Mariposa
Child-Care Center

Emergency Card

TODAY'S DATE

This emergency card information is for the educator's first aid kit, which they must take with them when leaving the child care premises.

1 CHILD INFORMATION

Name ▸	FIRST	MIDDLE	LAST	
Address ▸	STREET	CITY	STATE	ZIP
Phone ▸	PHONE 1	PHONE 2		
Birthdate ▸	MONTH	DAY	YEAR	

2 INSTRUCTIONS

Describe how to best reach the child's parent or guardian ▸	

3 PARENT/GUARDIAN INFO

A

Name ▸	FIRST	LAST		
Address ▸	STREET	CITY	STATE	ZIP
Phone ▸	MOBILE	Email ▸	EMAIL	
Employment ▸	COMPANY NAME	Phone ▸	WORK PHONE	
Address ▸	STREET	CITY	STATE	ZIP

B

Name ▸	FIRST	LAST		
Address ▸	STREET	CITY	STATE	ZIP
Phone ▸	MOBILE	Email ▸	EMAIL	
Employment ▸	COMPANY NAME	Phone ▸	WORK PHONE	
Address ▸	STREET	CITY	STATE	ZIP

4 MEDICAL PROFESSIONAL INFO

Physician Name ▸	FIRST LAST	Phone ▸	PHONE	
Address ▸	STREET	CITY	STATE	ZIP

5 EMERGENCY CONTACT

A

Contact Name ▸	FIRST	LAST		
Address ▸	STREET	CITY	STATE	ZIP
Phone ▸	PHONE 1	PHONE 2		

B

Contact Name ▸	FIRST	LAST		
Address ▸	STREET	CITY	STATE	ZIP
Phone ▸	PHONE 1	PHONE 2		

Mariposa
Child-Care Center

Transportation Plan

TODAY'S DATE

This form is to indicate how my child will be arriving and departing the program.
Drop-off hours are from 7 am till 9 am. Pick-up hours are from 5 pm till 6 pm.

1 CHILD INFORMATION

Name ▶ FIRST | MIDDLE | LAST

Address ▶ STREET | CITY | STATE | ZIP

Phone ▶ PHONE 1 | PHONE 2

Birthdate ▶ MONTH | DAY | YEAR

2 DROP-OFF INFO

How my child will arrive to the program ▶

- ☐ PARENT DROP OFF
- ☐ SUPERVISED WALK
- ☐ UNSUPERVISED WALK
- ☐ PUBLIC/PRIVATE VAN
- ☐ PROGRAM VAN/BUS
- ☐ CONTRACT/VAN
- ☐ PRIVATE TRANSPORTATION ARRANGED BY PARENT
- ☐ OTHER — PLEASE SPECIFY

3 PICK-UP INFO

How my child will depart from the program ▶

- ☐ PARENT PICK UP
- ☐ SUPERVISED WALK
- ☐ UNSUPERVISED WALK
- ☐ PUBLIC/PRIVATE VAN
- ☐ PROGRAM VAN/BUS
- ☐ CONTRACT/VAN
- ☐ PRIVATE TRANSPORTATION ARRANGED BY PARENT
- ☐ OTHER ▶ PLEASE SPECIFY

4 PARENT/GUARDIAN SIGNATURE

A

Name ▶ FIRST | LAST

Today's Date ▶ MM/DD/YYYY | Signature ▶

B

Name ▶ FIRST | LAST

Today's Date ▶ MM/DD/YYYY | Signature ▶

Mariposa Child-Care Center

Authorization Forms

TODAY'S DATE

MEDICAL EMERGENCY TREATMENT

The Department of Early Education and Care recommends checking with your local hospital about the acceptability of this statement.

This is to allow the school to authorize transport to a medical facility and recieve emergency medical treatment.

I, hereby give SCHOOL **permission to administer basic First Aid and/or CPR to my child** FIRST LAST **, and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.**

Parent/Guardian ▶ FIRST LAST

Today's Date ▶ MM/DD/YYYY **Signature ▶**

TOPICAL MEDICATION OR OINTMENT APPLICATION

This is to allow the school's educator(s) to administer the following medications/ointment to your child's skin:

- ☐ SUNSCREEN
- ☐ INSECT REPELLENT/BUG SPRAY
- ☐ DIAPER OINTMENT
- ☐ MEDICATION ▶ PLEASE SPECIFY
- ☐ OTHER ▶ PLEASE SPECIFY

Parent/Guardian ▶ FIRST LAST

Today's Date ▶ MM/DD/YYYY **Signature ▶**

Child's Name ▶ FIRST MIDDLE LAST

THE COMMONWEALTH OF MASSACHUSSETTS DEPARTMENT OF EARLY EDUCATION AND CARE

TODAY'S DATE

Developmental History and Background Information

Regulations for licensed child care facilities requre this information to be on file to address the needs of children while in care. Please provide information for Infants and Toddlers (marked) as appropriate to the age of your child.*

Name ▸ FIRST | MIDDLE | LAST

Birthdate ▸ MONTH | DAY | YEAR

1 DEVELOPMENTAL HISTORY

Age your child began ▸ SITTING: | CRAWLING: | WALKING: | TALKING:

***Does your child pull up?** ▸ YES | NO

***Does your child crawl?** ▸ YES | NO

***Does your child walk with support?** ▸ YES | NO

▸ Any speach difficulties?

▸ Special words to describe needs:

▸ Language spoken at home:

▸ *Any history of colic?

***Does your child use pacifier or suck thumb?** ▸ PACIFIER | THUMB

***When?** ▸

***Does your child have a fussy time?** ▸ YES | NO

***When?** ▸

▸ *How do you handle this time?

2 HEALTH

▸ List any known complications at birth:

▸ List any serious illnesses and/or hospitalizations:

▸ List any special physical conditions or disabilities:

▸ List any allergies:

I.E. ASTHMA, HAY FEVER, INSECT BITES, MEDICINE, FOOD REACTIONS

▸ List any regular medications:

Child's Name ▸ FIRST | MIDDLE | LAST

THE COMMONWEALTH OF MASSACHUSSETTS DEPARTMENT OF EARLY EDUCATION AND CARE

TODAY'S DATE

Developmental History and Background Information

3 EATING HABITS

▸ Special characteristics or difficulties:

▸ *If infant is on a special formula, describe its preperation in detail:

Favorite foods ▸

Foods refused ▸

***How is your child fed?** ▸ ☐ HELD IN LAP ☐ HIGH CHAIR

***What does your child eat with?** ▸ ☐ SPOON ☐ FORK ☐ HANDS

4 TOILET HABITS

***My child uses** ▸ ☐ DISPOSABLE DIAPERS ☐ CLOTH DIAPERS

***Is there a frequent occurrence of diaper rash?** ▸ YES ☐ NO ☐

***Do you use** ▸ OIL ☐ POWDER ☐ LOTION ☐ OTHER ☐ PLEASE SPECIFY OTHER

***Are your childs bowel movements regular?** ▸ YES ☐ NO ☐ **How many per day?** ▸

***Is there a problem with diarrhea?** ▸ YES ☐ NO ☐ **Constipation?** ▸

***Has toilet training been attempted?** ▸ YES ☐ NO ☐

▸ *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?

Child's Name ▸ FIRST | MIDDLE | LAST

THE COMMONWEALTH OF MASSACHUSSETTS DEPARTMENT OF EARLY EDUCATION AND CARE

TODAY'S DATE

Developmental History and Background Information

5 SLEEPING HABITS

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.

***Where does your child sleep?** ▸ CRIB BED

▸ Does your child become tired or nap during the day?

NAP TIMES AND DURATION

▸ When does your child go to bed at night?

TIME

▸ When does your child wake up in the morning?

TIME

▸ Describe any special characteristics or needs (stuffed animal, story, mood on waking, etc):

6 SOCIAL RELATIONSHIPS

▸ How would you describe your child?

▸ Previous Experience with other children/daycare:

▸ Reaction to strangers?

▸ Able to play alone?

▸ Favorite toys & 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?

Child's Name ▸ FIRST MIDDLE LAST

THE COMMONWEALTH OF MASSACHUSSETTS DEPARTMENT OF EARLY EDUCATION AND CARE

TODAY'S DATE

Developmental History and Background Information

7 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:

SCHEDULE DETAILS

▶ Is there anthing else we shoudl know about your child?

ADDITIONAL INFO

8 PARENT/GUARDIAN SIGNATURE

A

Name ▶ FIRST LAST

Today's Date ▶ MM/DD/YYYY Signature ▶

B

Name ▶ FIRST LAST

Today's Date ▶ MM/DD/YYYY Signature ▶

Child's Name ▶ FIRST MIDDLE LAST