

VALLEY CHILD CARE
93 Leddy Street
Buffalo, New York 14210
Phone: 823-8299 Fax: 823-4254

REGISTRATION FORM

CHILD INFORMATION

Name: _____
Birthdate: _____ Sex: _____
Does your child attend a Child Care Center now: _____
Where? _____

FAMILY INFORMATION

Mother's Name: _____
Address: _____
Home phone: _____ Cell Phone: _____
Place of Employment: _____
Work number: _____ Work Hours: _____

Father's Name: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Place of Employment: _____
Work Number : _____ Work hours: _____

Marital Status (Please Check One)

Single Married Separated Divorced Spouse deceased

If single or separated, who has custody of the child? _____

Other members living in the household:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
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HEALTH HISTORY

Was your child carried to full term or born premature? _____

Were there any complications at delivery? _____

Please Explain: _____

What was your child's birth weight? _____

Has your child had any childhood diseases or other illnesses? _____

Please Explain: _____

Has your child ever been hospitalized? _____

How long and for what? _____

Has your child had any of the following?

Ear infections _____ Allergies _____

Nose Bleeds _____ Broken bones _____

Sore Throat _____ Stomach Pains _____

Swollen ankles _____ Weight Loss _____

Pneumonia _____ Jaundice _____

Pain during urination _____ Convulsions _____

Dizzy Spells _____ Headaches _____

DEVELOPMENTAL HISTORY

At what age did your child first:

Sit Alone _____ Walk _____

Dress Alone _____ Say Sentences _____

Say Single Words _____ Toilet Train _____

Does your child exhibit any fears: _____

EMERGENCY MEDICAL RELEASE

Please give _____

Whatever medical care is reasonable in my absence.

Parent _____ Date _____

Allergies _____

Doctor's Name and Phone Number _____

Hospital _____

CHILD SURVEY AND INFORMATION FORM

Child's Name _____ Nickname _____

Age _____ Allergies _____

Describe your child's personality _____

Scheduled days to attend day care _____

Name and Ages of Brothers

Name and ages of Sisters

Has your child been cared for by anyone other than parents? _____

Has your child previously attended a day care before? _____

Does your child use the restroom independently? _____

Does your child need help dressing or undressing? _____

Does your child take a nap? _____

Does your child have any special fears? _____

Does your child have anything particular that makes them happy? _____

Does your child dislike any particular foods? _____

Does your child require any special medical care? _____

Please Explain: _____

Does your child have any history of physical impairment? _____

Visual problems? _____ Speech problems? _____ Hearing Problems _____

Please Explain _____

Current prescribed medication _____

PLAY EXPERIENCES

Favorite games _____

Favorite Toys _____

Outdoor fun _____

With other children _____

Books _____

Favorite TV Show _____

Other _____

VALLEY CHILD CARE RELEASE FORM

1. In the event of an accident or injury, I give permission for my child to be treated in a hospital if I cannot be reached. _____ Parent Initials

2. In the event of an emergency, when I am not able to be reached please contact:

Contact #1 Name: _____
 Relationship: _____
 Phone Number(s): _____

Contact #2 Name: _____
 Relationship: _____
 Phone Number(s): _____

3. I authorize the use of my child's photographs for advertising publicity purposes.

4. Name of person(s) allowed to pick up my child from school:

5. Name of person(s) NOT ALLOWED to pick up my child from school:

Parent Signature _____

Date: _____