

Children's Records must be maintained for at least five (5) years after a child has left the program

FAMILY CHILD CARE ENROLLMENT PACKET FACE SHEET

***PHOTO OF CHILD
(*Optional)
PLUS
PHYSICAL
DESCRIPTION**

Please fill out these forms completely. If a question does not apply to your child, write N/A (not applicable). The forms must be in the educator's possession on or before the first day your child begins care. Please notify your educator if any of the information changes.

Eye Color _____
Hair Color _____ Sex _____
Height _____ Weight _____
Other: _____

General Information

Date of Admission _____ Age at Admission: _____

Date of Discharge _____

Reason for Discharge: _____

Child's full name _____ Date of Birth _____

Address: _____ City: _____ Zip: _____

Telephone Number: _____ Nickname _____

Primary Language of Child _____ Primary Language of Parents _____

Allergies/Special Diets _____

Name of Parent(s)/Guardian(s) _____

Home address (if different) _____

Telephone Number: _____

Email Address: _____

Parent(s)/guardian(s) business address/location during child care:

Parent/Guardian: _____ Parent/Guardian _____

Where: _____ Where: _____

Telephone: _____ Telephone: _____

Cell Phone: _____ Cell Phone: _____

Instructions: _____ Instructions: _____

Emergency Contact/Authorized pick-up person

In the event of an emergency when I may not be reached, the Educator may contact the following individuals (in the order given) whom I authorize to take my child from the child care premises.

(1) Name: _____ Address _____

Telephone _____ Cell Phone _____

(2) Name: _____ Address _____

Telephone _____ Cell Phone _____

Child's Name _____

TRANSPORTATION PLAN / AUTHORIZED PICK- UP

| My child will arrive to the program by: | My child will depart the program by: |
|--|--|
| <input type="checkbox"/> Parent Drop-Off | <input type="checkbox"/> Parent Pick Up |
| <input type="checkbox"/> Supervised Walk | <input type="checkbox"/> Supervised Walk |
| <input type="checkbox"/> Unsupervised Walk | <input type="checkbox"/> Unsupervised Walk |
| <input type="checkbox"/> Public/Private Van | <input type="checkbox"/> Public/Private Van |
| <input type="checkbox"/> Bus | <input type="checkbox"/> Program Bus/Van |
| <input type="checkbox"/> Private Transportation Provided by Parent | <input type="checkbox"/> Private Transportation Provided by Parent |

In the space below, please note any important information regarding transportation of your child to and from the program (i.e.--indicate who will be supervising children during transport or prior to their arrival at the program, who supervises the walk from a bus stop, etc.)

I additionally authorize the following individual to take my child from the child care premises. (Please let me know at the beginning of the day when your child will be picked up by one of the authorized individuals.)

Name _____ Address _____

Telephone _____ Cell Phone _____

Name _____ Address _____

Telephone _____ Cell Phone _____

Anticipated Days/Time of Attendance

| <u>Day</u> | <u>Arrival Time</u> | <u>Departure Time</u> | <u>Day</u> | <u>Arrival Time</u> | <u>Departure Time</u> |
|------------|---------------------|-----------------------|------------|---------------------|-----------------------|
| Monday | _____ | _____ | Friday | _____ | _____ |
| Tuesday | _____ | _____ | Saturday | _____ | _____ |
| Wednesday | _____ | _____ | Sunday | _____ | _____ |
| Thursday | _____ | _____ | | | |

If applicable: Name of School Child Attends: _____

Copies of any custody agreements, court orders, restraining orders (if applicable)

Notes:

Child's Name _____

Written Acknowledgement of Receipt of Parent Handbook

I acknowledge that I have received a copy of the provider's parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook).

Parent/Guardian

Date

Parental Visit Notice

I understand that I may visit this family child care home unannounced at any time during the hours that my child is in care.

Parent/Guardian

Date

Child's Physician or Health Care Professional

Name: _____ Telephone: _____

Address: _____

Information on allergies, special diets, chronic health conditions, special limitations, concerns including medications child is taking at home/school and possible side effects:

Medical Insurance Information (OPTIONAL)

Subscriber's Name: _____ Policy #: _____

Type of Insurance: _____

[] Copy of Insurance Card

SCHOOL AGE ONLY

Current School: _____

School Address: _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements are on file at my child's school.

Parent/Guardian initials: _____

Child's Name _____

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care programs require this information to be on file to address the needs of children while in care.

CHILD'S NAME _____ **DATE OF BIRTH** _____

*Note: Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting _____ crawling _____ walking _____ talking _____

*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____

Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____ *Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____ *When? _____

*How do you handle this time? _____

HEALTH

Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail _____

Favorite foods: _____

Foods refused: _____

* Is your child fed held in lap? _____ High chair? _____

* Does your child eat with Spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

*Are disposable or cloth diapers used? _____

*Is there a frequent occurrence of diaper rash? _____

*Do you use: baby oil _____ powder _____ lotion _____ Other _____

*Are bowel movements regular? _____ how many per day? _____

*Is there a problem with diarrhea? _____ Constipation? _____

*Has toilet training been attempted? _____

*Please describe any particular procedure to be used for your child at the program

What is used at home? Potty chair? _____ special child seat? _____ regular seat? _____

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

Is your child ever reluctant to use the bathroom? _____

Does the child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____
Does your child become tired or nap during the day (include when and how long)? _____

Please Note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child’s sleeping position with your educator. Your educator will place your infant on his/her back unless there is a written physician’s order that specifies otherwise.

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 walking etc) _____

SOCIAL RELATIONSHIPS

How would you describe your child: _____

Previous experience with other children/child care: _____
Reaction to strangers: _____ Able to play alone: _____
Favorite toys and activities: _____

Fears (the dark, animals, etc.): _____

How do you comfort your child: _____
What is the method of behavior management/discipline at home: _____

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

DAILY SCHEDULE: Please describe your child’s schedule on a typical day.
***For Infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.**

Is there anything else we should know about your child? _____

Parent/Guardian Signature: _____ Date: _____

Permissions (for each child enrolled)

General Permission-(Basic Transport) (Parents should not sign this permission unless specific places where your child is allowed to go are listed by your educator.) By signing this form, I am allowing my child to be taken off the child care premises.

I, hereby give _____ permission to take my child _____
(educator/assistant)

off the premises of the family child care home for the following excursions: (specific places your child is allowed to go): _____

using the following forms of transportation: _____

Parent/Guardian Signature Date

I do not want my child to be taken off the child care premises.

Parent/Guardian Signature Date

Permission - (Transport to Medical Facility and Receive Emergency Medical Treatment)

Medical Emergency Treatment (Department of Early Education and Care recommends checking with your local hospital about the acceptability of this statement)

I, hereby give _____ permission to administer basic first aid and/or
(educator/assistant)

CPR to my child _____, and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

Parent/Guardian Signature Date

Topical Medication/Ointments (Please list only those medications/ointments which you will allow the educator(s) to administer to your child's skin): Ex: sunscreen, insect repellent (bug spray), diapering ointment.

Parent/Guardian Signature Date

Child's Name _____

Emergency Card Information

REMINDER : *This emergency card information is for the educator's first aid kit. The educator(s) must take first aid materials when leaving the child care premises.*

Child's Name: _____ Date of Birth: _____

Child's Home Address: _____

_____ Phone: _____

Instructions to Reach Parent or Guardian

1. _____
(Name, Address, Home and Cell Phone #)

2. _____
(Name, Address, Home and Cell Phone #)

Contact Information for Physician or Health Care Professional

1. _____
(Physician's Name, Address, Phone #)

Emergency Contact Person(s)

1. _____
(Name, Address, Home and Cell Phone #)

2. _____
(Name, Address, Home and Cell Phone #)

Emergency Medical Treatment

I hereby give _____ permission to
(Name of educator/assistant)

administer basic first aid and/or CPR to my child _____
(Name)

and/or take my child _____, to a hospital for medical treatment
(Name)

when I cannot be reached or when delay would be dangerous to my child's health.

Parent/Guardian

Date

Medical Insurance Information (Optional)

Subscriber's Name: _____

Type of Insurance: _____

Policy Number: _____

Copy of insurance card

Other pertinent medical information: _____

Dear Physician: _____
(Child's Name)

is enrolled in a family child care home which is licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one (1) year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone # _____

Name of Parents: _____

Address: _____

Date of Examination of Child: _____

What is your opinion concerning the child's general health and appearance:

Has this child been screened for lead poisoning? Yes _____ No _____

(*At least one (1) time between ages 9-12 months; Annually-Ages 2 & 3; at Age 4 if High Risk for Lead Poisoning)

If Yes, date screened: _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care educator? If so, please detail below:

Physician's Signature: _____ Date: _____

Comments: _____

Please return this form and the child's immunization record to:

