Dominican Child Development Center
P.O. Box 5668, Hagatna Guam 96932
Tel: (671) 477 7228 * Fax: (671) 472 4282

PLEASE ATTACH PASSPORT SIZE PHOTO HERE

REGISTRATION FORM

Name: ____________________ Date of Birth: ________________ Grade: _______

Home Address: ______________________________ Resides with _____________ Sex: _____________

Mailing Address: ____

School last attended: ____

Address: ____

Father: ______________________________ Religion: ____________________
Last First M.I.

Place of Employment & Occupation: ____

Home Phone: ______________________________ Work Phone: ______________________________

Citizenship: ______________________________ Ethnic Group: ______________________________
US/Filipino/Korean/etc. Chamorro/Filipino/Caucasian/Etc.

Mother: ______________________________ Religion ____________________
Last First M.I.

Place of Employment & Occupation: ____

Home Phone: ______________________________ Work Phone: ______________________________

Citizenship: ______________________________ Ethnic Group: ______________________________
US/Filipino/Korean/etc. Chamorro/Filipino/Caucasian/Etc.

Marital Status: ______Married _____ Divorced _____Separated ____Widowed _____Single

Persons to notify in case of emergency:

	Phone Number

Church attended: ______________________________ Pastor: ______________________________

Has child ever had disciplinary difficulties? ____

AGREEMENT RESPONSE

I/We ______________________________ and __________________________ the parent(s) guardian(s)

of __________________________. Have read and do understand the Dominican Child Development Center Parent*Pupil Handbook. I/We pledge our support of School Policy and agree to conform with the new regulations and obligations. I/We may asked to withdraw my/our children.

______________________________ ______________________________
Signature of Parent/ Guardian Signature of Parent/Guardian

Date: ______________________________ Date: ______________________________

Date of Admission: __________________________ Date Left: ______________________________

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CHILD'S PREADMISSION HEALTH HISTORY - PARENT'S REPORT

Child's Name: ________________________________ Sex: _____ Birth Date: _____________ Grade: ________
Father's Name: ____________________________ Age: _____ Does Father live in home with child? _______
Mother's Name: ___________________________ Age: _____ Does Mother live in home with child? _______
Has child been under supervision of Physician? ___________ Date of last examination: ________________

DEVELOPMENTAL HISTORY

Walk	Begin talking at	Toilet training started at
_____ months	_______ months	_________ months

PAST ILLNESS - Check those child has had and approximate dates

	Dates		Dates		Dates
( ) Chicken Fox		( ) Diabetes		( ) Poliomyelitis	
( ) Asthma		( ) Epilepsy		( ) 10-Day Measles Rubella	
( ) Rheumatic Fever		( ) Whooping Cough		( ) 3-Day measles (Rubella)	
( ) Hay Fever		( ) Mumps			

Other serious or severe illness or accidents: ___________

Does child have frequent colds? _____ How many last year? _______ List any allergies should be aware of

DAILY ROUTINES

What time does a child fed up?	What time does child go to bed?	Does child sleep well?
Does child sleep during the day?	When?	How long?

Diet Pattern:	What are usual eating hours?
Breakfast	
Noon meal	
Evening	

Any food dislikes? __________________________ Any eating problems? ______________
Are bowel movement regular? _______________ What is usual time? ______________
Word use for: Bowel movement ______________ Urination : __________________________________
Parent's evaluation of child's health: ____

Parent's evaluation of child's personality.

How does child get along with parents, brothers, sisters and other children?

Has the child had group play experiences? __________________________
Does the child have any special problem - fears? (Explain) ______________________________

What is plan for care when child is ill? ____
Reason for requesting day care placement: ____

Parent signature/Date:____________________________

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IDENTIFICATION AND EMERGENCY INFORMATION

To be completed by Parent or Guardian

Child's Name:	Telephone:
Address:	Birth date:
Father' Name:	Business Phone
Home Address:	Home Phone:
Mother's Name:	Business Phone
Person Responsible for Child:	Home Phone:

NAMES OF PERSON AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(Child will not be allowed to leave with any other person without written Authorization from Parent or Guardian)

Name	Relationship

ADDITIONAL PERSONS WHO MAY BE CALLED IN EMERGENCY

Name	Address	Phone	Relationship

PHYSICIAN TO BE CALLED IN EMEGENCY

Name	Telephone
Address	

If Physician cannot be reached, what action should be taken?

○ Call emergency Hospital ○ Other

Time child be called for:

Signature of Parent or Guardian ________________ Date: ________________

Date of Admission: ______________________________ Date left: ________________________

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MEDICAL CLEARANCE FOR ADMISSION

Name: Date of Birth: ______________ Sex: ____________

Father:

Work Employment Work Phone

Home Address:

Mother:

Work Employment Work Phone

MEDICAL HISTORY

1. Any history of allergy?	Yes ( )	No ( )	If yes, what?
2. Any previous illness?	Yes ( )	No ( )	If yes, what?
3. Any history of heart problem?	Yes ( )	No ( )	
4. Any history of convulsion?	Yes ( )	No ( )	
5. Any physical handicap?	Yes ( )	No ( )	If yes, what?

PHYSICAL EXAMINANTION

Height		Weight		Pulse			
Respiration		Blood Pressure		Vision		Right : ________	Left: _______
Hearing		Right		Left			

GENERAL INSPECTION

Head		Eyes		Ears		Nose		Mouth	
Throat		Teeth		Neck		Chest		Heart	
Lungs		Abdomen		Spleen		Genitalia		Hernia	
Extremities					Neurological System				

Has this child significant problem (physical, social or emotional) which will interfere with his/her school experiences? (Yes ( ) No ( )
Problems, Remarks, recommendations or Special Restriction, if any.

IMMUNIZATION HISTORY

(Please fill in dates of immunizations that were given)

VACCINE					
DTP					
TOPV	1	2	3	4	5
MMR	1	2	3	4	5
HIB	1	2	VARRICELLA	1	2
HEP	1	2	3	4	
PPD	Date Given:		Date Read:		Result:

Date

Examiner's Signature: