



CHILD LEARNING CENTERS
APPLICATION FORM

For Office Use:

Billing: _____

Entered: _____

Withdrawn: _____

Please fill out this application completely. Accurate information is necessary so that we may best serve your child. It is your responsibility to notify us immediately of any changes in residence, telephone, employer or emergency contacts.

Days and Hours Care is needed:

Age Group

Table with 4 columns: Day (Monday-Friday), From, To, and Age Group (Infant, Toddler, Pre K, Latchkey).

Child's: First Name: _____ Last Name: _____

Birthdate: ____/____/____ Male _____ Female _____ Soc. Security # ____ - ____ - ____

Mother's Name: _____ Father's Name: _____

Soc. Security # ____ - ____ - ____ Soc. Security # ____ - ____ - ____

Home Address: Street _____ City _____ Zip _____

Home Telephone: _____ Who referred you to the Center? _____

Parent can be reached at following location during hours of care:

Mother at: _____ Phone #: _____
Father at: _____ Phone #: _____

List all members of the household and relationship to child: _____

Names of any persons not allowed to pick up your child: _____

EMERGENCY INFORMATION

EMERGENCY CONTACTS - Persons authorized to pick up your child(ren) if necessary:

- 1. Name: _____ Relation: _____
Home phone: _____ Work phone: _____
2. Name: _____ Relation: _____
Home phone: _____ Work phone: _____
3. Name: _____ Relation: _____
Home phone: _____ Work phone: _____

PERSONAL HISTORY

Medical

Birth: Normal _____ Other _____ Full term _____ Premature _____ # of weeks early _____
Weight _____ Length _____

Hospitalizations or surgery since birth No _____ Yes _____

Medications needed regularly No _____ Yes _____

Allergies:

to foods No _____ Yes _____

to medications No _____ Yes _____

Has child ever had:

a seizure No _____ Yes _____

heart problems No _____ Yes _____

feeding difficulties No _____ Yes _____

Please give details about any 'yes' answers: _____

Toilet Habits

Trained _____ Being trained _____ Occasional Accidents _____ Verbalizes toilet needs: yes _____ no _____

Social Relationships

First experience in day care Yes _____ No _____

Has child had experience playing with other children Yes _____ No _____

Usually, your child's disposition is:

What frightens or upsets your child?

How does your child show anger?

Does your child have any special needs? Yes _____ No _____

Formally identified through evaluation by: _____

Please describe: _____

Parent Comments:

Parent Signature

Date

Director/Head Teacher Signature

Date