NEW HORIZONS
CHILD CARE

INTAKE FORM

2/2021

New Horizons Child Care Enrollment Packet

FACE SHEET

GENERAL INFORMATION

Date of Admission_____ Age at Admission_____

Date of Discharge_____

Reason for Discharge_____

_____

Child's Full Name:_____ Date of Birth:_____

Address:_____

Telephone Number:_____ Secondary #_____

Primary Language of Child _____ Parent_____

Allergies/Special Diets _____

_____

CHILD PHOTO PHYSICAL DESCRIPTION

Eye Color_____

Hair Color_____

Sex _____

Height _____

Weight _____

Other _____

_____

_____

PHOTO

Developmental History and Background Information

Child's Name_____ Date of Birth_____

**Note please provide information for infants and toddlers (marked*) as appropriate to the age of the child.*

Developmental History

Age began sitting_____ crawling _____ walking _____ talking_____

*Does child pull up? _____ *crawl _____ *walk with support _____

Any speech difficulties? _____

Special words to describe needs_____

Language spoken at home _____ *Any history of colic? _____

*Does child use pacifier or suck thumb? _____ *When? _____

*does your child have a fussy time? _____ *When? _____

*how do you handle this time? _____

_____

Health

Any known complications at birth? _____

Serious illness and/or hospitalization _____

Special health conditions, disabilities _____

Allergies i.e. asthma. hay fever, insect bites, medications, food reactions

_____

_____

Regular medications: _____

Eating Habits

Special characteristics or difficulties _____

*Infants on special formula, describe its preparation in detail_____

Favorite foods_____

Foods refused _____

*Is your child fed held in lap? _____ High Chair? _____

*Does child eat with Spoon? _____ Fork?_____ Hands?_____

Toilet Habits

*Are disposable or cloth diapers used? _____

*Is there a frequent occurrence of diaper rash? _____

*Do you use baby oil_____ powder _____ lotion _____ other _____

*Afe bowel movements regular? _____ how many per day? _____

*Is there a problem with diarrhea? _____ Constipation? _____

*Has toilet training been attempted? _____

*Please describe any procedure to be used for your child at the program _____

_____

What is used at home? Potty Chair_____ special seat? _____ regular seat_____

How does indicate bathroom needs (include special words) _____

Is your child ever reluctant to use the bathroom? _____

Does child have accidents? _____

Comments:

Child's Name_____

Sleeping Habits

*Does child sleep in a crib? _____ Bed? _____

Does child become tired or nap during the day (include when and how long? _____

Please note The American Academy of pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your educator. Your educator will place your infant on his/her back unless there is a written physician's order that specifies otherwise.

When does your child go to bed at night? _____ and get up in the morning? _____

Describe any special characteristics or needs (stuffed animals, story, mood on walking etc.)

_____

Social Relationship

How would you describe your child _____

_____

Previous experience with another children/childcare _____

Reaction to strangers _____ Able to play alone_____

Favorite toys and activities _____

Fears) the dark, animals, etc.) _____

how do you comfort your child? _____

What is the method of behavior management/discipline at home? _____

_____

What would you like your child to gain from his child care experience? _____

Daily Schedule Please describe your child's schedule on a typical day.

***For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.**

_____

_____

_____

Is there anything else we should know about your child? _____

_____

_____

Parent/Guardian Signature_____ Date _____

Child's Name_____

New Horizons Child Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (applied to open wound/ broken skin) _____

My child has previously taken this medication_____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____
Date(s) medication to be given: _____
Times medication to be given: _____
Reasons for medication: _____
Possible side effects: _____
Directions for storage: _____

Name and phone number of the prescribing health care practitioner:
_____

Child's Health Care Practitioner Signature _____Date_____ I,

_____, (parent or guardian) gives permission

(print name) to authorize the child care to administer medication to my child as indicated above.

Parent/Guardian Signature _____ Date_____ For

topical, non-prescription NOT applied to open wound / broken skin (parent signature only)

New Horizons Child Care

Photography & Videography

I understand that photographs/videos of the children in our programs may appear in newspapers, magazines, brochures, publicity materials and/or educational trainings. Your child's photo will also be posted on our classroom and childcare-wide website and Facebook sites. I understand that they are to be used without compensation.

Parent/Guardian Signature: _____Date: _____

Thank you for selecting New Horizons Child Care as your child care provider

Child's Name_____

EMERGENCY CARD INFORMATION

FIRST AID KIT

Child's Name_____ Date of Birth_____

Child's home address_____

Phone_____

instructions to reach parents

NAME ADDRESS HOME & CELL PHONE

1_____

2._____

Contact Information for physician or healthcare professional

Physician's Name Address & Phone #

_____

Emergency Contact Person(s)

Name Address Home & Cell Phone

1_____

2_____

Emergency Medical Treatment

I hereby give New Horizons Child Care staff permission to administer basic first aid and/or CPR to my child _____ and/or to take my child _____ to the hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____

Parent/Guardian Date

Medical Insurance Information (optional)

Subscriber's Name_____

Type of insurance_____

Policy Number _____

( ) Copy of Insurance card