$40 (Non-Refundable) Application Fee

Child's Application

Full Name of Child: _____ Date of Admission: _____

Child's DOB: _____ Name the child goes by: _____

Is the child related to the primary caregiver? ☐ No ☐ Yes – Relationship: _____

Child's school (if applicable): _____
Name Address Phone

Are the child's immunization records housed at the above school: ☐ Yes ☐ No If no, list the school where they are housed: _____
Name Address Phone

Parents/Custodial Parents:

Mother's Name: _____ Father's Name: _____

Home Address: _____ Home Address: _____

_____ _____
City State Zip City State Zip

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Cell Phone Network:_____ Cell Phone Network:_____

Email Address: _____ Email Address: _____

Employment: _____ Employment: _____

Work Address: _____ Work Address: _____

_____ _____
City State Zip City State Zip

Work Phone: _____ Work Phone: _____

Transportation Plan:

Please list any other adults to whom your child may be released or are authorized to provide transportation for your child. List names and phone numbers…

_____
_____
_____
_____
_____
_____

Emergency Contact Information:

1. Name of person, other than the child care provider, authorized to act for parent in an emergency.

_____

Home Address: _____ Home Phone: _____
City State Zip

Place & Address
of Employment/School: _____
City State Zip

Work Phone: _____ Work Hours: _____

Alternate Phone Numbers (cell): _____

2. Name of person, other than the child care provider, authorized to act for parent in an emergency.

_____

Home Address: _____ Home Phone: _____
City State Zip

Place & Address
of Employment/School: _____
City State Zip

Work Phone: _____ Work Hours: _____

Alternate Phone Numbers (cell): _____

3. Name of person, other than the child care provider, authorized to act for parent in an emergency.

_____

Home Address: _____ Home Phone: _____
City State Zip

Place & Address
of Employment/School: _____
City State Zip

Work Phone: _____ Work Hours: _____

Alternate Phone Numbers (cell): _____

Physician Contact Information:

Name of Physician: _____ Phone: _____

Address: _____
City State Zip

Background Information:

Other Children in the Family	Date of Birth	School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Experiences with Others:
What are some of the ways the child plays at home? _____

Does he/she play with children from other families? _____ How? _____

Does he/she react when he/she does not get his/her own way? _____
_____

Is the entire family together for any time during the day? _____

Eating Habits:
At what time does the child eat breakfast? _____ Lunch? _____ Dinner? _____
Between-meal Snacks? _____ Does the child feed himself/herself? _____
What is the child's general attitude toward eating? _____
If the child refuses to eat, how is this handled and by whom? _____
_____
_____
Food Favorites: _____
Food Dislikes: _____
Food Allergies: _____
If the child is an infant, use a separate sheet for information about the formula, bottle schedule, etc.

Sleep Habits:
Has own room: _____ Shares room with: ☐ Other Children ☐ Parents
At night sleeps from _____ to _____ Average Hours of Sleep Per Night: _____
Naps from _____ to _____ Average Hours of Naps: _____
Attitude toward going to bed: _____
If there is difficulty, how is this handled? _____
Habits associated with going to bed? _____
Is bed wetting an issue? _____ At nap time? _____ At night? _____
If yes, how is the situation handled? _____

Toilet Habits:
Time at which child is taken to the bathroom? _____
Can the child take themselves? _____ Time of bowel movement? _____ Regular? _____
Constipated? _____ Does the child tell you when he/she needs to go and does he/she go willingly? _____
Can he/she manage his/her clothes at the toilet? _____ What words does he/she use for:
Urinating: _____ BM: _____

Speech and physical Growth:
The child talks: ☐ Well ☐ Fairly Well ☐ Not Very Well ☐ Not at All
Does anyone read to the child? _____ How regularly? _____ At what age did the child creep? _____
Crawl? _____ Walk? _____ Which of the following words would you use to describe the child (check all that apply):
☐ active ☐ quiet ☐ thin ☐ average weight ☐ heavy ☐ tall ☐ average height ☐ short ☐ friendly ☐ unfriendly
Is there any other information you think we should have about the child? _____
_____
_____

Ongoing Medical Care:
Does the child have any medical diagnosis that requires ongoing care? _____
If yes, explain what type of care is administered at home and by whom? _____
_____
Are you requesting that this care be provided at the facility? ☐ Yes ☐ No If yes, describe the care required:
_____
_____
(Request a doctor's statement for any specified requests for care at the facility).

How did you hear about us:
Walk in ❒ Online ❒ Referred ❒ Other ❒

Name of who referred_____

Parent Declarations:
I received a summary of the licensing requirements.
I do hereby authorize emergency medical care for my child (a limited power of attorney may be required for military dependents).
I visited the facility prior to enrolling my child. Pre-enrollment Visit Date: _____
I received a copy of the child care facility's policy statement or handbook, and payment contract, and I have signed their copy, verifying by receipt my understanding and agreement of their content.
I authorize the agency to transport my child as specified in the transportation plan section (see page 1).

_____ _____
Signature of Parent(s)/Guardian(s) Date

Date of Child's Withdrawal: _____Reason for Withdrawal: _____

This form/information shall be maintained for one year after date of disenrollment.

Information on this form shall be updated annually or as needed to ensure the protection of the child.

Date of last update with parent's initials:
