

BRIGHT HORIZONS
CHILD'S INFORMATION

Child's Name: _____ Date of Birth: _____

Place of Birth: _____ Primary Language: _____

Child's Schedule: MON _____ TUE _____ WED _____ THU _____ FRI _____

Parent/Guardian Information

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Home E-mail Address: _____ Home E-mail Address: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Home Phone: _____

Others in Family Relationship: _____

Parent/Guardian Business Information

Company Name: _____ Company Name: _____

Address: _____ Address: _____

Business Phone: _____ Business Phone: _____

E-mail Address: _____ E-mail Address: _____

Medical Information

Eye Color: _____ Hair Color: _____ Sex: _____

Height: _____ Weight: _____ Race: _____

Identifying Marks: _____

Identified Allergies: _____

Health Insurance Provider: _____

Physician Information

Name of Physician/Clinic: _____ Phone: _____

(Parent/Guardian Signature)

(Date)

FOR CENTER USE

Center: _____ Date of Admission: _____ Age of Admission: _____

Date Registration Fee Received: _____ Director's Initials: _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES



Medical Statement of Child in Childcare

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:
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Immunizations required for entry into day care

Yes No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: _____ Mantoux Results: Positive Negative _____ mm

TB Tests are at the physician's discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: _____

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year _____ Result: _____ mcg/dL Venous Capillary

2 years _____ Result: _____ mcg/dL Venous Capillary

Most recent date of lead screening (if different from above):

_____ Result: _____ mcg/dL Venous Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.



Medical Statement of Child in Childcare

(continued)

Health Specifics	Comments
Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to Day Care Providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in day care. Yes No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	Phone
	Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

BRIGHT HORIZONS AUTHORIZATION AND CONSENT / CHILD RELEASE

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child, _____. If I cannot be reached, I understand that the emergency contacts listed below will be called. However, I hereby authorize Bright Horizons to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. I understand the staff in the child care Center/School is trained in the basics of first aid and CPR and I authorize them to give my child first aid. In the best interests of my child, I realize any member of the teaching staff assigned responsibility for the care and education of my child may view my child's health information, as well as state licensors to ensure compliance.

Child's Health Insurance Provider: _____
Name of Insured: _____ Policy Number: _____

To ensure children's safety, Bright Horizons will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below as undersigned by the parent/guardian.

By signing this form, I understand that Bright Horizons will not release my child to any other person unless I notify the Center/School, following the guidelines listed below:

- If the person (spouse, relative, friend) picking up my child is listed on this form but does not regularly pick up my child or has never before picked up my child, I will notify the center/school verbally, in advance.
- If the person picking up my child is **NOT** listed on this form, I must notify the Center/School in writing, in advance.
- Photo identification will be required of any person picking up my child.

Child's Name: _____ Date of Birth: _____

1. Name: _____ Relationship: _____

Address: _____ Day Phone #: _____

City/Town & Zip: _____ Evening Phone #: _____

Cell Phone #: _____

2. Name: _____ Relationship: _____

Address: _____ Day Phone #: _____

City/Town & Zip: _____ Evening Phone #: _____

Cell Phone #: _____

3. Name: _____ Relationship: _____

Address: _____ Day Phone #: _____

City/Town & Zip: _____ Evening Phone #: _____

Cell Phone #: _____

4. Name: _____ Relationship: _____

Address: _____ Day Phone #: _____

City/Town & Zip: _____ Evening Phone #: _____

Cell Phone #: _____

(Parent/Guardian's Signature) (Date)

(Parent/Guardian's Signature) (Date)

BRIGHT HORIZONS

PARENT/GUARDIAN INFORMATION FORM

There may be times phone numbers and addresses of families are requested by parents/guardians so that children may have "play dates" outside of the center/school.

Please check the information that Bright Horizons **MAY** give to other parents/guardians enrolled in the center/school upon request.

Child's Name: _____

Parent/Guardian Name: _____

- Parent/Guardian Home Phone Number
- Parent/Guardian Work Phone Number
- Parent/Guardian Cell Phone Number
- Parent/Guardian Home Address
- Parent/Guardian E-mail Address

Parent/Guardian Name: _____

- Parent/Guardian Home Phone Number
- Parent/Guardian Work Phone Number
- Parent/Guardian Cell Phone Number
- Parent/Guardian Home Address
- Parent/Guardian E-mail Address

Please do not give out any of the information listed above.

The information detailed above will be shared only with parents/guardians whose children are currently enrolled in the center/school.

(Parent/Guardian's Signature)

(Date)

BRIGHT HORIZONS PHOTO/VIDEO PERMISSION

Bright Horizons takes photographs and videos of children enrolled at its centers on a regular basis for its business purposes. Bright Horizons retains all rights, title and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment. Bright Horizons takes care that any use, display, or dissemination of photographs or videos of children, whether at a particular center where the child attends or for its general business purposes, is accomplished in a thoughtful, safe, and secure manner appropriate under the particular circumstances.

For example, at your Center, these materials may be used to better communicate with families and to illustrate the daily curriculum, to chronicle a child's development, or to document Center activities. These photos may be shared with you and other families on a secure Bright Horizons' website, by e-mail, by posting in the Center or in a parent newsletter

By signing below, you grant permission to Bright Horizons to take photographs and videos of your child during his/her enrollment and its use of these photographs for its business purposes.

Child's Name

Parent/Guardian Signature

Date

**BRIGHT HORIZONS
SUNSCREEN AND INSECT REPELLANT PERMISSION SLIP**

- All sunscreen or sun block will have a UVB and UVA protection of at least 15 or higher.
- All sunscreen/sun block and insect repellent must be provided in the original container (please note, the use of aerosol cans are not allowed for safety purposes).
- All products require a valid expiration date, where applicable.
- Containers must be labeled clearly with the child's full name.

Note: When recommended by public health authorities or requested by a parent/guardian, the use of insect repellents containing DEET should be used. Repellents containing DEET are to be applied only to children over the age of 2 months and *no more than once a day*.

All sunscreen/sun blocks and insect repellents will be applied according to the directions on the label. Insect repellents will be washed off when the child has returned indoors.

Combined sunscreen/sun block and insect repellents should be avoided due to the variation in application times.

I give Bright Horizons permission to apply (*name of sunscreen*) _____

and/or (*name of insect repellent*) _____

to my child, _____.

From: _____ To: _____ (not to exceed one year)

Special Instructions:

Sunscreen/Sun Block:

Insect Repellent:

(Parent/Guardian Signature)

(Date)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
WRITTEN MEDICATION CONSENT FORM



- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:
7A. Frequency to be administered: _____		
OR		
7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____		
8A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects (parent must supply)		
AND/OR		
8B. Additional side effects: _____		
9. What action should the child care provider take if side effects are noted:		
<input type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (parent must supply)		
AND/OR		
10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____		
11. Reason the child is taking the medication (unless confidential by law): _____		
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #33-#34 on the back of this form.		
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #35-#36 on the back of this form.		
14. Date prescriber authorized:	15. Date to be discontinued or length of time in days to be given (<i>this date cannot exceed 6 months from the date authorized or this order will not be valid</i>):	
16. Prescriber's name (please print):	17. Prescriber's telephone number:	
18. Licensed authorized prescriber's signature: X		

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
WRITTEN MEDICATION CONSENT FORM

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) Yes N/A No

Write the specific time(s) the day care program is to administer the medication (i.e.: 12pm):

20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____

(child's name)

21. Parent or legal guardian's name (please print):

22. Date authorized:

23. Parent or legal guardian's signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:

25. Facility ID number:

26. Facility telephone number:

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Authorized child care provider's name (please print):

29. Date received from parent:

30. Authorized child care provider's signature:

X

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____

(date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Licensed Authorized Prescriber's Signature:

X

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE:

By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:

X

BRIGHT HORIZONS

INFANT/TODDLER DEVELOPMENTAL HISTORY

Child's Name: _____ Date of Birth: _____

What would you like us to call your child? _____

DEVELOPMENTAL HISTORY

Age child began sitting: _____ crawling _____ walking _____ talking _____

Does child: pull up crawl walk with support

Times child is fussy: _____

How do you handle these fussy times? _____

FAMILY INFORMATION

With whom does child reside? _____

Who else lives in the home (siblings, extended family, pets)?

What does child call family members? _____

Language spoken at home: _____

Are books read in languages other than English? _____

Are there words in your home language that we should know?

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful:

HEALTH/ DEVELOPMENT

Serious illnesses or hospitalizations (describe)?

Any history of colic?

Special physical conditions, disabilities, or allergies (describe)?

Is your child presently or ever been diagnosed with a special need? _____

If so, is he/she receiving any special services? _____

Regular medications? _____

EATING HABITS

Special characteristics or difficulties? _____

Special diet: _____ Formula: _____ Breast Milk: _____

Any food allergies? _____

Have solid foods been introduced? yes no If yes, please identify:

Favorite foods: _____ Foods refused: _____

Child eats: on lap in high chair other

Child eats with: spoon fork hands other

TOILETING/DIAPERING HABITS

Is there frequent diaper rash? yes no

Do you use: oil powder lotion other

Does child wear: disposable diapers cloth diapers

Are bowel movements: regular how often: _____

Is there a problem with: diarrhea constipation

Is your child toilet trained: yes no If yes, when did you begin? _____

urination bowels or both

What is used at home: potty-chair special seat regular seat

Word used for urination: _____ bowel movement: _____

Does your child have accidents? yes no If yes, how often/when?

SLEEPING HABITS

Does child sleep in: crib bed with parents

Does child sleep on: back side stomach

Times child take naps? Times: a.m. _____ - _____ p.m. _____ - _____

What does child take to bed? _____ mood on awakening: _____

What time does child go to bed at night: _____ awake in morning: _____

Are there any sleep/wake time rituals? If so, please describe.

SOCIAL RELATIONSHIPS

Has child had any experience playing with children? If so, please describe.

Is child: friendly aggressive shy withdrawn

Reaction to strangers?

Have you had any previous child care experience? yes no If yes, did it meet your needs and expectations? Explain:

Prefers to play: alone in small groups

Favorite toys and activities?

Is child frightened by: animals rough children loud noises dark other

Explain: _____

How do you comfort your child?

How does your child prefer to be held?

What is your style of disciplining?

DAILY SCHEDULE

Please describe by approximate time your child's current daily activities (e.g., awakening, eating, time out of crib, napping, toilet habits, fussy time, bedtime):

MORNING

AFTERNOON

--

PARENTING PHILOSOPHY

Do you have ideas about parenting that would help us to better care for your child as an individual?

--

What do you, as a family, hope to get out of this child care experience?

--

(Parent's/Guardian's Signature)

(Date)

**BRIGHT HORIZONS
PRESCHOOL/KINDERGARTEN DEVELOPMENTAL HISTORY**

Child's Name: _____ Date of Birth: _____

What would you like us to call your child? _____

DEVELOPMENTAL HISTORY

Age child began sitting: _____ crawling _____ walking _____ talking _____

Any speech difficulties? _____

FAMILY INFORMATION

With whom does the child reside? _____

Who else lives in the home (siblings, extended family members, pets)?

What does child call family members? _____

Language spoken at home: _____

Are books read in languages other than English? yes no If yes, what language(s)?

Are there words in your home language that we should know?

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful:

HEALTH/DEVELOPMENT

Serious illnesses or hospitalizations (describe):

Any physical/chronic conditions, disabilities, including allergies? Describe:

Regular medications:

Is your child presently or ever been diagnosed with a special need? yes no If so, is he/she receiving any special services? Explain:

EATING HABITS

Any food allergies? _____

Special diet:

Special characteristics or difficulties?

Favorite foods: _____ Foods refused: _____

Child eats with: spoon fork hands other

TOILETING HABITS

How does child indicate bathroom needs (include special words)?

Is child reluctant to use the bathroom? yes no If yes, how do you handle?

Does child have accidents? yes no If yes, how often and when?

SLEEPING HABITS

Does child become tired or nap during the day (include when and how long)? _____

What time does child go to bed at night: _____ awake in morning: _____

Describe any special characteristics or needs (stuffed animal, story, mood on waking):

Are there any sleep/wake time routines?

SOCIAL RELATIONSHIPS

How would you describe your child?

Describe any previous experience with children:

Has there been any previous child care experience? yes no If so, did it meet your needs and expectations?

Reaction to strangers: _____

Prefers to play alone or in groups? _____

Favorite toys and activities:

Fears (e.g., the dark, animals):

How do you comfort your child?

How do you discipline your child?

DAILY SCHEDULE

Describe your child's schedule on a typical day:

What would you like your child to gain from the child care experience?

Anything else you would like us to know about your child?

(Parent/Guardian's Signature)

(Date)

Bright Horizons

Child's Allergy Information

All allergies requiring medication and/or special meal requirements must be documented by the child's physician.

Name of Child _____ Date of Birth _____

Allergen:	Symptom:	Treatment*/Substitution:*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*If treatments require medication administration, it will be necessary to have medication authorization paperwork completed and the physician's signature must be in place as required.

Further Emergency Response Procedures:

Additional Information/Instructions:

Referred for Allergy Testing: Yes No Allergy Testing completed: Yes No

I know of no known food allergy at this time, no dietary adjustments indicated

Physician's Signature

Date

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a note from the child's physician stating that the child is no longer allergic to that item(s) (and may now have that specific food(s)), nor can we add an item(s) or change a medication without a note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the homebases and kitchen on the Allergy Awareness Chart.

Parent/Guardian Signature

Date

This form is only required for children who have mild to severe allergies that require medication to be administered if exposed to the allergen. If your child does not have any allergies, you and your child's physician do not need to complete this form.

Bright Horizons Individual Health Plan for Children with Allergies

Child's Name: _____ DOB: _____
Parent/Guardian Name: _____ Phone: _____
Physician's Name: _____ Phone: _____
Allergies: _____

If the child is exposed to an allergen, watch for the following signs of a *mild* allergic reaction:

- Hives Lightheadedness Red, swollen or itchy eyes
 Flushing Nausea/vomiting Tingling
 Other: _____

If the child is exposed to an allergen, watch for the following signs of a *severe* allergic reaction:

- Lips/tongue swelling Tightness in chest or throat (child may
 Wheezing/difficulty breathing complain of a lump in the throat or a
scratchy throat)
 Other: _____

Medication should be administered at the following signs/severity:

Prescribed Medication/Dosage*:

Actions to be taken for a *Mild* Allergic Reaction

- Stay calm and do not leave the child unattended
 Medication Administration
- Wash your hands
 - Shake the bottle; measure the correct amount of medication using an approved medication spoon or medication medicine cup
 - Follow Medication Administration Procedures using the Medication Administration Log
 - Observe the child for relief of symptoms
 - Wash the child's hands and yours with soap and water
 - Offer cool compress to skin areas that are irritated
- Notify the child's parents
 Notify a member of the Administrative Team
 Document the administration of the medication on the Administration of Medication Log
 Other: _____

Actions to be taken for a *Severe* Allergic Reaction

- Stay calm and do not leave the child unattended.
 Have someone call 911. Be sure to tell the dispatcher that the child is receiving an EpiPen.
 Medication Administration (EpiPen)
- Remove the gray protector cap
 - Hold the child's thigh tightly and administer to the side of the thigh area. An EpiPen can be administered through clothing. Ask for assistance to help hold the child, if necessary.
 - Press the injector to the thigh firmly until a click is heard and hold in place for 10 seconds.
 - Remove the EpiPen and discard in a Sharp container, if available, or provide to the Emergency Response Personnel when they arrive for proper disposal.

This form is only required for children who have mild to severe allergies that require medication to be administered if exposed to the allergen. If your child does not have any allergies, you and your child's physician do not need to complete this form.

- Note the time you administered the EpiPen to the child.
 - Stay with the child and monitor his/her condition.
- Notify the child's parent(s)
- Notify a member of the Administration Team
- Document the administration of the medication on the Administration of Medication Log
- Other:
-

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Director/Principal: _____ Date: _____

*For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the *Authorization for Administration of Medication* form.

NEW YORK STATE
 OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE REGISTRATION

**PHOTO OF CHILD
 (Optional)**

Child's Full Name: _____

Does your child have any allergies? Yes No
 If Yes, what is your child allergic to? _____

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name: _____ Telephone Number: _____

Child's Source of Dental Care/Dentist's Name: _____ Telephone Number: _____

Name Of Medical Care Facility/Hospital: _____ Telephone Number: _____

Would you like information on Child Health Plus? Yes No

EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
				_____ <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				_____ <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				_____ <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				_____ <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

Provider/Day Care Facility Name and Address:

CHILD'S FULL NAME:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
CHILD'S HOME ADDRESS:		DATE OF BIRTH:
		HOME TELEPHONE NUMBER:
DATE OF ACCEPTANCE:	DATE OF DISCHARGE:	
NAME OF PERSON APPLYING FOR CHILD:	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____	HOME TELEPHONE NUMBER:
		DAYTIME TELEPHONE NUMBER:
ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):		
AGREEMENTS		
I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.		
I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No		
In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. <input type="checkbox"/> Yes <input type="checkbox"/> No		
I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. <input type="checkbox"/> Yes <input type="checkbox"/> No		
I agree to review and update this information whenever a change occurs and at least once every six months. <input type="checkbox"/> Yes <input type="checkbox"/> No		
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE		DATE:



This form will help us understand your child in their cultural context as well as to help identify their interests so as to help us make your child's educational experience as individualized as possible.

Child/Family Information Sheet

Child's Name: _____

Any nicknames? _____

DOB: _____

Siblings? Ages?

Any other significant people with whom your child has close, regular contact?

What are your child's interests? Please list:

Does your child have any needs that you wish us to be aware of?



What is your cultural background?

Do you or your extended family celebrate any festivals or special days? Please list:

Do you have any religious or other beliefs that you wish the center to be aware of?

**Do you have any interests/skills that you would like to share with the children at the center?
This could be an interest in reading, cooking, completing an art activity, playing a musical
instrument, or sharing a special day/festival from your culture!**
