



REGISTRATION FORM

DATE OF ADMISSION: _____
UPDATED DATE: _____

GENERAL INFORMATION

Child's Name: _____
Last First Middle

The name your child is called: _____
(Nickname or shortened form)

Child's Birth date: _____ Sex: _____

Place of birth: _____

FAMILY INFORMATION

Mother

Father

Full Name: _____

Address: _____

Phone: _____

Employer: _____

Work Address: _____

Phone: _____

Marital Status: _____

If parents are separated or divorced, are there special custody arrangements that we need to know?

Names and birth dates of other children in the family ?

Does anyone else live with your family besides parents and children? _____

Languages spoken in your home _____

DEVELOPMENTAL HISTORY

Type of birth: Normal () Premature () Any Complications? _____

Age of Walking _____ Talking _____

Does your child speak words _____ Sentences _____

Any difficulties with Speaking ? _____

Are there any development traits or problems concerning your child that we should know about?

HEALTH

What illnesses has your child had ? (give approximate dates)

| | | | |
|-------|---------------|-------|-----------------|
| _____ | Chicken pox | _____ | Measles |
| _____ | Ear Infection | _____ | Other (specify) |
| _____ | Diabetes | _____ | Scarlet Fever |

Any known allergies ? _____

Has your child ever been hospitalized ? _____

Anything that we need to know or be aware of to help care for your child ? _____

Does your child take any medication on a regular basis? _____

Does any members of your household have any health problem that caused concern for your child ?

If there any other information which might help us understand your child's health ? _____

Does child have frequent ear infection ? _____

EATING HABITS

Any food allergies ? _____

Any food restrictions ? _____

What are your child's favorite foods ? _____

Identify any concerns regarding your child's eating habits. _____

What food do your child dislike ? _____

Does child feed himself? yes () no ()

Does your child drink from a cup ? yes () no ()

TOILETING HABITS

Age at Toilet Training _____

What is usual time ? _____

Word used for Bowel Movement ? _____ Urination ? _____

Do your child have regular Bowel Movements ? _____

Bedwetting Problems: yes () No ()

Does your child need any help with toileting ? yes () no ()

If so, what kind of help ? _____

SLEEPING HABITS

What time does your child go to bed _____ awaken _____

Does your child use an aid for falling asleep ? _____

Does your child take naps ? _____ How long ? _____

Identify concerns regarding your child's sleep routines ? _____

SOCIAL RELATIONSHIPS/INTERESTS

List other group experiences your child has had (other, schools, Sunday School, lessons, etc.)

1. _____ 2. _____

3. _____ 4. _____

Does your child have any special friends ? If so, list their names and ages. _____

Favorite toys and activities at home? _____

What activities does your child seem to dislike ? _____

What makes your child upset ? _____

What frightens your child ? _____

How does your child react to your leaving ? _____

What else could you tell us about your child that would be significant in understanding him/her?

PARENTS ATTITUDES AND INTERESTED

Describe how you would handle your child when he/she is doing something that you do not approve of

What kinds of things do you enjoy doing with your child ? _____

PARENTS ATTITUDES AND INTERESTS CON'T

What do you see as your child strengths and abilities ? _____

In what way can we help your child ? _____

Have child had previous day care? _____

Where: _____

Reason for moving: _____

Dates: _____

Signature (s) of person (s) responsible for child
