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 PARENT                       _____ OTHER - DEPART WITH PARENT

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 ___________________________________________________________
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:______________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________