CHILD CARE APPLICATION

Requested First Day of Attendance: ________________

CHILD INFORMATION

Full Name of Child ____ Goes by ____________________

Address________________________________ City___________________ State_________ Zip____________

Date of Birth _________________________ Age _________ Male ☐ Female ☐

Allergies____________________________________ Medical Conditions_________________________________

Are any of the allergies or medical conditions severe or life-threatening? Yes / No

Child's Physician _________________________________Office Number ________________________

Address________________________________ City___________________ State_________ Zip____________

PARENT INFORMATION

Child lives with (check all that applies):

Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Grandparent(s) ☐ Other ☐ (specify) ___________________

Mother's Name____

Address________________________________ City___________________ State_________ Zip___________

Home phone __________________________________ Cell phone___________________________________

E-Mail ____

Employer___________________________ Business phone___________________ Work Hours ____________

Emergency contact Yes / No May pick up child Yes / No Has custody Yes / No

Father's Name____

Address________________________________ City___________________ State_________ Zip___________

Home phone __________________________________ Cell phone___________________________________

E-Mail ____

Employer___________________________ Business phone___________________ Work Hours ____________

Emergency contact Yes / No May pick up child Yes / No Has custody Yes / No

Who has legal custody __________________________________ Relationship____________________________

Note: Custodial documentation is required.

____
Parent Initials and Date

Full Name of Child ____ Goes by ______________________

EMERGENCY (Name of person(s), other than child care staff, authorized to act for parent in an emergency)

Contact Name ____ Relationship to Child __________________

Address ________________________________ City ___________________ State _________ Zip ____________

Home phone ___________________________________ Cell phone ___________________________________

E-Mail ____

Employer ___________________________ Business phone ___________________ Work Hours ____________

Contact Name ____ Relationship to Child __________________

Address ________________________________ City ___________________ State _________ Zip ____________

Home phone ___________________________________ Cell phone ___________________________________

E-Mail ____

Employer ___________________________ Business phone ___________________ Work Hours ____________

TRANSPORTATION PLAN
Persons authorized to pick up and transport the child other than parent/guardian or emergency contact.

Name	Phone Numbers	Relationship

If you want a person who is not identified above to pick up your child, you must notify the child care in advance, and in writing. Your child will not be released without written authorization.

Is there anyone that is not allowed to pickup child? Yes / No If Yes, who? ________________________________

____
Parent Initials and Date

Full Name of Child ____ Goes by _________________________

DEVELOPMENTAL HEALTH HISTORY

Write N/A (non-applicable) if your child is too young for the following questions to apply.

PHYSICAL HISTORY

What health problems has your child had in the past? ____

What health problems does your child have now? ____

Does your child have any allergies? ____

Does your child have a medical condition? ____

Are any of the allergies or medical conditions severe or life-threatening? Yes / No

Explain in detail ____

____

Does your child take any medication regularly? If so, describe? ____

Has your child ever been hospitalized? If so, when and why? ____

Does your child have any recurring chronic illness or health problems such as? ☐ Asthma ☐ Cerebral Palsy

☐ Developmental Delay ☐ Seizure Disorder ☐ Diabetes ☐ Frequent Earaches ☐ Hemophilia

☐ Other ____

If medically diagnosed, what is the name of the doctor who diagnosed the illness or health problem?

____

Do you have any other concerns about your child's health? ____

DEVELOPMENT

How well does your child talk? ☐ Well ☐ Fairly well ☐ Not very well ☐ Not at all

Does your child have any problems with talking or making sounds? Please explain: _________________________________

At what age did your child Crawl? ___________ Walk? __________

Does your child have any problems with walking, running or moving? Please explain_________________________________

Does your child have any problems seeing? Please explain: ____

Does your child have any problems hearing? Please explain: ____

Does your child have any problems using his/her hands (such as with puzzles, small building pieces)?

Please explain: ____

TOILETING

Is your child potty trained? Yes / No Does your child manage toileting on his/her own? Yes / No

How does your child indicate bathroom needs? ____

Word(s) for urination ___________________________ Word(s) for bowel movement ____________________________

What is your child's bladder and bowel pattern? ____

Does your child need help getting dressed? ____

Special words for body parts ____

____

Parent Initials and Date

Full Name of Child ____ Goes by ________________________

DEVELOPMENTAL HEALTH HISTORY (continued)

Write N/A (non-applicable) if your child is too young for the following questions to apply.

EATING

At what time does the child eat? Breakfast __________ Lunch __________ Dinner __________ Snack(s) __________

Does your child feed him/herself? Yes / No Drink from a regular cup? Yes / No

What is your child's general attitude toward eating? ____

If your child refuses to eat, how is this handled? ____

Favorite foods____

Disliked foods ____

Is your child on any special diet? Yes / No Please describe: ____

If your child is an infant, please complete the infant/toddler information sheet. Parents must work closely with the child care while introducing new baby foods and table foods to the child.

SLEEPING PATTERN

Awakens at _______________ Naps ______________________________________ Goes to bed _______________

Does your child need a favorite item for nap? Yes / No What? ____

What is your child's bedtime routine? ____

SOCIAL AND PLAY

List name(s) and age(s) of siblings____

List name(s) and age(s) of most frequent playmates? ____

Is your child friendly? Yes / No Aggressive? Yes / No Shy? Yes / No Withdrawn? Yes / No

Is your child frightened by (circle all that apply)? Animals Loud Noises Dark Storms _____________________

Does your child play well alone? ____

What is your child's favorite toy? ____

What are some ways your child plays at home? ____

Does your child have a special comforting item (such as a blanket, stuffed animal, doll)?

____

Who does most of the discipline? ____

Reaction if your child does not get their way? ____

Is the entire family together for any time during the day? ____

Is there any other information that you wish to share that would assist in meeting your child's needs?

____

____

____

Parent Initials and Date

Full Name of Child ____ Goes by ________________________

CHURCH AFFILIATION
Church Name ____ Denomination ______________________________

REFERRED BY ______________________________________

PERMISSION TO PHOTOGRAPH
I authorize Covenant Family Child Care to use photographs or videos of my child(ren) for the purpose of telling a story or promoting the interests of Covenant Family Child Care in publications and on the website (children's last names are not used on the website)? Yes / No

I authorize Covenant Family Child Care to use photographs or videos of my child(ren) within the child care setting? Yes / No

- I visited the child care facility prior to enrolling my child.
- I have received a summary of the licensing requirements and a copy of the child care facility's parent policy statement, verifying by receipt my understanding and agreement of their content.
- I do hereby authorize the child care facility's staff to obtain emergency medical care for my child, such as 911, the case of accident, injury or illness.
- I understand any changes in the above information must be entered immediately, initialed and dated.

The above information is true and accurate to the best of my knowledge.

____
Parent Signature and Date

If you have any question, concerns, or a complaint, call Child Care Resource and Referral at 1-800-462-8261

OFFICE USE ONLY

Enrollment Date ______________________ Child's first day ________________________

Date child was withdrawn _____________

Reason for withdrawal ____

INFANT & TODDLER INFORMATION SHEET

Full Name of Child ____ Goes by _____________________

Date of Birth ____________________________

Allergies____ Medical Conditions_________________________________

Are any of the allergies or medical conditions severe or life-threatening? Yes / No

BOTTLES
Brand of formula _________________________________ Water used ____

How many ounces per bottle? _______________________ How many hours between bottles? ____________________

Temperature? ___________________________________

MEALS
Breakfast (Cereal, how is it made (water, juice or formula)? Served with fruit? Served warm or room temperature?)

____

Lunch ____

Snack(s)____

Favorite foods ____

FOOD ALLERGIES? ____

NAPS
Morning, when and how long? ____

Afternoon, when and how long? ____

How does your baby like to sleep? ____

GENERAL
Pacifier? ____

What do you do when your baby is fussy? ____

What do you use for diaper rash? ____

Does your baby have any problems with gas? If so, what do you do to help? _______________________________

____

Is there any other information that you wish to share that would assist in meeting your child's needs? ________________

____

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____
Parent Initials and Date