



# Kercha Childcare

## Enrollment Form

Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Child's Birthday \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Contact Information:

Mom's name \_\_\_\_\_ Address: \_\_\_\_\_

Dad's name \_\_\_\_\_ Address: \_\_\_\_\_

(Mother)Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

(Mother)Work Phone \_\_\_\_\_ Email: \_\_\_\_\_

Best number to reach you: \_\_\_\_\_

(Father)Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

(Father)Work Phone \_\_\_\_\_ Email: \_\_\_\_\_

Best number to reach you: \_\_\_\_\_

### Emergency Contacts

1 \_\_\_\_\_ Phone # \_\_\_\_\_

2 \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have a backup care provider? \_\_\_\_\_

Name(s) \_\_\_\_\_ Phone # \_\_\_\_\_

**Service Info:**

Beginning date needing care\_\_\_\_\_

Hours:

Monday\_\_\_\_\_ Tuesday\_\_\_\_\_

Wednesday\_\_\_\_\_ Thursday\_\_\_\_\_

Friday\_\_\_\_\_ Saturday\_\_\_\_\_

Sunday\_\_\_\_\_

Times you plan to drop your child off\_\_\_\_\_

Times you plan to pick up your child\_\_\_\_\_

**Your Child's Health**

CHILD'S HEALTH RECORD: (A copy of your child's immunizations and current physical will be needed)

General state of health:

\_\_\_\_\_  
\_\_\_\_\_

Doctor's name\_\_\_\_\_

Doctor's phone number\_\_\_\_\_

Dentists' name\_\_\_\_\_

Are your child's immunizations up to date? \_\_\_\_\_ (Please attach a copy of immunizations. This should include the signature of nurse or doctor who administered medications.)

Does your child have any known allergies?

\_\_\_\_\_  
\_\_\_\_\_

Are you concerned that your child may be prone to any type of allergies?\_\_\_\_\_

Describe:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any medical conditions which I should be made aware of?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had the following common childhood illnesses? (*Please circle*)

Constipation	Asthma
Convulsions	Bronchitis
Diarrhea	Chicken Pox
Fainting Spells	Diabetes
Frequent Colds	Heart Disease
Frequent Ear Infections	Hepatitis
Frequent Sore Throats	Impetigo
Lice	Measles
Ringworm	Mumps
Skin Rash	German Measles
Soiling	Polio
Stomach Upsets	Scarlet Fever
Urinary Problem	Tuberculosis
Worms	Whooping Cough

Does your child have any speech, hearing or visual problems?

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Would there be any restrictions to play or activities?

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### **About Your Child**

Has your child ever been in child care before? \_\_\_\_\_

What type (center, family daycare, grandma etc.) \_\_\_\_\_

Was it a positive experience? \_\_\_\_\_

Why are you looking for child care?

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How does your child feel about daycare and being left without his/her mommy/daddy?

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Are there any recent traumatic situations the child has been exposed to such as a death in the family, divorce, new sibling etc.?

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What is your normal method of discipline?

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What is your child's temperament? Are they easy going, hard to please, demanding, aggressive, etc.

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Are there any food restrictions?

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What is your child's favorite food(s)?

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what food(s) does your child dislike?

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Can your child be relied upon to indicate bathroom wishes? \_\_\_\_\_

If not please explain:

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What words does your child use for: Bowel movements \_\_\_\_\_  
urination \_\_\_\_\_

what time does your child awaken? \_\_\_\_\_

what time does your child go to sleep at night?

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Do he/she sleep through the night?

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Does your child sleep in a bed or crib, other?

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Are there any siblings? Please name them and specify ages and gender.

Name _____	age _____	gender _____
Name _____	age _____	gender _____
Name _____	age _____	gender _____

Has your child had experience playing with other children?

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What language(s) are spoken at home?

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Does your child have any security objects such as a blanket, soother, bottle, toy etc.?

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What are your child's favorite activities, toys, books, or games?

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Are there any other comments or information you would like to let me know about?

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Any specific  
concerns?

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