

Enrollment Form

Mom's name _____
Dad's name _____
Child's name _____
Child's age _____
Child's Birthday _____ Nickname _____
Address _____
(Mother's) Home/Cell Phone _____
(Father's) Home/Cell Phone _____

(Mother's)
Email address: _____
(Father's)
Email address: _____

Parents are:

Married _____	Divorced _____	Separated _____	Widowed _____	Single _____
---------------	----------------	-----------------	---------------	--------------

Mother's Employer (include name and address):

Hours of employment are from _____ a.m. to _____ p.m.

Father's Employer: (include name and address):

Hours of employment are from _____ a.m. to _____ p.m.

Beginning date child(ren) needing care _____

Hours: Monday _____ Tuesday _____

Wednesday _____ Thursday _____

Friday _____

Times you plan to drop your child off. _____

Times you plan to pick up your child. _____

Is there anyone besides you that will be picking up your child? Yes or No

If yes, Names:

This is for your child's protection: Said person(s) will need to be listed on the child pick-up form.

Has your child ever been in childcare before? _____

What type (center, family daycare, grandma etc....) _____

Why are you looking for childcare?

Will you be giving a two week notice to your current provider?

What is your normal method of discipline?

What is your child's temperament? Are they easy going, hard to please, demanding, aggressive, etc.

What are some of your child's favorite activities?

Are there any food restrictions?

Does your child have any special needs or concerns?

What is your child's napping habits?

What are your hopes/expectations for your child here?

When we are closed, you will need a back up care for your child. What is the name of your Backup?

CHILD'S HEALTH: (A copy of your child's immunizations will be needed)

General state of health:

Doctor's name _____

Doctor's phone number _____

Dentists' name _____

Dentists' name _____

Are your child's immunizations up to date? _____ (Please attach a copy of immunizations. This should include the signature of nurse or doctor who administered medications.)

Does your child have any known allergies?

Are you concerned that your child may be prone to any type of allergies? _____

Describe:

Does your child have any medical conditions which I should be made aware of?

Has your child had any of the following common childhood illnesses? *(Please circle)*

Does your child have any problems with any of these?

Constipation
Convulsions
Diarrhea
Fainting Spells
Frequent Colds
Frequent Ear Infections
Frequent Sore Throats
Lice
Ringworm
Skin Rash
Soiling
Stomach Upsets
Urinary Problem
Worms

Has your child had any of these diseases?

Asthma
Bronchitis
Chicken Pox
Diabetes
Heart Disease
Hepatitis
Impetigo
Measles
Mumps
German Measles
Polio
Scarlet Fever
Tuberculosis
Whooping Cough

Does your child have any speech, hearing, or visual problems?

Has your child ever been tested for the above?

Has your child ever had any surgeries or do they have any prosthetic limbs etc.?

If yes, please describe:

Would there be any restrictions to play or activities? I.e. Is your child handicapped, allergic to grass, etc.

Age your child began to: Sit _____, Crawl _____, Walk _____

Age your child began to: Talk _____ Any difficulties with speech? Yes or No.

If yes to above question, please specify: _____

Have you made any special arrangement for child's care during illness? Yes or No.

Please specify: _____

What is your child's favorite foods? _____

What food does your child dislike? _____

Child's favorite color _____

Child's favorite song _____

Does your child know the basic shapes? _____

Which one does he/she know? Put a check mark: ABC's _____ colors _____ numbers _____

Does your child eat with a spoon _____ fork _____ hands _____? (check all that apply)

Can your child be relied upon to indicate bathroom wishes? _____

Does your child have any fears related with toileting? _____

Does your child have any "accidents"? _____

What words does your child use for: Bowel movements _____ urination _____

What time does your child awaken? _____

What time does your child go to sleep at night? _____

Do they sleep through the night? _____

Does your child sleep in a bed or crib, other? _____

Does your sleep alone or with someone else? _____

Are there any siblings? Please name them and specify ages and gender.

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Has your child had experience playing with other children? _____

Please give a brief description of your child's disposition. Is he friendly by nature, aggressive, shy, withdrawn, imaginative, demanding? Etc.

How does your child show his/her feelings?

When afraid: _____

When happy: _____

When angry: _____

What forms of discipline are most often used in child's home?

How does your child feel about daycare and being left by his/her mommy/daddy?

Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new sibling etc.?