# THE LEARNING JOURNEY CHILD CARE CENTER

## Registration Form For Child Care

*(Please complete both sides of this form for each child)*

Date of Enrollment: ___________________________

Name of Child: ______________________________ Birthdate: ____/____/____ Sex: M __ F __
yy mm dd

Full name of Parent(s)/Guardian:

1. ______________________________________________________________

2. ______________________________________________________________

Address:

1. ______________________________________________________________

2. ______________________________________________________________

Telephone Numbers: HOME: 1. ______________________ WORK: 1. _____________________

2. ______________________ 2. _____________________

MOBILE: 1. ______________________

2. ______________________

Place of work: 1. ____________________________________________________________

2. ____________________________________________________________

Care Card Number: __________________________ Family Doctor: __________________________

Phone Number: __________________________

| PERSONS AUTHORIZED TO CALL FOR THE CHILD AND CONTACT IN EMERGENCY: Name | Telephone Number |
|---|---|
| 1. _________________________________________ | __________________________ |
| 2. _________________________________________ | __________________________ |
| 3. _________________________________________ | __________________________ |
| 4. _________________________________________ | __________________________ |

Names of other children in family: ____________________________ Birthdate: ________________

____________________________ (yy/mm/dd) ________________

____________________________ (yy/mm/dd) ________________

Has the child had previous experience away from home? NO ☐ YES ☐ If YES, explain:

______________________________________________________________________________.

Do you think your child feels comfortable leaving parents? NO ☐ YES ☐ If YES, explain:

______________________________________________________________________________.

Special instructions concerning Care, Medication, Diet, or **Custody**:

_______________________________________________________________________________.

NO ☐ YES ☐ ***ATTACH DOCUMENTATION***

## HEALTH HISTORY

Has this child any known health problems or depressed immune system?
NO ☐ YES ☐ - If YES, attach documentation.

List communicable diseases child has had: ________________________________

Has he/she had any recent illness? NO ☐ YES ☐ - If YES: ________________________

Any allergies? NO ☐ YES ☐ - If YES, list ALLERGENS: ________________________
Attach special instructions to follow in the event of an allergic reaction.

What are the child's eating habits? ________________________________

Favorite foods: ________________________________

Strong dislikes: ________________________________

| **Basic Schedule and Record of Immunization as submitted by Parent or Guardian**<br>(ATTACH IMMUNIZATION RECORD OR RECORD THE DATES) | | | |
|---|---|---|---|
| | **Date (yy/mm/dd)** | | **Date (yy/mm/dd)** |
| 1st visit – 2 months of age: | | 4th visit – 12 months of age: | |
| ☐ Diphtheria | ____________ | ☐ Measles | ____________ |
| ☐ Pertussis | ____________ | ☐ Mumps | ____________ |
| ☐ Tetanus | ____________ | ☐ Rubella | ____________ |
| ☐ Polio | ____________ | ☐Meningococcal C | ____________ |
| ☐ Haemophilus Influenzae Type b (Hib) | ____________ | | |
| ☐ Hepatitis B | ____________ | 5th visit – 12 months after 3rd visit: | |
| ☐Pneumococcal | ____________ | ☐ Diphtheria | ____________ |
| | | ☐ Pertussis | ____________ |
| 2nd visit – 2 months after 1st visit: | | ☐ Tetanus | ____________ |
| ☐ Diphtheria | ____________ | ☐ Polio | ____________ |
| ☐ Pertussis | ____________ | ☐ Haemophilus Influenzae Type b (Hib) | ____________ |
| ☐ Tetanus | ____________ | ☐ Measles, Mumps, Rubella | ____________ |
| ☐ Polio | ____________ | ☐Pneumococcal | ____________ |
| ☐ Haemophilus Influenzae Type b (Hib) | ____________ | | |
| ☐ Hepatitis B | ____________ | 4 – 6 years of age: | |
| ☐ Pneumococcal | ____________ | ☐ Diphtheria | ____________ |
| | | ☐ Pertussis | ____________ |
| 3rd visit – 2 months after 2nd visit: | | ☐ Tetanus | ____________ |
| ☐ Diphtheria | ____________ | ☐ Polio | ____________ |
| ☐ Pertussis | ____________ | | |
| ☐ Tetanus | ____________ | Other Immunizations: | |
| ☐ Polio | ____________ | ____________________ | ____________ |
| ☐ Haemophilus Influenzae Type b (Hib) | ____________ | ____________________ | ____________ |
| ☐ Hepatitis B | ____________ | ____________________ | ____________ |
| ☐ Pneumococcal | ____________ | | |

I authorize the child care provider to obtain the following services for this child as necessary: Physician and/or Ambulance in the event of an emergency.

_______________ _______________________ _______________________
Date Signature of Parent/Guardian Signature of Child Care Provider

# PLEASE TELL US ABOUT YOUR CHILD

NICKNAMES: ________________________________________________________________________________

FAVORITE ACTIVITIES: ________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

FAVORITE FOOD: ____________________________________________________________________________

____________________________________________________________________________

LEAST FAVORITE FOOD: _______________________________________________________________________

_______________________________________________________________________

HABITS: ________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

NAPS/SLEEPING

WHAT IS THE USUAL TIME AND LENGTH OF NAPS TAKEN EACH DAY: ______________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

HOW DOES YOUR CHILD LIKE GO TO SLEEP: _____________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

ARE THERE ANY SPECIAL OBJECTS/TOYS YOUR CHILD NEEDS IN ORDER TO GO TO SLEEP: ______________

____________________________________________________________________________________________

____________________________________________________________________________________________

HOW LONG DOES YOUR CHILD USUALLY SLEEP AT NIGHT: _________________________________________

____________________________________________________________________________________________

SPECIAL REQUESTS: ____________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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THANK YOU!

STAFF