



Shining Stars Childcare

Application Form

7_2015

Child's name _____

Nickname _____

Child's age _____

Child's date of birth _____

Date _____

Address _____

Mother's Name _____

Father's Name _____

Mother's Home Phone _____

Mother's Work Phone _____

Mother's Cell Phone _____

Father's Home Phone _____

Father's Work Phone _____

Father's Cell Phone _____

Mother's Email Address _____

Father's Email Address _____

Mother's Driver's License # _____ Mother's SS # _____

Father's Driver's License # _____ Father's SS # _____

Parents are:

- Married
- Divorced
- Separated
- Single

Mother's Employer

Name _____

Address: _____

Telephone: _____ Ext: _____

Hours of employment are from _____ a.m. To _____ p.m.

Father's Employer:

Employer _____

Address _____

Telephone _____ Ext _____

Hours of employment are from _____ a.m. To _____ p.m.

Beginning date care is needed _____

Has your child ever been in child care before? Yes No

What type? (center, family daycare, grandma etc.) _____

Was it a positive experience? Yes No

Experience Comments: _____

Will you be giving a two week notice to your current childcare provider? Yes No

Why are you looking for child care?

Are there any areas you would like to see your child working on? Yes No

Comments: _____

What is your method of discipline?

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

What are some of your child's favorite activities?

Are there any food restrictions? Yes No

List restrictions: _____

Does your child have any special needs or concerns? Yes No

Comments: _____

What are your child's napping habits?

What are your hopes/expectations for your child while attending Shining Stars Child Care?

Is someone available to pick up your child by closing time? Yes No

Do you have a backup care provider? Yes No

CHILD'S HEALTH RECORD: (A copy of your child's immunizations 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? Yes No

(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? Yes No

Are you concerned that your child may be prone to any type of allergies? Yes No

Describe: _____

Does your child have any medical conditions which we should be made aware of? Yes No

Has your child had any of the following childhood diseases or conditions listed below?

(Please check any that apply)

- Constipation Yes No
- Asthma Yes No
- Convulsions Yes No
- Bronchitis Yes No
- Diarrhea Yes No
- Chicken Pox Yes No
- Fainting Spells Yes No
- Diabetes Yes No
- Frequent Colds Yes No
- Heart Disease Yes No
- Frequent Ear Infections Yes No
- Hepatitis Yes No
- Frequent Sore Throats Yes No
- Impetigo Yes No
- Lice Yes No
- Measles Yes No
- Ringworm Yes No
- Mumps Yes No
- Skin Rash Yes No
- German Measles Yes No
- Soiling Yes No
- Polio Yes No
- Stomach Upsets Yes No
- Scarlet Fever Yes No
- Urinary Problem Yes No
- Tuberculosis Yes No
- Worms Yes No
- Whooping Cough Yes No

Does your child have any speech, hearing or visual problems? Yes No

Explain: _____

Does your child have any IEP's? Yes No (If yes, please provide us with documentation).

Has your child ever been tested for the above? Yes No

Has your child ever had any surgeries or do they have any prosthetic limbs etc.? Yes No

If yes, please describe: _____

Does your child have any restrictions to play or activities? I.e. is your child handicapped, allergic to grass, etc. Yes No

Age your child began to: Sit _____ Crawl _____ Walk _____

Age your child began to: Talk _____ Any difficulties with speech? Yes No

If yes, please specify: _____

Have you made any special arrangement for child's care during their illness? Yes No

Please specify _____

Child's favorite color _____

Child's favorite song _____

Does your child know:

Basic geometric shapes? Yes No

ABC's Yes No

Colors Yes No

Numbers Yes No

Does your child eat with a Spoon _____ Fork _____ Hands _____ (check all that apply)

Is your child able to indicate bathroom needs? Yes No

Does your child have any fears related with toileting? Yes No

Does your child have any "accidents"? Yes No

What words does your child use for: Bowel movements _____ Urination _____

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? Yes No

Comments _____

Please give a brief description of your child's disposition. Is he/she friendly by nature, aggressive, shy, withdrawn, imaginative, demanding? Etc.

How does your child show his/her feelings?

When afraid: _____

When happy: _____

When angry: _____

When intolerant: _____

What forms of discipline are most often used in child's home? _____

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

What language(s) are spoken at home? _____

Does your child have any security objects such as a blanket, soother, bottle, toy etc. ? Yes No

Comments: _____

How does your child behave when he is sick? _____

How is your child most easily settled when upset or afraid? _____

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? Yes No

Have you read and agree to abide by the policies in our handbook? Yes No

Are you in agreement with our payment policies and procedures? Yes No

Any specific concerns? Yes No

Comments: _____

In the next 30 - 60 days, would you like to conference about your child's enrollment, (A get to know you meeting)? _____

(Every six months and at any time during enrollment you can set up a meeting to discuss your child's developmental progress).

Parent Signature: _____

Parent Signature: _____

REFERRAL SOURCES (Please check all that apply)

Advertisement

Drive-by Sign

Local Bulletin

Flyer

Newspaper

Shining Stars Child Care Website

Referral - Name: _____

Parental Referral - Parent's Name: _____

Center Referral - Employee Name: _____

Subsidy Program Referral

Dept. Hum. Res