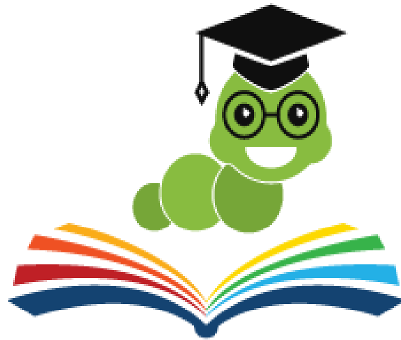
Children's Records must be maintained for at least five (5) years after the child has left the program

Small Tales Early Learning and Day Care Center Enrollment Packet

*PHOTO OF CHILD
(OPTIONAL)
PLUS
PHYSICAL DESCRIPTION
EYE COLOR_________
HAIR COLOR_________
HEIGHT_______ WEIGHT________
OTHER:_________________________
____



PLEASE FILL OUT THESE FORMS COMPLETELY IF A QUESTION DOES NOT APLY TO YOUR CHILD, WRITE N/A (NOT APPLICABLE) THE FORM MUST BE IN OUR STAFF'S POSSESION ON OR BEFORE THE FIRST DAY YOUR CHILD BEGINS CARE. PLEASE NOTIFY YOUR CHILDS TEACHER IF ANY INFORMATION CHANGES.

General Information

Date of Admission___________ Age at Admission_____________ Date of Discharge_______________

Reason for Discharge____

____

Child's Full Name____

Address____

Telephone Number_____________________________________

Primary Language of the Child____

Allergies or Special Diet ____

Name of Parent(s) or Guardian(s)____

Home Address (if different)____

Telephone Number____

Email Address____

Parent(s)/guardian(s) business address/location during childcare Parent/Guardian:___________________________ Where:____________________________________ Telephone:________________________________ Cell Phone:_______________________________ Instructions:______________________________ ____	**Parent(s)/guardian(s) business address/location during childcare** Parent/Guardian:___________________________ Where:____________________________________ Telephone:________________________________ Cell Phone:_______________________________ Instructions:______________________________ ____

Emergency Contact/Authorized pick-up person

In the event of an emergency when I may not be reached, the Teacher/Director may contact the following individuals (in the order given)

Name: ____ Telephone: ____________________

1. Name___________________________________
   Address____
   Telephone___________________________ Cell Phone______________________________
2. Name___________________________________
   Address____
   Telephone___________________________ Cell Phone______________________________
3. Name___________________________________
   Address____
   Telephone___________________________ Cell Phone______________________________
4. Name___________________________________
   Address____
   Telephone___________________________ Cell Phone______________________________

TRANSPORTATION PLAN / AUTHORIZED PICK- UP

My child will arrive to the program by:

__Parent Drop-Off

__Supervised Walk

__Unsupervised Walk

__Public/Private Van

__Bus

__Private Transportation Provided by Parent

My child will depart the program by:

__Parent Pick Up

__Supervised Walk

__Unsupervised Walk

__Public/Private Van

__Program Bus/Van

__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 staff 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

Day Arrival Time Departure Time Day Arrival Time Departure Time

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)

____

____

____

Child's Name ______________________

Written Acknowledgement of Receipt of Parent Handbook

I acknowledge that I have received a copy of Small Tales Early Learning and Daycare Center Parent Handbook.

____ ______________

Parent/Guardian Date

Parental Visit Notice

I understand that I may visit Small Tales 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)

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

Medical Emergency Treatment Small Tales Early Learning and Daycare Center

I, hereby give ___________________________________ permission to administer basic first aid and/or
(Small Tales Staff)

CPR to my child _______________________________, and/or accompany 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 staff 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 Teachers first aid kit. The Teacher(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 Small Tales Staff to administer basic first aid/CPR to my _____________________________
(Name)

I understand that Small Tales Staff will contact 911 to assist my child in a life threatening emergency or if they require transport to the local hospital.

Parent/Guardian Signature______________________________ 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:

____

Small Tales Early Learning and Daycare Center