____

Address: _____ Town _____ Zip Code: _____

I give my consent for the day care provider named _____, to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the child care provider to seek medical attention in an emergency at _____.

(hospital or walk-in clinic)

X _____
Signature

Printed Name

Date

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State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)



To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child’s health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child’s Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity	
Primary Health Care Provider:	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other	
Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance?	Y N	
Does your child have dental insurance?	Y N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have HUSKY insurance?	Y N	

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if “yes” or **N** if “no.” Explain all “yes” answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child’s:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all “yes” answers or provide any additional information:

Have you talked with your child’s primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child’s health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child’s health and educational needs in the early childhood program.	_____ Signature of Parent/Guardian	_____ Date
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Part II – Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ Date of Exam _____
(mm/dd/yyyy) (mm/dd/yyyy)

I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT _____ in/cm _____% *Weight _____ lbs. _____ oz / _____% BMI _____ / _____% *HC _____ in/cm _____% *Blood Pressure _____ / _____
(Birth – 24 months) (Annually at 3 – 5 years)

Screenings

<p>*Vision Screening</p> <p><input type="checkbox"/> EPSTD Subjective Screen Completed (Birth to 3 yrs)</p> <p><input type="checkbox"/> EPSTD Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <p>Type: <u>Right</u> <u>Left</u></p> <p style="padding-left: 20px;">With glasses 20/ 20/</p> <p style="padding-left: 20px;">Without glasses 20/ 20/</p> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	<p>*Hearing Screening</p> <p><input type="checkbox"/> EPSTD Subjective Screen Completed (Birth to 4 yrs)</p> <p><input type="checkbox"/> EPSTD Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <p>Type: <u>Right</u> <u>Left</u></p> <p style="padding-left: 20px;"><input type="checkbox"/> Pass <input type="checkbox"/> Pass</p> <p style="padding-left: 20px;"><input type="checkbox"/> Fail <input type="checkbox"/> Fail</p> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	<p>*Anemia: at 9 to 12 months and 2 years</p> <hr/> <p>*Hgb/Hct: _____ *Date _____</p> <p>*Lead: at 1 and 2 years; if no result screen between 25 – 72 months</p> <p style="padding-left: 20px;">Lead poisoning (≥ 10ug/dL)</p> <p style="padding-left: 20px;"><input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>*TB: High-risk group? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Test done: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____</p> <p>Results: _____</p> <p>Treatment: _____</p>	<p>*Dental Concerns <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Referral made to: _____</p> <p>Has this child received dental care in the last 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>*Result/Level: _____ *Date _____</p> <p>Other: _____</p>

***Developmental Assessment:** (Birth – 5 years) No Yes **Type:** _____

Results: _____

***IMMUNIZATIONS** Up to Date or Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
 Rescue medication required in child care setting: No Yes

Allergies No Yes: _____
 Epi Pen required: No Yes
 History/risk of Anaphylaxis: No Yes: Food Insects Latex Medication Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes No Yes: Type I Type II **Other Chronic Disease:** _____

Seizures No Yes: Type: _____

This child has the following problems which may adversely affect his or her educational experience:
 Vision Auditory Speech/Language Physical Emotional/Social Behavior

This child has a developmental delay/disability that may require intervention at the program.

This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

No Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

No Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

No Yes This child may fully participate in the program.

No Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) _____

No Yes Is this the child's medical home? I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____		
(Date)	(Confirmed by)	
Exemption: Religious _____	Medical: Permanent _____	†Temporary _____ Date _____
‡Recertify Date _____	‡Recertify Date _____	‡Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16-18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹	1 dose after 1st birthday ¹
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given ³	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴	1 booster dose after 1st birthday ⁴
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease ^{1,2}	1 dose after 1st birthday or prior history of disease ^{1,2}	1 dose after 1st birthday or prior history of disease ^{1,2}
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday ⁵	1 dose after 1st birthday ⁵	1 dose after 1st birthday ⁵	2 doses given 6 months apart ⁵	2 doses given 6 months apart ⁵
Influenza	None	None	None	1 or 2 doses	1 or 2 doses ⁶	1 or 2 doses ⁶	1 or 2 doses ⁶	1 or 2 doses ⁶	1 or 2 doses ⁶

1. Laboratory confirmed immunity also acceptable
 2. Physician diagnosis of disease
 3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
 4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
 5. Hepatitis A is required for all children born after January 1, 2009
 6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

Initial/Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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CHILD DAY CARE LOG

CHILD'S NAME: _____

Important: The purpose of this log is to record accidents, illnesses, unusual behaviors that occur at the facility, observations of the child made by the provider and important discussions with parents.

Date	Time	Person Present	Description