



Email _____

1133 Rock Springs Road
Smyrna, TN. 37167
615-223-7413

Young Child's Application



(All information is required and must be completed by the parent(s) or legal custodian(s) / if unknown use N/A or none until it can be added later and initialed)

Child's information:

Child's birth date _____ Date of admission _____
Full name of child _____ What does the child like to be called _____

Parent's information:-

Mother's name _____ Father's name _____
Address: _____ Address: _____
Phones: Home _____ Work _____ Phones: Home _____ Work _____
Where employed: _____ Hours _____ Where employed: _____ Hours _____
Mom's S.S. # _____ Dad's S.S. # _____
Custodial Parent if divorced _____ (Provide the child care a copy of the custody order) yes _____ no _____

Persons authorized to pick up and transport the child other than parent or custodian: [Give full name and phone number of the person whom the child may be released. They must be listed below to insure the child's safety. A phone call is not acceptable permission of the parent(s) or custodian(s)]:

Emergency Information:

1) Name of person(s) and the phone numbers, other than the child care staff, authorized to act for parent in an emergency _____

Address _____ Home phone _____ Work phone _____
Employer _____ Work hours _____

2) Name of person(s) and the phone numbers, other than the child care staff, authorized to act for parent in an emergency _____

Address _____ Home phone _____ Work phone _____
Employer _____ Work hours _____

Name of Physican: _____ Office phone _____ Home phone _____

Medical association and address: _____ Chart # _____

Special written doctor's instructions for care or medical treatment given the child care: _____

To whom any medical training and/or instructions and permission given: _____

Any food, environmental and/or medical **allergies:** _____

Other children and members of the family:	Birthdate	School / Work
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Eating Habits:

At what time does the child eat breakfast? _____ Dinner/lunch? _____ Dinner/supper? _____

Between meal snack? _____ Does he feed himself? _____ What is the child's general attitude toward eating? _____

Does the child refuse to eat? _____ How is this handled and by whom? _____

The child's favorite foods: _____

[If your child is an infant, use a separate sheet for information about the formula, bottle schedule, etc. The parent must work closely with the child care facility while introducing new baby foods and table foods to the child.]

Potty Training:

Is your child potty trained? _____ Does your child need assistance using the bathroom? _____

DEVELOPMENTAL HEALTH HISTORY

(Infants - Young Children)

PHYSICAL HISTORY

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

What health problems does your child have now? _____

Other Than What You Listed Above:

Does your child have any allergies? If so, to what? _____

How severe? _____

Does your child take any medication regularly? If so, what and when? _____

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? _____

DEVELOPMENTAL (compared to children this age)

Does your child have any problems with talking or making sounds? Please explain. _____

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 her or his hands (such as with puzzles, small building pieces)? Please explain. _____

DAILY LIVING

What is your child's typical eating pattern? _____

Is your child on any special diet? Please describe. _____

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

How well does your child use table utensils (cups, fork, spoon)? _____

How does your child indicate bathroom needs? _____

Word(s) for urination: _____

Words for bowel movement: _____

Special words for body parts: _____

What are your child's regular bladder and bowel patterns? Do you want us to follow a particular plan for toileting? _____

For toddlers, please describe use of diapers or toileting equipment (such as potty, toilet seat adapter). _____

What are your child's regular sleeping patterns?

Awakes at _____ Naps at _____ Goes to bed at _____

What help does your child need to get dressed? _____

SOCIAL RELATIONSHIPS / PLAY

