

# Longfellow Preschool @ Wellesley

## APPLICATION FORM 2026 -2027

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

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

CHILD'S ADDRESS: \_\_\_\_\_

TOWN: \_\_\_\_\_ ZIP: \_\_\_\_\_

BEST PHONE # TO CALL FIRST: \_\_\_\_\_ Who? \_\_\_\_\_

PARENT/GUARDIAN'S NAME:  
\_\_\_\_\_

PARENT EMAIL FOR NEWSLETTERS:

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### DAYS YOU WANT YOUR CHILD ENROLLED: (PLEASE CIRCLE)

MON      TUE      WED      THU      FRI

#### Monthly Fees - 9 am to 1 pm:

2 DAYS..... \$399.00  
3 DAYS..... \$550.00  
4 DAYS..... \$725.00  
5 DAYS.....\$899.00

- Extended Day available 8:30 – 9 am and 1 pm – 4 pm at \$16 per hour
- SIBLINGS RECEIVE A DISCOUNT OF 10%
- FULL FAMILY LONGFELLOW MEMBERS RECEIVE DISCOUNT OF 10%
- PAYMENTS ARE BASED ON AN ANNUAL AMOUNT DIVIDED INTO **10 EQUAL MONTHLY PAYMENTS** - SEPT. TO JUNE.

**\$100.00 (per child) NON-REFUNDABLE REGISTRATION FEE**

EMAIL, DROP OFF OR MAIL TO:  
'DIRECTOR –LONGFELLOW PRESCHOOL @ WELLESLEY  
LONGFELLOW WELLESLEY TENNIS & HEALTH CLUB, WELLESLEY MA. 02482  
Or email to [longfellowkids@gmail.com](mailto:longfellowkids@gmail.com)

**GROUP CHILD CARE AND SCHOOL AGE CHILD CARE  
CHILD'S ENROLLMENT FORM**

Child's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Program: **Longfellow Preschool @ Wellesley**  
Date of Admission: \_\_\_\_\_ Child's Age at Admission: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Skin Color: \_\_\_\_\_  
Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Identifying Marks: \_\_\_\_\_

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

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

Tel: #: \_\_\_\_\_

- Any Food Allergies? \_\_\_\_\_
- Medication Allergies? \_\_\_\_\_
- Other Allergies? \_\_\_\_\_
- Special Diets? \_\_\_\_\_
- Does your child require an epi-pen, inhaler or medication whilst at preschool? If yes, please complete the form attached.
- Are there any copies of any custody agreements, court orders, or restraining orders pertaining to the child? If yes, please attach. \_\_\_\_\_
- Any other special limitations or concerns?  
\_\_\_\_\_  
\_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

1. Parent/Guardian name: \_\_\_\_\_

Business Telephone #: \_\_\_\_\_

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

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

2. Parent/Guardian name: \_\_\_\_\_

Business Telephone #: \_\_\_\_\_

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

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

**Nanny/Au Pair Name :** \_\_\_\_\_

**Cell #:** \_\_\_\_\_

**GROUP CHILD CARE AND SCHOOL AGE CHILD CARE  
FIRST AID AND EMERGENCY MEDICAL CARE  
CONSENT FORM 102 CMR 7.09(3)**

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

I authorize staff in the program ***Longfellow Preschool @ Wellesley*** trained in CPR and 1st Aid to give my child CPR/1st Aid 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: \_\_\_\_\_

Any Health Conditions: \_\_\_\_\_

**Emergency Contacts (*In order to be contacted*) They can NOT be parents and must be aware that they are emergency contacts and live close by. If you wish, you may write "No One".**

**1. Name:** \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other Tel: # \_\_\_\_\_

Do you give permission for your child to be released to this person? \_\_\_\_\_

**2. Name:** \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other Tel: # \_\_\_\_\_

Do you give permission for child your to be released to this person? \_\_\_\_\_

|                                      |
|--------------------------------------|
| Health Insurance Coverage: Policy #: |
| Subscriber:                          |
|                                      |

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TRANSPORTATION PLAN AND AUTHORIZATION**

[7.09(3) AND 7.12(1)]

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

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

\_\_\_\_\_ **PARENT OR AUTHORIZED DROP OFF**

**MY CHILD WILL DEPART FROM THE PROGRAM BY:**

\_\_\_\_\_ **PARENT OR AUTHORIZED PICK UP**

I give permission for my child to be released from the program at end of the day as stated above and I give my permission to the following people to pick up my child at the end of the day.

**If no one is authorized, please indicate below by writing "NO ONE"**

**If the same as 'Emergency Contacts' write 'Same as Emergency Contacts'**

1. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

2. NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITING AND MAINTAINED IN THE CHILD'S FILE OR THE ABOVE PLAN MUST BE IMPLEMENTED. THIS PERMISSION IS VALID FOR ONE PROGRAM YEAR FROM THE DATE OF SIGNATURE.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

## PARENT/GUARDIAN AGREEMENT

I have received the Parent Handbook and fully understand the policies, guidelines and all the information regarding payments, children's information, 30 day notice period, holidays, early releases and snow days.

I understand that I will receive any updates regarding changes to the 'Parent Handbook' in a timely manner and also understand that the 'Parent Application Forms' will need to be completed again in full, each year that my child attends the program.

Please read and sign below.

I agree to all the policies, guidelines and regulations.

I agree that my child may swim at Longfellow with Staff and lifeguards in attendance in swim lessons and free swim.

I give permission that staff may clean boo boo's with water and give band-aids and ice if needed.

I agree that my child can participate in any Longfellow program such as soccer and yoga.

Longfellow has permission to photograph or video my child for program promotional purposes only with **NO names or tags.**

*(Literature, Email Newsletters, Brochures & Longfellow Facebook, Instagram & Website)*

I would like to receive all information regarding after school news (health issues, pesticide application notifications, school holiday programs, upcoming events, staff changes, introduction of pets, policy changes etc.) BY E-MAIL. I will be responsible for checking my emails routinely and notifying the program if my email changes.

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

Print Name: \_\_\_\_\_

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

**DEVELOPMENTAL HISTORY**

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

Language spoken at home \_\_\_\_\_

Will you need an interpreter for meetings or paperwork? \_\_\_\_\_

Are you raising your child to be bilingual? \_\_\_\_\_

If yes, which language? \_\_\_\_\_

Does your child receive English as a second language classes? \_\_\_\_\_

**HEALTH**

Special physical conditions, disabilities etc. that may require accommodations:

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Regular medications taken at home:

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If your child will need to take any medication at preschool, you will need to complete a Medication Consent Form. If your child has a chronic medical condition such as asthma, allergies, diabetes and febrile seizures, you will need to complete the Individual Health Care Plan form – see attached.

**EATING HABITS**

Special characteristics or difficulties:

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Favorite foods:

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**TOILET HABITS**

Please describe any particular toileting procedure to be used for your child at the center, if any:

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How does your child indicate bathroom needs (include special words)?

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Is your child ever reluctant to use the bathroom?

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Does your child have accidents?

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**SLEEPING HABITS**

Does your child become tired or nap during the day?

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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)

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**SOCIAL RELATIONSHIPS**

How would you describe your child's personality?

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Previous experience with other children/day care:

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Able to play alone? \_\_\_\_\_ With others? \_\_\_\_\_

Favorite toys and activities:

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Fears (the dark, animals, etc.):

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What would you like your child to gain from this childcare experience?

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**DAILY SCHEDULE**

Please describe your child's schedule on a typical day.

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Is there anything else we should know about your child?

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\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

Dear Families,

In our classroom we love learning about various peoples, cultures, holidays, and traditions. Listed below are a variety of holidays and celebrations that we may discuss or learn more about in our classroom.

Please fill out the following questionnaire so that I am aware of what holidays, seasons, cultural traditions, your family celebrates.

Please check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Hanukkah                         | <input type="checkbox"/> Cinco De Mayo                    |
| <input type="checkbox"/> International Human Rights Day   | <input type="checkbox"/> Ramadan                          |
| <input type="checkbox"/> Christmas                        | <input type="checkbox"/> World Culture/Diversity Day      |
| <input type="checkbox"/> Kwanzaa                          | <input type="checkbox"/> Memorial Day                     |
| <input type="checkbox"/> New Years Eve/Day                | <input type="checkbox"/> Eid Alfitr                       |
| <input type="checkbox"/> Makar Sankranti Harvest Festival | <input type="checkbox"/> Native American Citizens Day     |
| <input type="checkbox"/> Mardi Gras                       | <input type="checkbox"/> Junteenth                        |
| <input type="checkbox"/> Valentines Day                   | <input type="checkbox"/> International Friendship Day     |
| <input type="checkbox"/> Lunar New Year                   | <input type="checkbox"/> Mexican Independence Day         |
| <input type="checkbox"/> Holi / Lantern Festival          | <input type="checkbox"/> Yom Kippur                       |
| <input type="checkbox"/> St. Patrick's Day                | <input type="checkbox"/> National Indigenous People's Day |
| <input type="checkbox"/> Good Friday                      | <input type="checkbox"/> Halloween                        |
| <input type="checkbox"/> Passover                         | <input type="checkbox"/> Diwali                           |
| <input type="checkbox"/> Easter                           | <input type="checkbox"/> Thanksgiving                     |
| <input type="checkbox"/> Night Journey                    | <input type="checkbox"/> _____                            |
| <input type="checkbox"/> Earth Day                        | <input type="checkbox"/> _____                            |
|   | <input type="checkbox"/> _____                            |

Student Name: \_\_\_\_\_

Would you be opposed to your student learning or joining in other cultural/holiday activities throughout the year? [ ] Yes [ ] No

If so please list below the holidays you would not like your child to participate in:

\_\_\_\_\_  
\_\_\_\_\_

What would you prefer your child do instead?

- |  |  |
|--|--|
| <input type="checkbox"/> Seasonal Activity | <input type="checkbox"/> Craft bin/ STEM |
| <input type="checkbox"/> Read              | <input type="checkbox"/> Draw / Color    |
| <input type="checkbox"/> Use of technology |  |

Thank you for taking the time to fill out this questionnaire to better serve our students!

## Later @ Longfellow EEC Individual Health Care Plan Form

To be placed in child's folder. Plan must be renewed annually or if child's condition changes. One form for each medication. For example – an epi pen and Benadryl require 2 forms.

|  |                |
|--|----------------|
| 1. Name of child:  | Date of Birth: |
| 2. Name of chronic health care condition:  |                |
| 3. Description of chronic health care condition:   |                |
| 4. Symptoms:   |                |
| 5. Medication/Medical treatment necessary while at the program:                          |                |
| 6. Potential side effects of treatment:  |                |
| 7. Potential consequences if treatment is not administered:                              |                |
| 8. Who has been trained and will be giving treatment while the child is at this program? |                |
| Caroline Donahue      Stefanie Stolpinski  |                |

Name and phone number of licensed Health Care Pediatrician:

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

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

Program Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_