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

Name of Agency: ____

Agency Address: ____

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: ____

Employment: ______________________________________ Employment: _______________________________________

Work Address: _____________________________________ Work Address: ____________________________________

____ ____

City State Zip City State Zip

Work Phone: ______________________________________ Work Phone: _______________________________________

Work Hours: ______________________________________ Work Hours: ____

Transportation Plan:

Please list any other adults to whom your child may be released or are authorized to provide transportation for your child.

____

____

Will the child be transported by the agency? ☐ No ☐ Yes If yes, check all that apply: ☐ to school ☐ from school ☐ to home ☐ from home ? ☐ field trips only – with prior written permission for each off-site activity.

CHILD'S APPLICATION

Emergency Contact Information:

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

____

Home Address: ____ Home Phone: ______________

City State Zip

Place and Address of Employment/School:

____

Work Phone: ____________________________________ Work Hours: ______________________________________

Alternate Phone Numbers (cell): ____

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

____

Home Address: ____ Home Phone: ______________

City State Zip

Place and Address of Employment/School:

____

Work Phone: ____________________________________ Work Hours: ______________________________________

Alternate Phone Numbers (cell): ____

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

____

Home Address: ____ Home Phone: ______________

City State Zip

Place and Address of Employment/School:

____

Work Phone: ____________________________________ Work Hours: ______________________________________

Alternate Phone Numbers (cell) : ____

CHILD'S APPLICATION

Background Information:

Other Children in the Family	Date of Birth	School

Experience 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 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, provide information about the formula, bottle schedule, etc.

______________________________:________

______________________________:________

______________________________:________

______________________________:________

______________________________:________

CHILD'S APPLICATION

______________________________ ________________ ______________________________
Child's Name Birth Date Parent or Guardian's Name

The answer to these questions will help us to know if your child has any medical problems. We need this information in case he/she should become ill and we would be unable to reach you right away. Please circle the right answer. We will go over the checklist with you when you have finished.

Pregnancy and Birth

Yes No 1) Were there any problems with pregnancy or child's birth?
Yes No 2) Was his/her birth weight under 5 ½ pounds?
Yes No 3) Did the baby have any problems in the hospital?

Medical Problems

Yes No 4) Has your child ever been in the hospital overnight?
Yes No 5) Is the child taking any medicine?
Yes No 6) Any allergies or reactions to medicine, DTP or other shots, or insects?
Yes No 7) Has your child had asthma or wheezing?
Yes No 8) Does the child have speech or hearing problems?
Yes No 9) Has the child had more than two ear infections in a year?
Yes No 10) Has the child had tonsillitis?
Yes No 11) Does your child have trouble with his/her eyes or seeing?
Yes No 12) Has your child had a bladder or kidney infection?
Yes No 13) Does he/she have burning when urinating?
Yes No 14) Does he/she have seizures, fits or shaking spells?
Yes No 15) Have you ever been told your child has a heart murmur?
Yes No 16) Is your child able to play as hard as other children?
Yes No 17) Has your child ever had a bumpy, swollen reaction to the TB skin test?
Yes No 18) Has your child ever been with anyone having TB?
Yes No 19) Has your child ever had worms?
Yes No 20) Does your child scratch his/her genital area?
Is his/her bottom or genitals red or sore? Yes No
Yes No 21) Is your child a hemophiliac (free bleeder)?
Yes No 22) Is your child on a heart monitor?
Yes No 23) Does your child have tubes in his/her ears?

Older Girls

Yes No 24) How old was your daughter when she had her first period?
Yes No 25) Does she have a problem with her period?

General Development

Yes No 26) Is your child in a special education class in school?
Yes No 27) Does your child get along with other children?
Yes No 26) Is he/she usually happy?
Yes No 27) Does your child have any special problems not indicated above?
Yes No 26) When did your child last see a doctor? ______________________ ________________
Month Year