IMAGINATION STATION

IMAGINATION STATION EXPRESS

CHILD REGISTRATION FORM

Child's Name: _____ Nickname(s):_____

Birthday: _____

Do you receive assistance with the payment of your bill? _____

If yes, which program assists you? _____

Mother's name: _____Father's name:_____

Soc. Security #: _____ Soc. Security #: _____

Home address: _____ Home address: _____

Home phone #: _____Home phone #: _____

Mother's DOB_____ Father's DOB:_____

Driver's License# _____ Driver's License #_____

Mom's place of employment: _____Work phone#: _____

Dad's place of employment: _____Work phone #: _____

Custody/Visitation Arrangements: _____

Health of child
(Physical examination within the last year is required for admission to the center)

Date of last complete exam: _____ Current state of health: _____

Physician's name: _____ Phone #: _____

Please describe any chronic illnesses: _____

Please describe any accidents or surgeries your child may have had? _____
_____

Does your child get frequent colds? Yes ( ) No ( ) Earaches? Yes ( ) No ( )

Sore throat? Yes ( ) No ( ) Stomach aches? Yes ( ) No ( ) Fevers? Yes ( ) No ( )

Please list any medications the child is currently taking (including Asthma and ADHD medications): _____

Does your child use an inhaler for any reason? Yes ( ) No ( )

Does your child have any special medical, physical, social or emotional needs that the staff should be aware of? _____
_____

Does your child have an IEP? Yes ( ) No ( )

Please list any known or suspected allergies (including allergies to food):_____
_____

Developmental level

Is the child fully responsible for his/her own toileting during the day? Yes ( ) No ( )

Is the child fully responsible for his/her own toileting at night? (no pull-ups/diapers) Yes ( ) No ( ) if not, what does he/she need? _____

Does the child use a bottle during the day? Yes ( ) No ( ) To go to sleep? Yes ( ) No ( )

Does the child use a pacifier? Yes ( ) No ( ) If yes when? _____

(The Anchorage Municipal Code section16.55.400 E: states that an infant shall be held by a caregiver for each bottle feeding, unless the child can hold their own bottle. We will not put a child to bed with a bottle or sippy cup for any reason at any time.)

Has the child been in a day care setting before? Yes ( ) No ( )

How many other children at a time is your child accustomed to being around? _____

Has the child ever been asked to leave another center or home day care? Yes ( ) no ( )

If yes, why? _____

What fears, if any, does the child have? _____

Any nervous habits? _____

Does the child eat without any help? Yes ( ) No ( ) Does your child use a high chair at home? Yes ( ) No ( )

Does the child take an afternoon nap? Yes ( ) No ( ) Approximate length: _____

Does the child use a crib to sleep in at home? Yes ( ) No ( )

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

What does your child eat for breakfast? _____ Lunch: _____

_____ Dinner: _____

How much television does your child watch a day? _____

Are any other languages besides English spoken in your home? Yes ( ) No ( ) If so what are they?
_____

How high can the child count? _____ Can he/she say the ABC's? _____

What form of behavior management do you use at home? _____
_____

Does your child accept correction easily? Yes ( ) No ( )

TODDLERS/PRE-SCHOOL AGED CHILDREN

Do you feel your child speaks clear? Yes ( ) No ( )

Can strangers understand your child speaks? Yes ( ) No ( )

Does your child play well alone? Yes ( ) No ( )

Does your child play well with others? Yes ( ) No ( )

	YES	NO
Does he/she: say the ABC's?	___	___
use scissors?	___	___
share effectively?	___	___
interact with other children?	___	___
color with crayons?	___	___
recognize colors?	___	___
recognize shapes?	___	___
recognize written letters?	___	___
write with a pencil?	___	___
use glue or paste?	___	___
speak clearly?	___	___
tie his/her own shoes?	___	___

INFANTS

	YES	NO
Does he/she: roll over?	___	___
sit up unassisted?	___	___
crawl?	___	___
pull to a stand?	___	___
take steps by him/herself?	___	___
feed him/herself with a spoon?	___	___
drink from a sippy cup?	___	___

Is your child eating veggies? Yes ( ) No ( ) Fruits? Yes ( ) No ( ) Meats? Yes ( ) No ( )
Solids? Yes ( ) No ( ) Cereals Yes ( ) No ( ) If so what types? _____
_____
_____