

The Commonwealth of Massachusetts  
Department of Early Education and Care

**Child's Enrollment Form**

**Child Information**

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

Age: \_\_\_\_\_ Grade: \_\_\_\_\_ (Fall) 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**

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**Date**