Children's Records must be maintained for at least five (5) years after a child has left the program

MAKING A DIFFERENCE STEP BY STEP LLC
CHILD DAY CENTER ENROLLMENT PACKET
FACE SHEET

*PHOTO OF CHILD
(*Optional)
PLUS
PHYSICAL
DESCRIPTION

Eye Color _____
Hair Color _____ Sex_____
Height _____ Weight _____
Other:_____
_____
_____
_____
_____

Please fill out these forms completely. If a question does not apply to your child, write N/A.
The forms must be in the educator's possession on or before the first day your child begins care.
Please notify your educator if any of the information changes.

General Information

Date of Admission:_____ Age at Admission: _____

Date of Discharge:_____

Reason for Discharge: _____
_____

Child's full Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip:_____

Telephone Number:_____ Nickname:_____

Primary Language of Child:_____ Primary Language of Parents:_____

Allergies/Special Diets:_____

Name of Parent(s)/Guardian(s):_____

Home address (if different):_____

Telephone Number:_____

Email Address:_____

Parent(s)/guardian(s) employment address:

Parent/Guardian: _____
Employer: _____
Home Phone: _____
Cell Phone: _____
Instructions: _____

Parent/Guardian _____
Employer: _____
Home Phone:_____
Cell Phone:_____
Instructions:_____

Emergency Contact/Authorized pick-up person

In the event of an emergency when I may not be reached, the Director/Teacher/Staff of the Child Day Center may contact the following individuals (in the order given) whom I have authorized to pickup my child from the child care premises.

(1) Name:_____ Address_____
Home Phone_____ Cell Phone _____
(2) Name: _____ Address _____
Home Phone _____ Cell Phone _____

Child's Name _____

TRANSPORTATION PLAN / AUTHORIZED PICK- UP

My child will arrive to the program by:	My child will depart the program by:
__Parent Drop-Off	__Parent Drop-Off
__Supervised Walk	__Supervised Walk
__Unsupervised Walk	__Unsupervised Walk
__Public/Private Van	__Public/Private Van
__Bus	__Bus
__Private Transportation Provided by Parent	__Private Transportation Provided by Parent

In the space below, please note any important information regarding transportation of your child to and from the Child Day Center (i.e.--indicate who will be supervising child/ren during transport or prior to their arrival at the Child Day Center, who supervises the walk from a bus stop, etc.)

_____

_____

_____

_____

I additionally authorize the following individuals to pickup my child from the Child Day Center premises. (Please let me know at the beginning of the day when your child will be picked up by one of the authorized individuals.)

Name _____ Address _____

Home Phone _____ Cell Phone _____

Name _____ Address _____

Home Phone _____ Cell Phone _____

Anticipated Days/Time of Attendance

Day	Arrival Time	Departure Time	Day	Arrival Time	Departure Time
Monday	_____	_____	Friday	_____	_____
Tuesday	_____	_____	Saturday	_____	_____
Wednesday	_____	_____	Sunday	_____	_____
Thursday	_____	_____			

If applicable: Name of School Child Attends: _____

□ Copies of any custody agreements, court orders, restraining orders (if applicable)

****Please keep in mind that the Child Day Center is not a point of exchange****

Notes: _____

_____

_____

Child's Name _____

Written Acknowledgement of Receipt of Parent Handbook

I acknowledge that I have received a copy of the provider's parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook).

_____ _____
Parent/Guardian Date

Parental Visit Notice

I understand that I may visit this Child Day Center unannounced at any time during the hours that my child is in care.

_____ _____
Parent/Guardian: Date:

Child's Physician or Health Care Professional

Name: _____ Telephone: _____

Address:_____

Information on allergies, special diets, chronic health conditions, special limitations, concerns including medications child is taking at home/school and possible side effects:

_____
_____
_____
_____

Medical Insurance Information (OPTIONAL)

Subscriber's Name:_____ Policy #:_____

Type of Insurance:_____
[ ] Copy of Insurance Card

Secondary Ins

Subscriber's Name:_____ Policy #:_____

Type of Insurance:_____
[ ] Copy of Insurance Card

Parent/Guardian initials: _____

Child's Name _____

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed Child Day Center require this information to be on file to address the needs of children while in care.

CHILD'S NAME _____ DATE OF BIRTH _____

*Note: Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child.

DEVELOPMENTAL HISTORY

Age began sitting _____ crawling _____ walking _____ talking _____
*Does your child pull up? _____ *Crawl? _____ *Walk with support? _____
Any speech difficulties?_____
Special words to describe needs _____
Language spoken at home _____*Any history of colic? _____
*Does your child use pacifier or suck thumb? _____ *When? _____
*Does your child have a fussy time? _____ *When?_____
*How do you handle this time? _____

HEALTH

Any known complications at birth? _____
Serious illnesses and/or hospitalizations: _____
Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:

_____

_____

Regular medications: _____

EATING HABITS

Special characteristics or difficulties: _____
*If infant is on a special formula, describe its preparation in detail _____
_____
Favorite foods:_____
Foods refused: _____
* Is your child fed held in lap? _____ High chair? _____
* Does your child eat with Spoon? _____ Fork? _____ Hands?_____

TOILET HABITS

*Are disposable or cloth diapers used? _____
*Is there a frequent occurrence of diaper rash? _____
*Do you use: baby oil _____ powder _____ lotion _____ Other _____
*Are bowel movements regular? _____ how many per day? _____
*Is there a problem with diarrhea? _____ Constipation? _____

*Has toilet training been attempted? _____
*Please describe any particular procedure to be used for your child at the program:

_____
What is used at home? Potty-chair? _____ special child seat? _____ regular seat? _____
How does your child indicate bathroom needs (include special words): _____
Is your child ever reluctant to use the bathroom? _____
Does the child have accidents? _____

SLEEPING HABITS

*Does your child sleep in a crib? _____ Bed? _____
Does your child become tired or nap during the day (include when and how long)? _____
_____

Please Note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your educator. Your educator will place your infant on his/her back unless there is a written physician's order that specifies otherwise.

When does your child go to bed at night? _____ and get up in the morning? _____ Describe any special characteristics or needs (stuffed animal, story, mood on walking etc) _____
_____

SOCIAL RELATIONSHIPS

How would you describe your child:_
_____
Previous experience with other children/child care: _____
Reaction to strangers: _____ Able to play alone: _____
Favorite toys and activities:_____
_____
Fears (the dark, animals, etc.): _____
_____
How do you comfort your child:_____
What is the method of behavior management/discipline at home: _____
_____
What would you like your child to gain from this child care experience?_____
_____

DAILY SCHEDULE: Please describe your child's schedule on a typical day.
***For Infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.**

_____
_____
_____
Is there anything else we should know about your child?_____
_____
_____

Parent/Guardian Signature:_____ Date: _____ Page |

Permissions (for each child enrolled)

General Permission- (Basic Transport) (Parents should not sign this permission unless specific places where your child is allowed to go are listed by your Director) By signing this form, I am allowing my child to be taken off the child care premises.

I, hereby give the Director/Teacher/Staff of the Child Day Center permission to take my child _____

_____ off the premises of the Child Day Center for the following excursions:

(specific places your child is allowed to go): Nature walks, Near by Park, Field Trips and Walks

_____

We will be using the following forms of transportation: Walking and Van Ride

_____

_____ _____

Parent/Guardian Signature Date

I do not want my child to be taken off the Child Day Center's premises.

_____ _____

Parent/Guardian Signature Date

Permission - (Transport to Medical Facility and Receive Emergency Medical Treatment)

Medical Emergency Treatment (Department of Social Services recommends checking with your local hospital about the acceptability of this statement)

I, hereby give the Director/Teacher/Staff of the Child Day Center permission to administer basic first aid

and/or CPR to my child _____, and/or take my child to a hospital for medical

treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____

Parent/Guardian Signature Date

Topical Medication/Ointments (Please list only those medications/ointments which you will allow the Director/Teacher/Staff of the Child Day Center to administer to your child's skin): Ex: sunscreen, insect repellent (bug spray), diapering ointment.

_____

_____

_____ _____

Parent/Guardian Signature Date

Child's Name _____

Emergency Card Information

REMINDER: This emergency card information is for the educator's first aid kit. The educator(s) must take first aid materials when leaving the childcare premises.

Child's Name:_____ Date of Birth:_____

Child's Home Address:_____
_____ Phone: _____

Instructions to Reach Parent or Guardian

1._____
(Name, Address, Home and Cell Phone #)

2._____
(Name, Address, Home and Cell Phone #)

Contact Information for Physician or Health Care Professional

1._____
(Physician's Name, Address, Phone #)

Emergency Contact Person(s)

1._____
(Name, Address, Home and Cell Phone #)

2._____
(Name, Address, Home and Cell Phone #)

Emergency Medical Treatment

I hereby give Director/Teacher/Staff of the Child Day Center permission to administer basic first aid

and/or CPR to my child _____ and/or take my child _____, to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____
Parent/Guardian Date

Medical Insurance Information (Optional)
Subscriber's Name:_____
Type of Insurance:_____
Policy Number:_____
[ ] Copy of insurance card Other pertinent medical information:_____
_____
_____

OFFICE USE ONLY
IDENTITY VERIFICATION

If proof of identity is required and a copy is not kept, please fill out the following.

Place of Birth:_____ Birth Date:_____

Birth Certificate#:_____ Date Issued:_____

Other Form of Proof:_____ Date Documentation Viewed:_____

Person Viewing Documentation:_____

Date of Notification of Local Law-Enforcement Agency (when required proof of identity is not

provided):_____ Date:_____

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placing agency (foster care and adoption agencies), record from a public school in Virginia, certification by a principal or his designee of a public school in the U. S. that a certified copy of the child's birth record was previously presented or copy of the entrustment agreement conferring temporary legal custody of a child to an independent foster parent. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia and the center assumes responsibility for the child directly from the school (i.e., after school program) or the center transfers responsibility of the child directly to the school (i.e., before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Section 63.2-1809 of the Code of Virginia states that the proof of identity, if reproduced or retained by the child day program or both, shall be destroyed upon the conclusion of the requisite period of retention. The procedures for the disposal, physical destruction or other disposition of the proof of identity containing social security numbers shall include all reasonable steps to destroy such documents by (i) shredding, (ii) erasing, or (iii) otherwise modifying the social security numbers in those records to make them unreadable or indecipherable by any means. **032-05-252/11 (06/05)**