"We Care For Your Children As If They Were Our Own"

Enrollment Information

Child's Information

Child's Name:			
_____			
Last Name	**First Name**	**Middle Name**	**Suffix**

Child's Nickname:	Date of Birth (mm/dd/yyyy):	Age:	Gender:
_____	_____/_____/_____	_____	☐ Male ☐ Female

Parent/guardian/sponsor primary language	Child's primary language
_____	_____

Child's home address	Apt:	City:	State:	Zip:
_____	_____	_____	_____	_____

Family Information

List family members your child lives with – include first names, relation and ages of siblings

Parent/guardian/sponsor name	Relationship to child	Home phone	Cell phone	Business phone

Home address *(if different from above)*	City	State	Zip

Employer *(Company)*	Employer Address	City	State	
			Zip	

Parent initial ___ **Date** ____ **Staff initial** ___ **Date** ____

Other Parent/guardian/sponsor name	Relationship to child	Home phone	Cell phone	Business phone

Home address *(if different from above)*	City	State	Zip

Employer *(Company)*	Employer Address	City	State	
			Zip	

Child's Emergency Contacts *(do not include parents/guardians/sponsors)*

PERSON 1:

Parent/guardian/sponsor name	Relationship to child	Home phone	Cell phone	Business phone

Home address	City	State	Zip

Employer *(Company)*	Employer Address	City	State	
			Zip	

PERSON 2:

Parent/guardian/sponsor name	Relationship to child	Home phone	Cell phone	Business phone

Home address	City	State	Zip

Employer *(Company)*	Employer Address	City	State	
			Zip	

Parent initial ___ Date ____ Staff initial ___ Date ____

Medical Information

Child's Name	Birth date	Height	Weight	Hair Color	Eye Color

Child's Medical & Developmental History

1. Does your child have any special medical conditions? ☐ **No** ☐ **Yes**
   Explain: _____
2. Does your child have any chronic illnesses? ☐ **No** ☐ **Yes**
   Explain: _____
3. Please list a brief history of your child's serious injuries and hospitalizations
   _____
   _____
4. Does your child have diabetes? ☐ **No** ☐ **Yes** | *If yes, please attach care instructions from your physician*
5. Does your child have asthma? ☐ **No** ☐ **Yes** *If yes, please attach care instructions from your physician*
6. Will medication be administered regularly? ☐ **No** ☐ **Yes** *If yes, please attach care instructions from your physician*
7. Does your child have any dietary needs/restrictions? ☐ **No** ☐ **Yes**
   Explain: _____
8. Is your child able to fully participate in all activities? ☐ **No** ☐ **Yes**
   Explain: _____
9. Does your child have any physical restrictions? ☐ **No** ☐ **Yes**
   Explain: _____
10. Does your child function at the level of other children in his/her/ age group? ☐ **No** ☐ **Yes**
    Explain: _____
11. Is your child able to walk? ☐ **No** ☐ **Yes**
12. Can your child communicate his/her needs? ☐ **No** ☐ **Yes**
    Explain: _____
13. Does your child need assistance at mealtime? ☐ **No** ☐ **Yes**
    Explain: _____
14. Does your child rest/nap during the day? ☐ **No** ☐ **Yes**
    Explain: _____
15. Is your child toilet trained? ☐ **No** ☐ **Yes**
    Explain: _____
16. Does your child use any special equipment, such as a breathing machine, wheelchair, hearing aid, braces, glasses etc.? ☐ **No** ☐ **Yes**
    Explain: _____
17. Does your child require one-to-one care/supervision on a regular basis for a significant period of time? ☐ **No** ☐ **Yes**
    Explain: _____
18. Does your child require any accommodations or modifications to fully and equally enjoy and participate in a group care setting? ☐ **No** ☐ **Yes**
    Explain: _____

Parent initial ___ **Date** ____ **Staff initial** ___ **Date** ____

Illness History *(please check all that apply)*

☐ Vision problems	☐ Nosebleeds	☐ Seizures
☐ Hearing problems	☐ Skin rashes	☐ Mouthsores
☐ Constipation	☐ Sore throats	☐ Fainting
☐ Diarrhea	☐ Ear infections	☐ Persistent cough
☐ Asthma/breating problems	☐ Urinary tract infections	☐ Other

Please attach care instructions from your child's physician for any of these illnesses

Disease History *(please check all that apply and add the date)*

Chichen Pox (Varicella) _____	☐ Bronchiolitis _____	☐ Botulism _____
☐ Measkes Ryvella _____	☐ Pneumonia _____	☐ Hemophilic Influenza _____
☐ Rubella _____	☐ Pertussis (Whooping Cough) _____	☐ Meningococcal Infection _____
☐ Mumps _____	☐ Tetanus _____	☐ Rabies _____
☐ Scarlet Fever _____	☐ Diphtheria _____	☐ Bacterial Meningitis _____

Allergies *(please list)*

Medication Allergies	**Reaction/s**	**Food Allergies**	**Reaction/s**
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
Bee Sting Allergies	**Reaction/s**	**Respiratory Allergies**	**Reaction/s**
1. _____	1. _____	1. _____	1. _____
	2. _____		2. _____
Other Allergies	**Reaction/s**		
1. _____	1. _____		
2. _____	2. _____		
3. _____	3. _____		

Are any of these allergies life-threatening?
☐ Yes ☐ No

Additional information please specify

_____
_____
_____
_____
_____
_____

To the best of my knowledge the information contained above is accurate.

Parent initial ___ **Date** ____ **Staff initial** ___ **Date** ____