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Grandma's Love Daycare

www.Grandmaslove.us

Registration Form

ADMISSION DATE: _____ **DAYS ATTENDING: _____**

CHILD'S NAME:_____ **DATE OF BIRTH: _____**

MOTHER'S NAME: _____

HOME PHONE: _____ **CELL:_____**

HOME ADDRESS: _____

WORK PHONE: _____

PLACE OF EMPLOYMENT:

_____

EMAIL:

_____

FATHER'S NAME: _____

HOME PHONE: _____ **CELL:_____**

HOME ADDRESS: _____

WORK PHONE: _____

PLACE OF EMPLOYMENT:

_____

EMAIL:

_____

Child's living arrangements:

_____

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Parental/Guardian Consent:

Who, other than the child's parents, has permission to pick the child up from the Daycare?

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

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I am willing for my child _____to go on outside expeditions with adequate adult supervision.

_____

Signature of Parent(s) or Guardian(s)

****

I am willing for my child_____ to receive medical attention, and be taken to the hospital in the case of an emergency, if I/we cannot be reached.

_____

Signature of Parent(s) or Guardian(s)

****

I am willing to allow my child _____ to be photographed participating in the programs offered by Grandma's Love Daycare for the purpose of advertising.

_____

Signature of Parent(s) or Guardian(s)

****

CHILD'S HEALTH QUESTIONNAIRE

To be completed by the parent/guardian (s)

Name of Child:_____ Date completed: _____

Provincial Health Card Number:_____ Expire Date: _____

In Case of Emergency

Adult to contact if you cannot be reached**:**

Name:_____ Relationship: _____

Phone (W):_____ (H):_____ (Cell): _____

Physician and/or clinic

Name:_____ Phone: _____

Address:_____ _____

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Health and Developmental History

Describe any difficulties or serious illnesses at birth, if any:

Describe your child's general health (e.g. recurrent colds, ear infections, stomach-aches, etc.):

Are there presently any serious medical problems? Yes_____ No _____

Is your child taking any medication? Please list all medications

Name of Medication	Dosage	Condition being treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been to a dentist? Yes_____ No _____

Does your child have any dental problems?

Describe how your child communicates:

How would you describe your child's emotional, physical and social growth, and development to this point?

Describe your child's diet (include types of food and fluids he/she is now taking):

Fluids/Beverages:

Food:

Food Allergies:

Does your child have any allergies to food or medications or contact allergies? Yes_____ No _____
If yes, please list:

Is the allergy severe enough to require medications or emergency treatment? Yes_____ No _____
If yes, describe and detail any medications required:

Has your child eaten peanut butter at home? Yes_____ No _____

Please list any dietary restrictions (cultural, religious):

Describe any particular concerns you have about your child's diet and/or eating habits:

Describe your child's sleeping habits and routine:

How frequently does your child have a bowel movement?

How far has your child progressed in toilet learning, if applicable?

Behavior Patterns and Habits

Describe your child's behavior and habits (e.g. temperament, energy level):

Describe an ordinary day in your child's life, from getting up in the morning to going to bed, including the times for naps, meals and play, interests, activities, etc.

Morning:

Afternoon:

Evening:

Describe your child's particular attachments (e.g. toy, blanket, pet, person) and any particular habits (e.g. thumb-sucking, rocking):

Describe any particular fears your child has shown (e.g. to animals, loud noises, strangers):

Describe how your child reacts to stressful situations (e.g. cries, withdraws, has tantrums, nightmares):

How does your child usually react to new situations?

We would appreciate your views on guiding your child's behavior and setting limits:

Is there anything else that you would like to tell us about your child to help us to provide good care?

Parent/Guardian's Signature: _____

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IMMUNIZATION RECORD - **Please provide dates D/M/Y**	
DPTP-Diptheria, Pertussis (Whipping Cough) Tetanus (Lockjaw), Polio & Hib	**MMR - Measles (red), Mumps, Rubella (German Measles)**
1st (2mo) day____ month ____ year	1st (12-15 mo) day ____ month ____ year
2nd (4 mo) day ____ month ____ year	2nd (5 yr) day _____ month _____ year
3rd (6 mo) day ____ month ____ year	OTHER (optional)
4th (18 mo) day ____ month ____ year	**Varicella: (Chicken Pox Vaccine)** day _____ month _____ year
DPTP (booster) 4-6 yr day ____ month ____ year	**Hepatitis "B"** 3 Doses 1st day _____ month _____ year 2nd day _____ month _____ year 3rd day _____ month _____ year