101 Central Avenue • Clifton, New Jersey 07011 • (973)772-1100 • (973)772-0979 (Fax)

Please Print –Fill IN ALL INFORMATION-INCOMPLETE FORMS WILL NOT BE ACCEPTED

Child's Name_____
First Middle Last

Date of Birth_____/ _____/ _____ Male _____ Female _____

Nickname_____

Home Address_____
Street

_____
City State

Home Phone # _(____)_____- _____

Is your child adopted? _____ Age of Adoption _____

PARENT / GUARDIAN 1 INFORMATION

Name_____
First Middle Last

Home Address_____
Street

_____
City State Zip Code

SS#_____-_____-_____ Home Phone #_____

Employer Name & Address_____
Street

_____
City State Zip Code

Employers Telephone Number & Extension_____ Ext._____

PARENT / GUARDIAN 2 INFORMATION

Name_____
First Middle Last

Home Address_____
Street

_____
City State Zip Code

SS#_____-_____-_____ Home Phone #_____

Employer Name & Address_____
Street

_____
City State Zip Code

Employers Telephone Number & Extension_____ Ext._____

* If either parent is a student, please list the name of the school attending and a phone number of the school in the box provided for Employer's Information. Please make sure that the director is given a current schedule at the beginning of each semester or school year.

Emergency Contacts & Allowed Pick-Up List (Please attach an additional list if necessary)

Name (Please Print)	**Relation to Child**	**Phone Number**	**Pick-Up**	**Emergency Contact**
1.			Yes / No	Yes / No
2.			Yes / No	Yes / No
3.			Yes / No	Yes / No
4.			Yes / No	Yes / No
5.			Yes / No	Yes / No

EMERGENCY INFORMATION

In case of an emergency (sudden illness or accident), please provide us with where you may be contacted during school hours, and the name of your family physician. If you or your physician can not be reached within a reasonable time, we will contact 911.

Please list below where you can be contacted during school hours, and name and telephone number of your family physician.

Contact Parent_____ Phone #_____

Physician_____ Phone # _____

Hospital Affiliation_____

I have read and understand the above statement concerning procedures to be followed in the event of medical emergency. I consent to this procedure and further agree that I will be responsible for payment of all medical bills incurred.

Parent/Guardian Signature: _____ Date: _____

HEALTH INSURANCE INFORMATION

Name of Person(s) Insured _____

_____

Name of Insurance Carrier _____

Identification / Policy Number _____

Family & Social History

Name of Child: _____ D.O.B._____

Mother/ Guardian: _____ Age: _____

Father/ Guardian: _____ Age: _____

Race: _____ Language spoken at home: _____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced

( ) Remarried Name: _____ ( ) Widow

Custody/ Visiting Arrangements:

_____

_____

_____

Sibling of Child:

Name: _____ Age: _____ In school? _____

Name: _____ Age: _____ In school? _____

Name: _____ Age: _____ In school? _____

Name: _____ Age: _____ In school? _____

Step family or other member of the household:

Name: _____ Age: _____ Relationship? _____

Name: _____ Age: _____ Relationship? _____

Name: _____ Age: _____ Relationship? _____

Indicate if your child has or had any of the following illness below, and if so at what age did it start or what age did it occur:

Chicken Pox: _____
Diabetes: _____
Scarlet Fever: _____
Hepatitis: _____
Mumps: _____
Measles: _____
Strep Throat: _____
Other: _____
Other: _____

Does your Child have frequent: **Circle Yes or No**
Colds: Yes / No
Stomach Aches: Yes / No
High Fevers: Yes / No
Unusual Range of fever: Yes / No If yes, please indicate how high it can get:
_____
Has your child had any serious accident? If yes, explain:
_____
_____

Has your child ever been hospitalized? If yes, explain:
_____
_____

Please indicate what the child is allergic to and how does it manifest itself when allergy occurs

Food Allergies:
_____
_____

Medication Allergies:
_____
_____

Seasonal Allergies:
_____
_____

Contact Allergies:
_____
_____

OTHER: _____

At what age did (or was) your child:

Walk Alone? _____

Name Simple Objects: _____

Sleep through the night: _____

My child is: ( ) Right handed ( ) Left handed

Toilet Trained: _____

List word used for urination: _____

List word used for bowel movements: _____

Does Child:

Dress themselves: Yes / No

Undress themselves: Yes / No

What times does your child eat: Breakfast? _____ Lunch? _____ Dinner? _____

Does your child have any dietary restrictions or allergies to food?

_____

_____

What time does your child: Go to bed? _____ Awake? _____

Does your child sleep well: Yes / No

Naps, if so how long? _____

What activities does child enjoy: Indoors? _____ Outdoors? _____

Does your child have fears? _____

What method of behavior control is used at home and who discipline child?

_____

Childs Personality, please describe: _____

The purpose of this information is to help the child care staff get to know your child. Your child's care during their attendance at our center is a responsibility we both share!

How did you hear about center? Circle which applies to you.

1. Yellow Pages
2. Internet
3. Flier/Mailer
4. 4c's
5. Other_____

Has your child had any prior experience? _____

If yes,where? _____

Did your child enjoy their daycare experience? _____

Explain:

_____

_____

_____

What do you consider to be your child's assets?

_____

_____

What do you consider to be your child's potential problems?

_____

_____

What do you expect your child to gain from his/her experience at Kidz Place Daycare & Preschool?