

# KIDDO'S ACADEMY



Our business is all about your child



Date: \_\_\_\_\_

Mom's name:		Dad's name:		Child's name:	
Child's Birthday		Child's age:		Nickname:	

**Mother's Information**

Home Phone:		Cell Phone:		Work Phone:		Email Address:	
Address:				City:		State:	Zip Code:
Social Security Number:		Driver License Number:		Parents are?			
				<input type="checkbox"/> Married		<input type="checkbox"/> Divorced	
Employers Name:		Employers Telephone:		<input type="checkbox"/> Separated		<input type="checkbox"/> Widowed	
				<input type="checkbox"/> Single			
Employers Address:				City:		State:	Zip Code:

**Hours:**  
 Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_  
 Thursday \_\_\_\_\_ Friday \_\_\_\_\_  
 Saturday \_\_\_\_\_ Sunday \_\_\_\_\_

**Father's Information**

Home Phone:		Cell Phone:		Work Phone:		Email Address:	
Address:				City:		State:	Zip Code:
Social Security Number:		Driver License Number:		Employers Name:		Employers Telephone:	
Employers Address:				City:		State:	Zip Code:

**Hours:**  
 Monday \_\_\_\_\_ Tuesday \_\_\_\_\_ Wednesday \_\_\_\_\_  
 Thursday \_\_\_\_\_ Friday \_\_\_\_\_  
 Saturday \_\_\_\_\_ Sunday \_\_\_\_\_

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Times you plan to drop your child off	Times you plan to pick up your child
Is there anyone besides you or your husband that will be picking up your child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please list their Names?
<b>We will need a call the day of the pickup to let us know. This is for your child's protection.</b>	

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

Why are you looking for childcare? \_\_\_\_\_

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

Are there any areas you would like to see your child working on? \_\_\_\_\_

What is your normal 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? \_\_\_\_\_

Does your child have any special needs or concerns? \_\_\_\_\_

What are your child's napping habits? \_\_\_\_\_

What are your hopes/expectations for your child here? \_\_\_\_\_  
\_\_\_\_\_

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

Do you have a backup care provider? \_\_\_\_\_

**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:	Doctor's name:	Doctor's phone number:
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Doctor's name:	Doctor's phone number:	Dentists' name	Dentists' phone number:
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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  
 If Yes Describe:  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Does your child have any medical conditions which we should be made aware of?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any specific concerns?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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**Has your child had the following common childhood illnesses? (Please circle)**

**Does your child have any problems with any of these?**

- Constipation
- Convulsions
- Diarrhea
- Fainting Spells
- Frequent Colds
- Frequent Ear Infections
- Frequent Sore Throats
- Lice
- Ringworm
- Skin Rash
- Soiling
- Stomach Upsets
- Urinary Problem
- Worms

**Has your child had any of these diseases?**

- Asthma
- Bronchitis
- Chicken Pox
- Diabetes
- Heart Disease
- Hepatitis
- Impetigo
- Measles
- Mumps
- German Measles
- Polio
- Scarlet Fever
- Tuberculosis
- Whooping Cough

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

If yes, please describe:

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

If yes, please describe:

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

If yes, please describe:

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Would there be any restrictions to play or activities? I.e. is your child handicapped, allergic to grass, etc.

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Age your child began to: Sit \_\_\_\_\_, Crawl \_\_\_\_\_, Walking \_\_\_\_\_

Age your child began to: Talk \_\_\_\_\_ Any difficulties with speech?  Yes  No.

If yes to above question, please specify: \_\_\_\_\_  
\_\_\_\_\_

Have you made any special arrangement for child's care during illness?  Yes  No  
Please specify: \_\_\_\_\_

What is your child's favorite food? \_\_\_\_\_

What food does your child dislike? \_\_\_\_\_

Child's favorite color \_\_\_\_\_ Child's favorite song \_\_\_\_\_

Does your child know the basic shapes  ABC's  colors  numbers others \_\_\_\_\_

Does your child eat with a  spoon  fork  hands other \_\_\_\_\_ (check all that apply)

Can your child be relied upon to indicate bathroom wishes?  Yes  No

Does your child have any fears related with toileting?  Yes  No  
If yes, please describe: \_\_\_\_\_

Does your child have any "accidents"? \_\_\_\_\_

What words does your child use for: Bowel movements \_\_\_\_\_ urination \_\_\_\_\_?

What words does your child use for describing his private parts? \_\_\_\_\_

What time does your child awaken? \_\_\_\_\_

What time does your child go to sleep at night? \_\_\_\_\_

Do they sleep through the night? \_\_\_\_\_

Does your child sleep in a bed or crib, other? \_\_\_\_\_

Does your sleep alone or with someone else? \_\_\_\_\_



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**Are there any siblings? Please name them and specify ages and gender.**

Name \_\_\_\_\_ age \_\_\_\_\_ gender  Male  Female

Name \_\_\_\_\_ age \_\_\_\_\_ gender  Male  Female

Name \_\_\_\_\_ age \_\_\_\_\_ gender  Male  Female

Has your child had experience playing with other children?  Yes  No

Please give a brief description of your child's disposition. Is he friendly by nature, aggressive, shy, withdrawn, imaginative, and 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?  
\_\_\_\_\_  
\_\_\_\_\_

How does your child feel about daycare and being left by his/her mommy/daddy?  
\_\_\_\_\_

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.?  
\_\_\_\_\_

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How does your child behave when he is sick?

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

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What are your child's favorite activities, toys, books, or games?

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Are there any other comments or information you would like to let me know about?

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Have you read Kiddo's Academy policies and handbook?  Yes  No

Are you in agreement with Kiddo's Academy payment policies and procedures?  Yes  No

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

## Referral Sources (Please circle all that applies)

### ADVERTISEMENT

- Drive-by Sign
- Local Bulletin
- Flyer
- Newspaper
- Internet

### REFERRAL

- Parental Referral
- Center Referral
- FIP Referral
- Subsidy Program Referral
- Dept. Hum. Res