Kiddie Time Educational Child Care Center

Supplement Form for Enrollment

CHILD INFORMATION

Child's First and Last Name: _____

Child's Date of Birth: _____

Age at Admission: _____

Date of Admission: _____

Child's Home Address: _____

Home Phone Number: _____

Primary Language: _____

Identifying Marks: _____

Eye Color: _____

Hair Color: _____

Skin Color: _____

Sex: _____

Height: _____

Weight: _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian 1 Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

Parent/Guardian 2 Name: _____

Relationship to Child: _____

Home Address: _____

Reachable Phone Number: _____

Email Address: _____

Business Name: _____

Business Address: _____

Business Phone Number: _____

Hours at Work: _____

ADDITIONAL INFORMATION

Child's Physician: _____

Address: _____

Phone Number: _____

Allergies?: _____

Any special (Vegetarian, no meat) Diets?: _____

Do you need an Individual Health Plan for your child or do you have an IEP (Individualized Education Plan) for your child? This would apply to children with a chronic health condition like Asthma, peanut allergies, etc or a plan IEP from an authorized therapist: _____

Copies of any custody agreements, court orders, and restraining orders pertaining to the child?: _____

Special limitations or concerns?: _____

My child will arrive and depart from Kiddie Time by?:

_____

DEVELOPMENTAL INFORMATION

Age Child began sitting: _____

Age Child began crawling:Allergies?: _____

Age Child began walking: _____

Age Child began talking: _____

Does your child pull up?: _____

Does your child crawl?:Allergies?: _____

Does your child walk with support?:Allergies?: _____

Does your child walk with support?:Allergies?: _____

Special words to describe needs: _____

Any history of colic?: _____

Does your child use pacifier or suck thumb?: _____

When do they use a pacifier or suck thumb?: _____

Does your child have a fussy time?:Allergies?: _____

When are they fussy?: _____

How do you handle this time?: _____

HEALTH INFORMATION

Any known complications at birth?: _____

Serious illnesses and/or hospitalizations?: _____

Special physical conditions, disabilities: _____

Special physical conditions, disabilities: _____

Regular medications?: _____

EATING

Any Special characteristics or difficulties eating?: _____

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

Favorite foods: _____

Foods refused: _____

Is your child fed held in lap?: _____

Is your child fed held in High chair?: _____

Does your child eat with a spoon?: _____

Does your child eat with a fork?: _____

Does your child eat with a fork?: _____

DIAPERING / TOILETING

Are disposable or cloth diapers used?: _____

Do they have frequent occurrence of diaper rash?: _____

Do you use baby oil?: _____

Do you use baby powder: _____

Do you use baby lotion: _____

Do you use anything else for diaper rash: _____

Are bowel movements regular?: _____

How many per day?: _____

Is there a problem with diarrhea?:Allergies?: _____

Is there a problem with constipation?: _____

Has toilet training been attempted?: _____

Please describe any particular procedure to be used for your child at the center:

_____

While toileting at home, do you use a Pottychair?: _____

While toileting at home, do you use a 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 your child have accidents?: _____

SLEEPING HABITS

Does your child sleep in a crib?: _____

Does your child sleep in a bed?: _____

Does your child become tired or nap during the day (include when and how long)?:

_____

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 waking etc):

SOCIAL DEVELOPMENT

How would you describe your child's personality?: _____

Previous experience with other children/day care?: _____

Reaction to strangers: _____

Able to play alone?: _____

Favorite toys and activities: _____

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

How do you comfort your child?: _____

How do you comfort your child?: _____

What would you like your child to gain from this childcare 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?: _____

FIRST AID, EMERGENCY AND MEDICAL CARE

We will contact you in an emergency, is there a specific hospital/medical facility you prefer we take your child?: _____

Emergency Contacts (In order to be contacted)

Name: _____

Address: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Do you give permission for child to be released to this person?: _____

Name: _____

Address: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Do you give permission for child to be released to this person?: _____

Name: _____

Address: _____

Relationship to child: _____

Home Phone: _____

Home Phone: _____

Do you give permission for child to be released to this person?: _____

Health Insurance Company: _____

Health Ins Policy Number: _____

Do you wish your child to have their teeth brushed at school?: _____

Do you wish diaper Cream to be applied?: _____

Do you wish sunscreen to be applied in the summer?: _____

Do you wish any lotion to be applied?: _____

Do you wish any other lotion to be applied?: _____

Parents Signature: _____

Date: _____