# Oliver Day School

## Child's Enrollment Form

Child's Name ______________________________ DOB __________________

Home Address ____________________________________________________

Telephone _____________________ Primary Language ____________________

Date of Admission _______________________ Age at Admission ____________

Identifying marks ______________________________

Allergies/Special Diets ________________________________________

## Parent/Guardian Information

Parent/Guardian Name:_______________________

Relation to Child:___________________________

Email: ____________________________________

Home phone: ______________________________

Cell Phone: _______________________________

Business name: _____________________________

Business address:____________________________

Business telephone: __________________________

Parent/Guardian Name:_______________________

Relation to Child:___________________________

Email: ____________________________________

Home phone: ______________________________

Cell Phone: _______________________________

Business name: _____________________________

Business address:____________________________

Business telephone: __________________________

## Additional Information

Child's physician/clinic: ______________________________

Address: ______________________________

Chronic health conditions: ______________________________

______________________________

Special limitations or concerns:

______________________________

______________________________

**Parent/Guardian Signature** ______________________ **Date** __________

## Toilet Habits

If your child is still in diapers, is there a frequent occurrence of diaper rash? __________

If yes, what do you use to treat it? Oil: _____ Powder: _____ Lotion/Cream: ____

Are bowel movements regular? ______ How many per day? __________

Is there a problem with: Diarrhea: __________ Constipation: __________

Has toilet training been attempted? __________

If yes, does your child use: Potty Chair __________ Child seat _______ Regular Seat ________

If yes, please describe methods/words used to train your child

______________________________

______________________________

How does your child indicate bathroom needs?: ______________________________

Is your child reluctant to use the potty?: ______________________________

Does your child have accidents? ______________________________

How does your child react? ______________________________

## Sleeping Habits

Does your child sleep in a: Bed__________ Crib:__________

Does your child take naps at home? ______________________________

If yes, what time and how many times a day? ______________________________

What time does your child: Go to bed __________ Wake up __________

Any known health complications at birth? ____________________

Any history of colic? ____________ If yes, is it still present? ____________

Any serious illnesses or hospitalizations? ____________________

Any special physical conditions or disabilities? ____________________

Any allergies or asthma? ____________________

If yes, what is used for treat reactions? ____________________

***Please make sure a medication authorization is signed and medication is at the center***

Is your child on any regular medications (prescribed or over the counter?) ____________

If yes, please list :____________________

## Eating Habits

Special characteristics difficulties or diet restrictions: ____________________

Food allergies: ____________________

If infant is on a special formula, please describe in detail the preparation:

____________________

____________________

Favorite foods: ____________________

Foods refused: ____________________

Does your child eat in: Your Lap_______ High chair: _______ Booster seat: _________

Does your child eat with: Hands ____________ Spoon __________ Fork ____________

## Developmental History And Background Information

***Regulations for licensed child care facilities require this information to be on file to address the needs of your child while in our care***

Childs name ____________________ DOB ____________________

***Please provide information as it pertains to your child currently***

## Developmental History

Age began: Sitting _____________ Crawling ___________ Walking __________ Talking ___________

Does you child: Pull self up ________ Crawl _______ Walk supported ______ Unsupported _______

Does your child: Use a pacifier ________ Suck thumb ________ If so, when? ________________

Does your child have a fussy time? ___________ If so, when? ____________________

Do you have any special routines required to go to sleep?

______________________________________________________________

______________________________________________________________

## Social Relationships

How would you describe your child?

______________________________________________________________

______________________________________________________________

Previous, if any, experiences with any other children?

______________________________________________________________

______________________________________________________________

How does your child react to new people?

______________________________________________________________

______________________________________________________________

Does your child have any fears we should know of (animals, noises, the dark etc?)

______________________________________________________________

______________________________________________________________

What methods are used to help calm your child?

______________________________________________________________

______________________________________________________________

What methods of discipline are used at home?

______________________________________________________________

## Daily Schedule

Please describe your child's schedule on a typical day. For infants and toddlers, please include sleeping, eating, changing times, etc.

______________________________________________________________

______________________________________________________________

______________________________________________________________

Is there anything else that you think we should know about your child?

______________________________________________________________

______________________________________________________________

**Parent/Guardian Signature** ______________________ **Date** ________________

## Health Information

How is this handled at home?

______________________________________________________________________

______________________________________________________________________

What language is spoken at home? ____________________________________________

Does your child have any speech difficulties? ____________________________________

Does your child use any special words to describe needs? If so, please list what they are and what they may request:

______________________________________________________________________

______________________________________________________________________

**Parent/Guardian Signature** ______________________________ **Date** ________________