DAYCARE CHILD INTAKE FORM

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. _____

Place of work: 1.

2.

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 TO EMAIL IF NECESSARY***

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
(ATTACH IMMUNIZATION RECORD OR RECORD THE DATES)

Date (yy/mm/dd)

1st visit – 2 months of age:
□ Diphtheria _____
□ Pertussis _____
□ Tetanus _____
□ Polio _____
□ Haemophilus Influenzae Type b (Hib)_____
□ Hepatitis B _____
□Pneumococcal _____

2nd visit – 2 months after 1st visit:
□ Diphtheria _____
□ Pertussis _____
□ Tetanus _____
□ Polio _____
□ Haemophilus Influenzae Type b (Hib)_____
□ Hepatitis B _____
□ Pneumococcal _____

3rd visit – 2 months after 2nd visit:
□ Diphtheria _____
□ Pertussis _____
□ Tetanus _____
□ Polio _____
□ Haemophilus Influenzae Type b (Hib)_____
□ Hepatitis B _____
□ Pneumococcal _____

Date (yy/mm/dd)

4th visit – 12 months of age:
□ Measles _____
□ Mumps _____
□ Rubella _____
□Meningococcal C _____

5th visit – 12 months after 3rd visit:
□ Diphtheria _____
□ Pertussis _____
□ Tetanus _____
□ Polio _____
□ Haemophilus Influenzae Type b (Hib)_____
□ Measles, Mumps, Rubella _____
□Pneumococcal _____

4 – 6 years of age:
□ Diphtheria _____
□ Pertussis _____
□ Tetanus _____
□ Polio
_____

Other Immunizations:
_____ _____
_____ _____
_____ _____

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