



WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF PARENTS FACTS INFORMATION

I acknowledge that I have received a copy of the enrollment packet (parent fact sheet) developed by the Department of Early Education and Care. At the time of my child initial registration.

Parent/Guardian

Date

PERMISSIONS

General Permission (Parents should not sign this permission unless specific places where your child is allowed to go are listed by your provider.) By signing this form, I am allowing my child to be taken off the child care premises.

I, hereby give _____ permission to take my child _____

(Provider/assistant) Off the premises of the family child care home for the following excursions: (specific places your child is allowed to go):

- WATERTOWN MALL
- NEIGHBORHOOD WALKS
- DOMENICK FILIPPELLO PLAY GROUND
- GORE PLACE

Using the following forms of transportation: _____

LITTLE NEST RED & BLUE FAMILY CHILD CARE

75 ELM ST. WATERTOWN, MA. 02472



Parent/Guardian Signature

Date

I do not want my child to be taken off the child care premises.

Parent/Guardian Signature

Date

E – MAIL: littlest13red-blue@hotmail.com

E – MAIL: littlestredblue@yahoo.com

Phone: 617 -744 6956

LITTLE NEST RED & BLUE FAMILY CHILD CARE

75 ELM ST. WATERTOWN, MA. 02472



Dear Physician:

_____ is enrolled in a family child care home which is licensed by the Department of Early Education and Care. The Department of Early Education and Care regulations require that the Medical History form be completed and signed by the child's physician or source of health care. Additionally, evidence that the child has been successfully immunized in accordance with the current Department of Public Health's recommended schedules must be submitted and signed by the physician or source of health care.

Evidence of a physical exam is valid for one year from the date the child was examined and shall be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone # _____

Name of Parents/Guardians: _____

Address: _____

Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance: _____

Has this child been screened for lead poisoning? Yes _____ No _____

If Yes, Date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:

Physician's Signature: _____ **Date:** _____ **Comments:** _____

Please return this form and the child's immunization record to:

Name of Provider: _____

Address _____

E – MAIL: littlest13red-blue@hotmail.com

E – MAIL: littlestredblue@yahoo.com

Phone: 617 -744 6956

LITTLE NEST RED & BLUE FAMILY CHILD CARE

75 ELM ST. WATERTOWN, MA. 02472



City, State ZIP _____

THE PROVIDER MAY ACCEPT FROM THE PARENTS OF SCHOOL AGE CHILDREN A WRITTEN STATEMENT THAT THE REQUIRED INFORMATION IS ON FILE WITH THE CHILD'S SCHOOL.

FURTHERMORE THE PARENT UNDERSTAND THAT STATE REGULATIONS PROHIBIT THE DAY CARE FROM GIVING ANY TYPE OF MEDICATION WITHOUT THE WRITEN PERMISSION THE CHILD'S DOCTOR AND THE PARENT

Parent signature

Date

***E – MAIL: littlest13red-blue@hotmail.com
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