

OAKHAM COUNTRY DAY SCHOOL
Student Application & Emergency Information

For Center Use only:

Date of Admission:

Age at Admission:

Student Name: _____

Address: _____

Street

Town

Zip code

Cell Phone: _____

Home Phone: _____

Date of Birth: _____

Place of Birth: _____

Email Address: _____

Child's Identifying Information (Required by EEC Regulations):

Sex

Eye Color

Hair Color

Height

Weight

Identifying Marks: _____

Allergies

:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____

Relationship to child: _____

Home Address: _____

Cell Phone: _____

Home Phone: _____

Parent/Guardian #2 Name: _____

Relationship to child: _____

Home Address: _____

Cell Phone: _____

Home Phone: _____

Child's Physician: _____

Telephone #: _____

Address: _____

Parent/Guardian Signature

Date

Days/Times (circle all that apply): Monday Tuesday Wednesday Thursday Friday

Preschool Only (9-12:00)

Preschool & Lunch:

Full day (please specify times):

Other Requests:

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 _____

*Note: Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child

DEVELOPMENTAL HISTORY

Age began sitting _____ crawling _____ walking _____ talking _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____ *When? _____

*How do you handle this time? _____

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:

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail _____

Favorite foods: _____

Foods refused: _____

* Is your child fed held in lap? _____ High chair? _____

* Does your child eat with spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

*Are disposable or cloth diapers used?

*Is there a frequent occurrence of diaper rash?

*Do you use: oil _____ powder _____ lotion _____ other _____

*Are bowel movements regular? _____ how many per day? _____

*Is there a problem with diarrhea? _____ constipation? _____

*Has toilet training been attempted? _____

*Please 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 the child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____
Does your child become tired or nap during the day (include when and how long)? _____

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

When does your child go to bed at night? _____ and get up in the morning? _____
Describe any special characteristics or needs (stuffed animal, story, mood on walking etc) _____

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 behavior management/discipline at home: _____

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

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.

Is there anything else we should know about your child?

Parent/Guardian Signature: _____ Date: _____

Oakham Country Day School

Authorization and Consent

Emergency Medical Treatment

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 Oakham Country Day School to transport, or arrange with appropriate emergency personnel to transport, my child to the nearest hospital and to secure my child for necessary medical treatment. I understand that the teachers at Oakham Country Day School are trained in the basics of First Aid and I authorize them to give my child First Aid when appropriate.

Parent Signature: _____ Date: _____

Release of Child to Non-Custodial Parent or Others (Please check all that apply)

I authorize Oakham Country Day School to release my child to the following people:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE: _____

LIVES WITH: _____ CALL FOR EMERGENCY: _____ PICK-UP IF NEEDED: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE: _____

LIVES WITH: _____ CALL FOR EMERGENCY: _____ PICK-UP IF NEEDED: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE: _____

LIVES WITH: _____ CALL FOR EMERGENCY: _____ PICK-UP IF NEEDED: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE: _____

LIVES WITH: _____ CALL FOR EMERGENCY: _____ PICK-UP IF NEEDED: _____



Oakham Country Day School
971 Old Turnpike Road
508 882-3198

Dear Parents:

Throughout the year, parents/guardians are asked to give the personnel at Oakham Country Day School permission to do the following activities with their child. Please check off any or all items listed that pertain to your child. Your signature will be valid for one year and placed in your child's file. Adjustments however, can be made at any time.

My child, _____, may participate in the following activities while in the care of the personnel at Oakham Country Day School.

Parent/Guardian: _____

Date: _____

___ Application of hand sanitizer as needed

___ Application of sunscreen or insect repellent as needed

___ Pictures taken for bulletin board displays or special occasions

___ Pictures taken can be posted on Instagram/Facebook Page for educational purposes

Please return as soon as possible. If you have any questions or concerns, please don't hesitate to ask.

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME: _____

MY CHILD WILL ARRIVE AT THE PROGRAM:

___ PARENT DROP OFF

___ SUPERVISED WALK

___ UNSUPERVISED WALK

___ PUBLIC/PRIVATE/VAN

___ PROGRAM BUS/VAN

___ CONTRACT/VAN

___ PRIVATE TRANS. ARRANGED BY PARENT

___ OTHER

MY CHILD WILL DEPART FROM THE PROGRAM:

___ PARENT PICK UP

___ SUPERVISED WALK

___ UNSUPERVISED WALK

___ PUBLIC/PRIVATE/VAN

___ PROGRAM BUS/VAN

___ CONTRACT/VAN

___ PRIVATE TRANS. ARRANGED BY PARENT

___ OTHER

PARENT /GUARDIAN SIGNATURE _____ DATE _____

REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION