

The Commonwealth of Massachusetts  
Department of Early Education and Care

**Child's Enrollment Form**

**Child Information**

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

Age at Admission: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

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

Home Phone Number: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Identifying Marks: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Skin Color: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Parent/Guardian Information**

Parent/Guardian Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

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

Reachable Phone Number: \_\_\_\_\_

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

Business Name: \_\_\_\_\_

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

Business Phone Number: \_\_\_\_\_

Hours at Work: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

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

Reachable Phone Number: \_\_\_\_\_

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

Business Name: \_\_\_\_\_

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

Business Phone Number: \_\_\_\_\_

Hours at Work: \_\_\_\_\_

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**Additional Information**

Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Allergies/Special Diets? \_\_\_\_\_

Individual Health Plan for child with a chronic health condition? If yes, please attach. \_\_\_\_\_

Copies of any custody agreements, court orders, and restraining orders pertaining to the child?  
If yes, please attach. \_\_\_\_\_

Special limitations or concerns? \_\_\_\_\_

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**School Age Only**

Current School: \_\_\_\_\_

School Address: \_\_\_\_\_ School Phone Number: \_\_\_\_\_

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file at my child's school. **Parent/Guardian initials:**

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

\_\_\_\_\_  
**Date**

THE COMMONWEALTH OF MASSACHUSETTS  
Department of Early Education and Care

**FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM**

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

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR 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. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to \_\_\_\_\_, and to secure necessary medical treatment for my child.

Child's Physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_  
Chronic Health Conditions: \_\_\_\_\_

**Emergency Contacts (In order to be contacted)**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Do you give permission for child to be released to this person? Yes \_\_\_\_\_ No \_\_\_\_\_

Health Insurance Coverage _____	Policy # _____
Parent/Guardian Name: _____	Phone _____ Cell _____
Parent/Guardian Name: _____	Phone _____ Cell _____

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

\_\_\_\_\_  
Date (valid for one year)

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

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CHILD'S NAME: \_\_\_\_\_

**MY CHILD WILL ARRIVE AT THE PROGRAM:**

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- SUPERVISED WALK
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- PUBLIC/PRIVATE/VAN
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- 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**

THE COMMONWEALTH OF MASSACHUSETTS  
Department of Early Education and Care

**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:** \_\_\_\_\_

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 your 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 waking 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)

## MULTIMEDIA CONSENT FORM

I, being the parent/guardian of \_\_\_\_\_, hereby consent that the photographs or videos taken of him/her during childcare while he/she is enrolled at Little Bees Lab Preschool as a student may be used by Little Bees Lab Preschool.

These pictures or videos may be used in slideshows, emails, newsletters, bulletin boards, preschool brochures, school website ([www.littlebeeslabpreschool.com](http://www.littlebeeslabpreschool.com)), Preschool Facebook page, etc. When any pictures or videos of students do appear on the web site there will not be any personal identification (i.e., student name).

Furthermore, I consent that such photographs and or videos shall be the property of Little Bees Lab Preschool which has the right to duplicate, reproduce, and make other uses as Little Bees Lab Preschool deem necessary.

- I give my permission to use my son/daughter's photograph, etc. AS DESCRIBED ABOVE.
- I give my permission for my son/daughter's pictures or videos to be used in slideshows and emails ONLY.
- I DO NOT give my consent to have photographs or videos of my son/daughter used by Little Bees Lab Preschool IN ANY WAY, as specified above.

**This form will be kept on file in the student's permanent record in the Center Director's office. Parents may update or make changes to this form at any time.**

\_\_\_\_\_  
Parent/Guardians Name (Print)

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_/\_\_\_/\_\_\_  
Date



## TOPICAL CONSENT FORM

The Administration of Medication Section (415.13.[vii][a]) of Massachusetts State Childcare Services (childcare subsidy, legally exempt providers) requires that:

“Over-the-counter products, including but not limited to over-the-counter topical ointments, lotions, creams, sprays, including sunscreen products and topically applied insect repellent can be administered by the provider for one day only, with verbal permission of the caretaker. If an over-the-counter product is to be administered on a subsequent day or an ongoing basis, written permission from the caretaker must have been provided to the provider.”

Child(ren)'s \_\_\_\_\_ DOB   /  /    
\_\_\_\_\_ DOB   /  /  

I give my consent for the daycare provider to administer the following over the counter, topical ointments, lotions, creams, and sprays to my child(ren):  
(Check the box for yes)

- Sunscreen \_\_\_\_\_ (name and expiration date)
- Diaper Cream \_\_\_\_\_ (name and expiration date)
- Lotion
- Other (Please List): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Directions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**All over-the-counter topical ointments and creams must be sent in the original container. The labels must give the name of the product and recommended uses and amounts. Information on the label must match the written and verbal information provided by the parent/guardian.**

\_\_\_\_\_  
Parent/Guardians Name (Print)                      \_\_\_\_\_                        /  /    
Parent/Guardian's Signature                      Date

Little Bees Lab Foxboro/Sharon

Snack List Permission Form

Morning and afternoon snacks are provided at Little Bees Lab Preschool. If you would like your child to participate in this program, please sign below as well as check which of the snacks you are giving permission for your child to consume while here at school. Labels and ingredients are available upon request.

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

Typical Snacks provided by center (highlighted offered to Infants if applicable)

- |   |   |                                    |
|---|---|------------------------------------|
| _____ strawberries  | _____ watermelon                            | _____ raisins                      |
| _____ Cheerios (Gluten Free)  | _____ bananas                               | _____ apples                       |
| _____ Graham crackers (wheat, soy)  | _____ grapes                                | _____ Pretzels (Sniders-wheat/soy) |
| _____ Goldfish (cheddar)(milk, wheat)   | _____ Cheese Stick                          | _____ applesauce                   |
| _____ Chocolate Sunbutter   | _____ Nilla Wafers                          | _____ Kix cereal (wheat)           |
| _____ Yogurt (strawberry, vanilla, berry)   | _____ Cinnamon Belvita biscuits(wheat, soy) |                                    |
| _____ Fruit Cups (peaches, pineapple, mandarin oranges)                                       |   |                                    |
| _____ Fruit & Grain Bars (Strawberry, Blueberry, Apple cinnamon) (wellsley farm variety pack) |   |                                    |
| _____ Cinnamon Toast Crunch Cereal (Wheat, Soy)   |   |                                    |

Special Occasion Snacks:

- \_\_\_\_\_ Dunkin/Honey Dew Munchkins  
\_\_\_\_\_ School Safe Cupcakes (vanilla, chocolate)  
\_\_\_\_\_ Popsicles

Parent Signature: \_\_\_\_\_

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



## Tuition Contract

Rates are as follows. Please circle the days and rates applicable:

### Weekly Rate (Effective through year of 2024)

Days	Infants	Toddlers Preschool/Pre-K
2	\$190	\$190
3	\$255	\$270
4	\$340	\$360
5	\$425	\$400

Our Hours are 7:30am-5:00pm. Please fill out the following for your Child:

Contracted schedule	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Drop-off time:</b>					
<b>Pick-up Time:</b>					

Please sign an initial next to each item and sign at the end. We want to make sure that you *understand* and *agree* to the tuition contract.

\_\_\_ A non-refundable \$50 annual renewal fee is due at the beginning of the new school year if you are renewing your contract with Little Bees Lab Preschool and will be applied to your account on Brightwheel.

\_\_\_ Tuition is due every Friday for the following week's care. A \$25.00 late fee will be applied every three days until the payment is made.

\_\_\_ A \$50.00 fee will be added to your payment if a check comes back bounced.

\_\_\_ A \$50.00 fee will be added to your payment if a debit/credit card comes back.

\_\_\_ You have contracted a slot on the roster for your child and tuition is due and payable whether your child is out due to sickness, vacation, holiday closing, weather emergency, or if the center is mandated to close by the MA Department of EEC because of circumstances beyond our control, such as loss of power.

\_\_\_ Families who choose to remove their child from the school for more than 3 weeks, must pay 60% of their child's weekly tuition to reserve their current spot.

\_\_\_ We understand that the minimum time at Little Bees Lab Preschool is six months. If I choose to break my contract without two weeks' notice, I will need to pay a termination fee of one week's tuition.

Discount Available:

10% off Sibling Discount

10% off Military/First responder discount

10% off if you pay 1 full year of tuition

**By adhering to this tuition contract, I understand what is expected of me regarding tuition.**

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

\_\_\_\_\_  
Date



## Enrollment Contract

Foxboro/Sharon Campus

It is my/our desire to have my/our child(ren) enrolled at Little Bees Lab Preschool. I/we have read the parent handbook, I/we understand and agree to abide by the policies contained therein. The staff will make observations and evaluations pertaining to the child(ren)'s ability to adapt to childcare surroundings and provide me with a daily report. I/we further understand that if the policies outlined in the handbook were not adhered to, it will be sufficient cause for the removal of the child(ren) from Little Bees Lab Preschool. I understand that I must follow all policies of the school set forth by the directors of the program.

Please initial next to each item and sign at the end. We want to make sure that you ***understand*** and ***agree*** to these policies.

\_\_\_\_\_ I/we understand that I/we must provide a complete enrollment packet with all the necessary documents including medical form, immunization record, lead testing and updated physical before or on the first day of childcare.

\_\_\_\_\_ I/we received, read, and understand the Little Bees Lab Preschool Parents Handbook. I/we agree with the policies they adhere to including but not limited to holiday closings.

\_\_\_\_\_ I/we read and understand that tuition payments are due every week on a Friday.

\_\_\_\_\_ I/we understand that tuition fees are paid regardless of absences, holiday closures, snow days, state of emergencies, and vacation weeks, the only exception is professional development days and the two days that we are closed to give the center/classrooms ready for the upcoming school year.

\_\_\_\_\_ I/we understand that a non-refundable \$50.00 annual renewal fee is due before the start of the next school year if I am renewing my contract with Little Bees Lab Preschool. This fee will be applied to the first week in Septembers tuition.

\_\_\_\_\_ I/we understand that there is a \$3.00 late pick up fee for every minute my child is at school past closing time (5:00 PM)

\_\_\_\_\_ I/we understand that there is a \$50.00 fee for early drop off (7:00 AM).

\_\_\_\_\_ I/we understand that whoever is picking up my child(ren) must be on the authorization pick-up list that is provided to me in the enrollment packet and must show a picture ID so a copy can be made and put into the child(ren)'s file or my child(ren) will not be dismissed.

\_\_\_\_\_ I/we read and understand the illness policy. Any child(ren) who is sick, persistent coughing, vomiting, fever (100.4 or above), runny nose, diarrhea (two or more) should stay home. If the child(ren) falls ill at school, parents will have to pick up immediately and the child(ren) will have to stay home for 24 hours and may return to school symptom free without help of medication such as Tylenol or Motrin.

\_\_\_\_\_ I/we read and understand that if my child(ren) is dismissed from school due to sickness, my child(ren) must come back with a doctor's note stating my child(ren) are healthy enough to be at school and to participate in the day-to-day activities such as going out for recess.

\_\_\_\_\_ I/we read and understand that the minimum time at Little Bees Lab Preschool is six months, if I choose to break my contract without two weeks' notice, I will need to pay a termination fee, which is a week's tuition.

\_\_\_\_\_ I/we read and understand Little Bees Lab Preschool behavior policy and shared the preschool rules with my/our child(ren). Children with aggressive behavior such as hitting teachers/peers, choking, biting teachers/peers and/or constant spitting will be terminated after a consecutive of three warnings to the parents.

\_\_\_\_\_ I/we read and understand that if we are away from the center for more than 3 weeks' time that we will need to pay 60% of the weekly tuition to hold our spot for our return to Little Bees. IE summer, longer vacation. If I choose to go away without reserving my spot or paying the fee, I/we understand that my child(ren) will lose their spot at Little Bees Lab Preschool.

Termination: The school may terminate the enrollment of child(ren) if the child(ren)'s needs cannot be met, the safety/care of other children/staff is in jeopardy, or accommodations for the childcare undue burden to the school. Parents/guardians will be notified of the reasons for termination and conditions for re-enrollment (if any), in writing, a minimum of one month prior to the termination date.

Immediate Termination: However, if the reason for termination is serious, termination can be immediate. If a parent/guardian displays inappropriate behavior either physically, verbally, or sexually, toward any staff member child or parent, then termination/referral procedures can be initiated at once. Parents/guardians will be notified in writing, at a face-to-face meeting when possible, including the reasons for termination, A copy of this letter will be kept in the child(ren)'s record. The center director will inform parents/guardians of the availability of information and referral for other childcare services in the area. When a child(ren)'s enrollment is terminated from the center, whether initiated by the center or the parents/guardians, the child(ren)'s teacher will prepare the child(ren) and family for their departure in a manner that is professional, respectful, and developmentally appropriate with regards to the child(ren)'s level of understanding.

Review and Updates: Enrollment contracts will be reviewed regularly to ensure its effectiveness. Updates will be made as needed and a new contract will be sent out to read, sign and return to the center director.

By adhering to this enrollment contract, I understand what is expected of me/us and our child(ren).

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Director

\_\_\_\_\_  
Date