IMAGINATION STATION Daycare

Child's 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 #: _____

Mom's place of employment: _____ wk. phone #: _____

Dad's place of employment: _____ wk. phone #: _____

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 list any chronic illnesses: _____

Please list any medications the child is currently taking: _____

Please list any known or suspected allergies: _____

Please list any serious illnesses or accidents: _____

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 help 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? _____

Has the child been in a day care setting before? yes ( ) no ( )

How many other children at a time is the 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 the 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 ( )

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

TODDLERS/PRE-SCHOOL AGED CHILDREN

		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 sip-type cup?	____	____