



Child Enrollment Information

Complete one form per child

Parent Name	Parent Name
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Child Name (First, Last)	Age Group	Classroom	Start Date	Weekly Rate		
	<input type="checkbox"/> Toddler	<input type="checkbox"/> Toddler 1		\$		
Birthdate	<input type="checkbox"/> Preschool	<input type="checkbox"/> Toddler 2	<input type="checkbox"/> Agency Reimbursement Agency _____			
	<input type="checkbox"/> Pre-K/ Kindergarten	<input type="checkbox"/> Preschool <input type="checkbox"/> Pre-K/Kinder				
<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thu	<input type="checkbox"/> Fri	<input type="checkbox"/> Full-Day	<input type="checkbox"/> Half-Day

Getting to know your child

Child's Nickname _____ Age _____ Lives with whom _____

Any siblings? _____ Any Pets? _____

Primary Language _____ Vocabulary/Speech Clarity _____

Describe any IEP or IFSP or Therapy _____

Describe any developmental delays _____

Any recent assessment done? YES NO Can we do an ASQ assessment with your child? YES NO

Has child been in a daycare before? Where and how long? _____

How did that go? _____

Your child's likes and dislikes _____

What is calming to your child? _____

What is upsetting to your child? _____

List some favorite things _____

Does your child have a regular bedtime schedule? YES NO

What time does your child usually go to bed at night? _____ And wake up in the morning? _____

Is your child used to napping? _____

Has your child had or does your child currently have any known health problems? YES NO

If yes, please describe:

What is your educational goal for your child over the next 6 months?

What is your social emotional or developmental goal for your child over the next 6 months?

Is there anything specific you need help from us in working with your child?

Does your child have any special needs or temperaments that need accommodation?