

# Small Steps Center Child's Enrollment Form

## Child Information

Child's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Age at Admission: \_\_\_\_\_ Date of Admission: \_\_\_\_\_  
Child's Nickname: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Identifying Marks: \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Skin Color: \_\_\_\_\_  
Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Parent/Guardian Contact Information

Mother/Guardian Name: \_\_\_\_\_  
Father/Guardian Name: \_\_\_\_\_  
If Guardian (Relationship to Child): \_\_\_\_\_

(Mother's) Home Phone \_\_\_\_\_  
(Mother's) Work Phone \_\_\_\_\_  
(Mother's) Cell Phone \_\_\_\_\_  
(Father's) Home Phone \_\_\_\_\_  
(Father's) Work Phone \_\_\_\_\_  
(Father's) Cell Phone \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Business Name: \_\_\_\_\_  
Business Address: \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_  
Contact's Phone \_\_\_\_\_  
Emergency Contact Person \_\_\_\_\_  
Contact's Phone \_\_\_\_\_

Do you have a backup care provider? \_\_\_\_\_

**Service Information**

Beginning Date \_\_\_\_\_  
Hours: Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_  
Thursday \_\_\_\_\_ Friday \_\_\_\_\_  
Times you plan to drop your child off \_\_\_\_\_  
Times you plan to pick up your child \_\_\_\_\_

**Your Child's Health Information**

CHILD'S HEALTH RECORD: (A copy of your child's immunizations and current physical will be needed)

General State of Health: \_\_\_\_\_  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_  
Doctor's Phone Number: \_\_\_\_\_  
Dentists' Name \_\_\_\_\_  
Dentists' Name \_\_\_\_\_

Are your child's immunizations up to date? \_\_\_\_\_ (Please attach a copy of immunizations. This should include the signature of nurse or doctor who administered medications.)

Does your child have any known allergies? \_\_\_\_\_  
\_\_\_\_\_

Are you concerned that your child may be prone to any type of allergies? \_\_\_\_\_  
Describe: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any medical conditions which I should be made aware of? \_\_\_\_\_  
\_\_\_\_\_

**Has your child had the following common childhood illnesses?**

*(please circle)*

\* Does your child have any problems with any of these?

- Constipation
- Convulsions
- Diarrhea
- Fainting Spells
- Frequent Colds
- Frequent Ear Infections
- Frequent Sore Throats

\* Has your child had any of these diseases?

- Asthma
- Bronchitis
- Chicken Pox
- Diabetes
- Heart Disease
- Hepatitis
- Impetigo

Lice  
Ringworm  
Skin Rash  
Soiling  
Stomach Upsets  
Urinary Problem  
Worms

Measles  
Mumps  
German Measles  
Polio  
Scarlet Fever  
Tuberculosis  
Whooping Cough

Does your child have any speech, hearing or visual problems? \_\_\_\_\_

Would there be any restrictions to play or activities? \_\_\_\_\_

### **About Your Child**

Has your child ever been in a preschool or child care before? \_\_\_\_\_ What type (center, family daycare, grandma etc.) \_\_\_\_\_

Was it a positive experience? \_\_\_\_\_

Why are you looking for childcare? \_\_\_\_\_

How does your child feel about daycare and being left by his/her mother/father? \_\_\_\_\_

Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new sibling etc? \_\_\_\_\_

What is your normal method of discipline? \_\_\_\_\_

What is your child's temperament? Are they easy going, hard to please, demanding, aggressive, etc. \_\_\_\_\_

Are there any food restrictions? \_\_\_\_\_

What is your child's favorite food? \_\_\_\_\_

What food does your child dislike? \_\_\_\_\_

Can your child be relied upon to indicate bathroom wishes? \_\_\_\_\_

What words does your child use for: Bowel movements: \_\_\_\_\_ Urination: \_\_\_\_\_

What time does your child awaken? \_\_\_\_\_

What time does your child go to sleep at night? \_\_\_\_\_

Do they sleep through the night? \_\_\_\_\_

Does your child sleep in a bed or crib, other? \_\_\_\_\_

Are there any siblings? Please name them and specify ages and gender:

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Has your child had experience playing with other children? \_\_\_\_\_

Does your child have any security objects such as a blanket, soother, bottle, toy, etc?  
\_\_\_\_\_

What are your child's favorite activities, toys, books, or games? \_\_\_\_\_

Are there any other comments or information you would like to let us know about?  
\_\_\_\_\_  
\_\_\_\_\_

Any specific concerns?  
\_\_\_\_\_  
\_\_\_\_\_