COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Oral Health Program

With concerns about the increase in tooth decay (cavities) among children, the Massachusetts Department of Early Education and Care (EEC) recently adopted a new regulation for child care settings, 606 CMR 7.11(11)(d), to promote oral health and prevent tooth decay.

Effective January 2010, child care teachers must assist children with brushing their teeth if:

- **The children are in care for more than 4 hours, or**
- **They have a meal while in care.**

All families that choose to have their child participate in the new oral health program will be responsible for providing a toothbrush and toothpaste for their child.
Your child's toothbrush should be replaced every three months or after they have been sick.
Please indicate below whether you want your child to participate in the oral health program.

Child's Name: _____

_____ I want my child to participate in the oral health program.

_____ I do not want my child to participate in the oral health program.

Comments:_____
_____
_____
_____
_____

Parent's Name: _____

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 the 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 facility or to _____, and to secure necessary medical treatment for my child.
Child's Physician Name: _____
Address:_____
_____Phone: _____

Child's Allergies:_____
Chronic Health Conditions: _____

Emergency Contacts (in order to be contacted):
Name _____ Relationship _____
Address _____
Home Phone _____ Cell Phone _____
Do you give permission for child to be released to this person? Yes _____ No _____

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

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

Health Insurance _____ Policy #_____

Parent/Guardian Name: _____
Phone # to be reached in an emergency: _____

Parent/Guardian Name: _____
Phone # to be reached in an emergency: _____
Parent/Guardian Signature _____ Date _____

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:	**MY CHILD WILL DEPART FROM THE PROGRAM:**
_____ SUPERVISED WALK	**_____ SUPERVISED WALK**
_____ UNSUPERVISED WALK	**_____ UNSUPERVISED WALK**
_____ PUBLIC/PRIVATE/CONTRACT VAN	**_____ PUBLIC/PRIVATE/CONTRACT VAN**
_____ PROGRAM BUS/VAN	**_____ PROGRAM BUS/VAN**
_____ PRIVATE TRANS. ARRANGED BY PARENT	**_____ PRIVATE TRANS. ARRANGED BY PARENT**
_____ OTHER - ARRIVE WITH PARENTS	**_____ OTHER - DEPART WITH PARENTS**

I give permission for my child to be released from the program at the end of the program day as stated above and/or I give permission to the following people to receive my child at the end of the day (if no one is authorized other than the parent/legal guardian please indicate below "NO ONE").
***IF A CHILD IS PROTECTED BY A RESTRAINING ORDER PLEASE SUBMIT ORDER TO THE PROVIDER.**

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ CELL _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ CELL _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE _____ CELL _____

PARENT/GUARDIAN SIGNATURE & DATE _____

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

Child's Health Record

Dear Parents,

The Department of Early Education and Care's regulations require at the time of admission a written statement or health form from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

Please fill-out, sign and attach a copy of your child's most recent health form (check the form to ensure that the date your child was last examined is not more than one year ago).

IDENTIFICATION

Name of Child:_____ Date of Birth:_____
Address: _____ Phone #_____
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 providers? If so, please detail below:
_____
_____
_____
_____

Parent's Signature:_____ Date: _____

Comments:_____
_____
_____