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

# Sunshine Daycare Center
# ENROLLMENT PACKET

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

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

**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.**

## 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: |
|---|---|
| __Parent Drop-Off<br>__Supervised Walk<br>__Unsupervised Walk<br>__Public/Private Van<br>__Bus<br>__Private Transportation Provided by Parent | __Parent Pick Up<br>__Supervised Walk<br>__Unsupervised Walk<br>__Public/Private Van<br>__Program Bus/Van<br>__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**

| 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)

Notes:

_____

_____

_____

**Child's Name** _____

Parental Signatures

**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

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## 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 Sunshine Daycare Center 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:

_____
_____
_____