



## *Welcome Letter*

Thank you for choosing to enroll your child at Waters Early Learning Center! We are looking forward to getting to know your child and your family. Enclosed please find several documents for you to complete:

- Complete and return the enrollment contract, along with a non-refundable two-week deposit, **within 5 days** of verbal notification a spot is available to reserve your child's space.
- All other forms must be completed BEFORE your child's first day at our center. If you have questions regarding any of the forms, please let us know.

**The Known Allergy form must be completed. If your child has any known allergies, we will meet and discuss these with you. If appropriate, we will provide you with an 'Individual Health Care Plan' to be signed by your child's physician. No child with a known allergy may attend the center before this has taken place. To ensure the safety of our students, every parent will be given a copy of our 'Allergy Policy.'**

- Please provide a copy of your child's most recent physical (within the last year), immunization records (current within last year), and lead test date (if applicable).
- The Parent Handbook outlining our policies and procedures can be emailed to you upon request.

Before your child starts at the center, you may call and pre-schedule some 'visiting days' in order to make the transition more comfortable for you and your child. If you should have any questions, please do not hesitate to contact us!

Again, thank you for choosing Waters ELC. We are honored you have chosen our center and are looking forward to watching your child grow!

Regards,

Lauren Noble  
Program Director



## *Enrollment Forms Checklist*

Child's Name: \_\_\_\_\_

- \_\_\_\_ Enrollment Application
- \_\_\_\_ Enrollment Contract
- \_\_\_\_ Emergency Contacts
- \_\_\_\_ Developmental History \*
- \_\_\_\_ Current Physical \*
- \_\_\_\_ Immunizations \*
- \_\_\_\_ Lead Test \*
- \_\_\_\_ Known Allergies \*
- \_\_\_\_ Individual Health Plan (if applicable) \*
- \_\_\_\_ Medication Authorization (optional) \*
- \_\_\_\_ Parental Consent: Topical/Media/Emergency/Transportation \*
- \_\_\_\_ Kid's Vision
- \_\_\_\_ Photo of Child

\* Must be renewed annually.



## Enrollment Application

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Application Date: \_\_\_\_\_

### Child's Identifying Information:

Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Skin Color \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

Allergies/Special Diets:

\_\_\_\_\_

Child's Address: \_\_\_\_\_

Who do they reside with? \_\_\_\_\_ Who should we call first? \_\_\_\_\_

Mother's (or Guardian's) Name: \_\_\_\_\_

Address if different than child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Father's (or Guardian's) Name: \_\_\_\_\_

Address if different than child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### Child's Physician

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_



## Emergency Contacts

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Email: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Father's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Email: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Address: \_\_\_\_\_

### Additional Contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Can this person pick up your child? Yes No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Can this person pick up your child? Yes No

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



## Developmental History

Age Began sitting? \_\_\_\_\_ Crawling? \_\_\_\_\_ Walking? \_\_\_\_\_ Talking? \_\_\_\_\_

Any speech difficulties? \_\_\_\_\_

Special words to describe needs? \_\_\_\_\_

Language spoken at home? \_\_\_\_\_ Any history of colic? \_\_\_\_\_

### Eating Habits:

Special characteristics or difficulties: \_\_\_\_\_

Is your child on a special formula? Describe its preparation in detail:

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### Toilet Habits:

Is your child potty trained? Yes No If 'No' complete below:

Has toilet training been attempted? \_\_\_\_\_ Please describe any particular procedure to be used for your child at the center: \_\_\_\_\_

What is used at home? Potty Chair? \_\_\_\_\_ Special Seat? \_\_\_\_\_ Toilet? \_\_\_\_\_

How does the child indicate bathroom needs? \_\_\_\_\_

Is the child ever reluctant to use bathroom? \_\_\_\_\_

Does the child have accidents? \_\_\_\_\_

### Sleep Habits:

Does your child sleep in a crib? \_\_\_\_\_ Bed? \_\_\_\_\_ With you? \_\_\_\_\_

When does your child usually nap? \_\_\_\_\_

When does your child go to bed at night? \_\_\_\_\_

Describe any special characteristics or needs (stuffed animals, mood on waking, etc.):

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**Social Relationships:**

How would you describe your child? \_\_\_\_\_

Has your child attended a previous day care? \_\_\_\_\_

Reaction to strangers: \_\_\_\_\_

Favorite toys and activities: \_\_\_\_\_

Fears: \_\_\_\_\_

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 child care experience? \_\_\_\_\_

\_\_\_\_\_

Has your child received and/or is currently receiving services from another agency?    Yes    No

If yes. Agency Name: \_\_\_\_\_

Is there anything else we should know about your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

Date



## Known Allergies

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

- My child has no Known Allergies. If I become aware of any Known Allergies I will alert the Program Director immediately.
- My child has the following Known Allergies. If I become aware of any other Known Allergies I will alert the Program Director immediately.

Known Allergy	Child's Reaction	Treatment

If the treatment for any of the above Known Allergies requires medication,  
a Medication Consent Form will also need to be completed.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Administrator Signature

\_\_\_\_\_  
Date

Entered on the Center Known Allergies List

Employee Initials \_\_\_\_\_

Posted in the Child's Classroom and on Food Storage Cabinets

Employee Initials \_\_\_\_\_

This form is valid for one year from the date signed.



## Authorization for Medication

If your child requires an over the counter medication, such as Motrin or Tylenol, we are required by the state of Massachusetts to have proper authorization on file for each medication. These medications are generally left at the center to be used in the case of your child having a fever, teething, or other ailments directed by you and your child's physician.

*Over the counter medication requires both parental and physician authorization.*

Provision of this form along with medication to the center is optional.

Name of Child: \_\_\_\_\_ First dose given at home: Yes No

Name of Medication: \_\_\_\_\_ Prescription: Yes No

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan: Yes No

Dosage: \_\_\_\_\_

Date(s) medication to be given: \_\_\_\_\_

Times medication to be given: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Directions for storage: \_\_\_\_\_

Special Instructions (i.e., taken with food): \_\_\_\_\_

I (parent / guardian) give permission to authorized staff members of Waters Early Learning Center to administer medication to my child as indicated above.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

### Non-Prescription Medication

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

Copied to the Emergency Evacuation File in the Medicine Cabinet      Employee Initials \_\_\_\_\_

**This form is valid for one year from the date signed.**





Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Transportation

I understand that I am responsible for my child's transportation to and from the center. I understand that it is against company policy for an employee of the center to transport a child in a vehicle.

*Acknowledge (initial)* \_\_\_\_\_

### Emergency First Aid / Medical Transportation

I authorize trained staff members to administer first aid to my child 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. In the event I cannot be reached, I authorize the center to transport my child to the nearest medical care facility *via an Emergency Medical Vehicle*.

*Acknowledge (initial)* \_\_\_\_\_

### Parental Consent for Topical Ointment and Spray Use

I authorize the center to use topical ointments and sprays on my child such as sunscreen and bug spray when appropriate.

*Authorize (initial)* \_\_\_\_\_

*Do NOT Authorize (initial)* \_\_\_\_\_

### Parental Consent for Media Exposure

Periodically, Waters Early Learning Center will take photographs of children to hang in the center or post to our Facebook page in order to give our families an opportunity to see what activities their children are doing throughout the week. Occasionally pictures or footage will be taken for promotional purposes. We will advise you in writing prior to the day this occurs. I hereby grant the center permission to photograph my child.

*Authorize (initial)* \_\_\_\_\_

*Do NOT Authorize (initial)* \_\_\_\_\_

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date



## *Oral Health Non-Participation Form*

In January 2010, EEC issued new regulations for child care programs that include a requirement that educators assist children with brushing their teeth if children are in care for more than four hours or if children have a meal while in care. This regulation is intended to:

- Help children learn about the importance of good oral health
- Provide information and resources regarding good oral health to child care programs and families
- Help address the high incidence of tooth decay among young children in Massachusetts, which is associated with numerous health risks.

EEC licensed programs must comply with this regulation. However, parents may choose that their child not participate in tooth brushing while present at the child care program.

You do not need to fill out this form to have your child participate in tooth brushing while they are in child care. However, if you do not want your child to brush while attending school, please fill out the information below.

I do not wish to have my child participate in tooth brushing while in care at  
Waters Early Learning Center.

Child's Name: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This form is valid for one year from the date signed.



A Window to your  
Children's World!

196 Charmant Dr., Suite 1, Ridgeland, MS 39157 ♦ Phone 601-354-9408 Fax 866-268-2125 ♦ Toll Free 1-888-Kids-Vsn (1-888-543-7876) ♦ [www.kidsvision.com](http://www.kidsvision.com) [info@kidsvision.com](mailto:info@kidsvision.com)

Although we've implemented maximum level security measures to protect against unauthorized access to the KidsVision system, you as parents and guardians have the responsibility of protecting your Usernames and Passwords.

Remember, your KidsVision Usernames and Passwords provide unique identifiers that enable our system to identify authorized users. Therefore, your login information is the first line of defense against unauthorized access.

As concerned parents and users of the KidsVision system, it is your responsibility to maintain exclusive control and use of your Username and Password and protect it from inadvertent disclosure to others.

**YOU SHOULD NEVER GIVE YOUR PASSWORD TO ANYONE.**

**Usernames should be between 4 and 8 characters**, and logins must be unique. All letters should be **lowercase**, although your username can use any combination of letters, numbers, and special characters. Do not include spaces in your username. The following are examples of adequate usernames: *'jpayne', 'ywqo875', 'e\_rbert'*.

**Strong passwords** can prevent someone from assuming your identity and accessing information. **Passwords should be between 6 and 8 eight characters** with a combination of uppercase, lowercase, numeric and special characters. Below are some guidelines for creating a secure password:

- ! Don't choose a password associated with you in any way (middle initial, maiden name, pet's name, child's name, etc.)
- ! Don't choose words that can be found in any dictionary, whether English or any language.
- ! Don't reverse the spelling of a dictionary word
- ! Use an acronym from an easy to remember phrase ('!A stitch in time saves nine!' can translate to '!ASITS9!')
- ! Make your Passwords 8 characters long.
- ! Use a mixture of letters, numbers and special characters. Example: *'JaFe9O+*

Once you have read and understand the guidelines/responsibilities, please sign and return the completed form to Waters Early Learning Center.

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I am a legal guardian of a child enrolled at Waters Early Learning Center. I have read the above information and understand that cameras have been installed at Waters Early Learning Center for the purpose of streaming enrolled children over the internet for parents and other authorized users to access. I will not share or disclose my password with anyone. I understand that I can submit up to three Usernames and Passwords in order to allow spouses and grandparents an opportunity to view the system.

I am requesting the following Usernames and Passwords be granted access to the **KidsVision** system:

Login 1  
Username \_\_\_\_\_ Password \_\_\_\_\_

Login 2 (optional)  
Username \_\_\_\_\_ Password \_\_\_\_\_

Login 3 (optional)  
Username \_\_\_\_\_ Password \_\_\_\_\_

### Contact Information

\_\_\_\_\_  
Child

Street Address: \_\_\_\_\_

\_\_\_\_\_  
Your Printed Name

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Your Signature

**Login 1** Work Number: \_\_\_\_\_

\_\_\_\_\_  
Date

Cell Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Login 2** Work Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Email Address: \_\_\_\_\_