



Pequeños Exploradores Immersion Daycare LLC

Child's Name: _____

Infant Application Form

Confidential

Child Enrollment Form



Child's Name (Last, First)		Child Nickname
Date of Birth	Date Entered Care	Age at Entry
ALLERGY ALERT Does your child have allergies? <input type="checkbox"/> YES* <input type="checkbox"/> NO *If yes, please complete an allergy care plan.		
Parent or Guardian Contact Information		
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Home Phone	Cell Phone	Email Address
Employer and Work Hours	Work Address (Street, City, Zip)	Work Phone
Name (First, Last)		Relationship
Home Address (Street, City, Zip)		
Home Phone	Cell Phone	Email Address
Employer and Work Hours	Work Address (Street, City, Zip)	Work Phone
Required Emergency Contact Information- person other than parent or guardian that is authorized to pick up child		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Non-Emergency Contact Information- person other than parent or guardian that is authorized to pick up child		
Name (First, Last)	Phone	Relationship
Name (First, Last)	Phone	Relationship
Medical Contact Information		
Insurance Provider and Policy Information (if applicable)		
Child's medical provider(s) or emergency care facility		Phone
Parent or Guardian Authorizations (not all of these authorizations are required in family child care)		
Please list any restrictions to permission of the following:		
My child may be taken on neighborhood walks. <input type="checkbox"/> Yes <input type="checkbox"/> No Note: A signed permission slip is required for all field trips out of the neighborhood.		
My child may use sunscreen <input type="checkbox"/> Yes <input type="checkbox"/> No My child may apply their own sunscreen under adult supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No		
My child may be photographed and/or recorded for publicity or news purposes: <input type="checkbox"/> Yes <input type="checkbox"/> No This applies to: <input type="checkbox"/> On-site <input type="checkbox"/> Off-site photography and video.		
CC/SC: my child may participate in religious or cultural events described in center policy, including special occasions where food is being served. <input type="checkbox"/> Yes <input type="checkbox"/> No		
I have reviewed a copy of this child care facility's current license certificate. <input type="checkbox"/> Yes <input type="checkbox"/> No		
I have received a written copy of the program's child care policies. <input type="checkbox"/> Yes <input type="checkbox"/> No		
In an emergency, the child care facility has my permission to call an ambulance or transport my child to any available physician or hospital at my expense to obtain medical treatment. In most emergencies, 911 is called and the child is transported to the nearest hospital and treated by the on-call physician. The parent or guardian of the child must be notified as soon as possible.		
Parent/Guardian Signature		Date

Has your child previously been in child care? Yes No If yes, what type of care and for how long?

Child General Information – please include any information that will assist us in providing quality care for your child

General likes and dislikes

Eating habits and schedule

Sleeping habits and schedule

Developmental and health history that could affect the child's participation in child care

Interactions with other children

How does your child like to be comforted?

Child's home language

Are there family cultural backgrounds, traditions, beliefs, or interests that you would like to share with us?

Does your child have any special needs (IFSP, IEP etc.)? Yes* No If yes, please complete a written care plan.

Child Medical Information

Does your child have any chronic health issues or specific care needs (such as previous serious illnesses or injuries)? Yes* No If yes, please complete a written care plan.

Does your child regularly need medication, or have medications prescribed for continuous, long-term use? Yes No If yes, why?

Other Children in the Home

Name	Age	School or other information you want to share:
Name	Age	School or other information you want to share:
Name	Age	School or other information you want to share:
Name	Age	School or other information you want to share:

Enrollment form annual review or update(s). A center must have the parent or guardian review, update, and sign or initial the enrollment form at least annually. Please date and initial below anytime the enrollment information is reviewed and/or updated.

Date: _____ Parent initials: _____
Date: _____ Parent initials: _____
Date: _____ Parent initials: _____

Infant and Toddler Additional Enrollment Information

This form should be used in addition to the Child Enrollment Form (PR-0185)



Child's Name	Nickname	Birthdate	Current age:
Name of Parent(s)			Date filled out by parent:

Individual Interests

Does your child say any words? What do they mean?

What are child's favorite games, toys and things to do?

Any information that might be important or helpful to caregivers?

Any pets in your home? If yes, type of pet(s)?

Typical Daily Schedule	Sleep
7:00	Any special sleeping routines?
8:00	
9:00	
10:00	Does your baby like to be rocked?
11:00	Is your baby always put on his/her back to sleep?
12:00	
1:00	When does your baby usually sleep?
2:00	
3:00	How long is a typical sleep period?
4:00	
5:00	

Liquids	Foods
<input type="checkbox"/> Cup <input type="checkbox"/> Bottle <input type="checkbox"/> Parent on-site Milk: <input type="checkbox"/> Formula <input type="checkbox"/> Whole Milk <input type="checkbox"/> Skim <input type="checkbox"/> Breast <input type="checkbox"/> Other: _____ Brand: _____ Type: <input type="checkbox"/> Powder <input type="checkbox"/> Ready to feed Temperature: <input type="checkbox"/> Heated <input type="checkbox"/> Room Temp <input type="checkbox"/> Cool Amount/Serving Size: _____ Juice: <input type="checkbox"/> Apple <input type="checkbox"/> Orange <input type="checkbox"/> Apricot <input type="checkbox"/> Grape <input type="checkbox"/> Peach <input type="checkbox"/> Pineapple Any other liquids? _____ Amount: _____ Frequency: _____	What does your child eat? <input type="checkbox"/> Baby Food <input type="checkbox"/> Table/Finger Foods Types/Amount: _____ _____ _____ _____ _____ _____

Emergency Authorization Form

Child's Name

Date of Birth _____

Child resides with: Mother Father Both parents Guardian

Mother or Guardian

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail Address _____

Father or Guardian

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail Address _____

Names of friends or relatives to call if you cannot be reached

Name _____ Relation to child _____ Phone No. _____

Name _____ Relation to child _____ Phone No. _____

Doctor to be called in an emergency

Phone No. _____

Insurance Company _____

Insurance Policy Number _____

Dentist to be called in an emergency

Phone No. _____

Insurance Company _____

Insurance Policy Number _____

Preferred Hospital

Date of last DPT shot

Food or medication allergies

Current medications

Special health conditions

I hereby grant permission for _____ or her/his staff to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include but are not limited to the following:

1. Attempt to contact a parent or guardian.
2. Attempt to contact the child's physician.
3. Attempt to contact a parent/guardian through any of the persons listed on the emergency information form you completed for us.
4. If we cannot contact you or your child's physician, we will do any or all of the following:
 - (a) Call another physician or paramedics, (b) call an ambulance, (c) have the child taken to an emergency hospital in the company of the provider or a staff member.
5. Any expenses under number 4, above, will be borne by the child's family.

Parent/Guardian Signature _____

Date _____

*Attach photo of child to this form

Child Pick Up Form

Child's Name: _____

Please list below the names and phone numbers of the people who may be allowed to pick up your child in the event of an emergency when you can not get here in time **(please include your own name and phone number because the form maybe used in the class emergency pack)**.

Name: _____ Relation to child: _____ Phone: _____

Name: _____ Relation to child: _____ Phone: _____

Name: _____ Relation to child: _____ Phone: _____

Name: _____ Relation to child: _____ Phone: _____

Name: _____ Relation to child: _____ Phone: _____

Name: _____ Relation to child: _____ Phone: _____

Please list anyone who you do not want to pick up your child. If you do not want the other parent to pick up your child please make sure I have legal documents to prevent them from doing so, otherwise I can not stop a parent from taking his or her child from my home.

Name: _____ Relation to child: _____ Phone: _____

Name: _____ Relation to child: _____ Phone: _____

Please try to keep this form current. Make sure I am told in the morning either in person or by phone that someone else will be picking up your child. If your child doesn't recognize the other person (such as His Grandma) I will need to see some identification unless they know the password.

Please write down the password that will be used by the person to pick up your child.

Password: _____

Parent Signature

Date



Medical Authorization for Non-Prescribed Medications

All over the counter medications including topical substances shall be in the original container and labeled with the child's name. My child may be given non-prescribed medication. This may include the following:

- | | | | |
|----------------------|--|----------------------|--|
| Acetaminophen | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ibuprofen | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Antibiotic cream | <input type="checkbox"/> Yes <input type="checkbox"/> No | Insect Repellent | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Antihistamine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip Balm | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Antiseptic wipes/gel | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rash Ointment/Cream | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Baby Lotion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Saline Nose Drops | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Baby Oil | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shampoo | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Baby Powder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sunburn Ointment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough Syrup | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sunscreen | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diapering Ointment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Teething medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diaper Wipes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Toothpaste | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hydrocortisone | <input type="checkbox"/> Yes <input type="checkbox"/> No | Petroleum Jelly | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other:

PARENT/GUARDIAN SIGNATURE

DATE

Consent for Sunscreen Application

Child's Name: _____

I hereby give _____ permission to apply the following sunscreen, in accordance with directions for use on the appropriate container:

Sunscreen provided by program:

Product Name:

SPF:

***Parents must be informed of the type of product, the SPF, and must be given opportunity to inspect the product and ingredients. One container of sunscreen may be used for child care children unless parent supplies an individual container for their child. The sunscreen shall be applied in a manner that prevents contaminating the container.*

Sunscreen provided by family/parent:

Product Name:

SPF:

***If sunscreen is supplied for an individual child, the sunscreen must be labeled with the child's first and last name and must be used for only that child.*

Parent/Guardian Signature: _____

Date: _____

****NO AEROSOL SUNSCREENS!!****

Infant Developmental/Health History

Infant's Full Name

Nickname

Date of Birth

Gender: Male Female

Health History

Is your infant usually healthy? Yes No

Is your infant taking any medications now? Yes No

If yes, please list and explain for what purpose:

In a year, has your infant had 3 or more ear infections? Yes No

In a year, does your infant usually have more than 3 colds or sore throat infections with a fever?

Yes No

What signs does your child show when they are ill/getting sick?

Is your infant allergic to anything? Yes No

If yes, please list and note what symptoms your infant exhibits when having an allergic reaction:

Does your infant have any health-related or other needs that you would like us to be aware of?

Yes No

If yes, please list:

Does your infant chew unusual things such as pencils, chalk, cribs, window ledges, paint chips, plaster, or hair? Yes No

If yes, please provide details:

Developmental History

How do you comfort your infant?

What are your infant's favorite toys?

What are your infant's favorite activities?

What language(s) is/are spoken in your home?

Sleeping

Please list any specific ways you help your infant go to sleep:

Where does your infant sleep?

Does your infant cry when going to sleep? Yes No

What is your infant's current sleeping schedule?

Nighttime:

Morning nap:

Afternoon nap:

Other (list):

At naptime, does your child use (check all that apply): pacifier stuffed animal/toy blanket

Feeding

Is your infant breast-fed? Yes No

Formula fed? Yes No

If your infant is formula fed, what type of formula do you use?

What type of bottle and nipple does your infant prefer?

Does your infant need to be burped? Yes No

Does your infant eat baby food? Yes No

If yes, please list any particular allergies/intolerances:

Does your infant eat solid food? Yes No

If yes, what types of food has he/she been fed thus far:

What is your infant's current eating schedule? (please specify times and amounts)

Morning:

Afternoon:

Snack time:

Nighttime:

Please list any special feeding concerns we should be aware of:

Toileting

How frequently does your infant have a bowel movement?

Please describe typical appearance of bowel movement:

What type of diapers does your infant have?

Does your infant often get a diaper rash? Yes No

If yes, how do you treat it?

Pequeños Exploradores

GUIDANCE POLICY

It is very important that a child's development is nurtured through caring, patience and understanding. Guidance used will help your child to develop self-control and respect for others. Guidance will be consistently applied and age appropriate and will include

- Being respectful to your child and their individual needs.
- Providing clear rules/expectations.
- Using positive language to explain desired behavior while at your child's eye level.
- Offering clear choices.
- Redirecting your child.
- Offering praise when your child's behavior is appropriate.

If any child's behavior can't be resolved I will discuss the issue with you privately. If we are unable to resolve the issue you may be asked to allow us to invite outside resources to help us better serve your child.

Child's Name

Date of Birth

As a parent you know your child best. Please use the space below to provide any additional techniques to be used with your child:

- Example: Like changes in behavior when tired or hungry.

Parent/Guardian Signature _____ Date _____

KEEP ME HOME IF...



Two or more times in 24 hours

Body rash, especially with a fever or itching. Lice or nits.

3 or more watery stools in 24 hours.

Thick mucus or pus draining from the eye.

With fever or swollen glands.

Unusually tired, pale, lack of appetite, confused or cranky.

Temperature of 100°F or more, (taken under the arm) AND sore throat, rash, vomiting, diarrhea, earache or just not feeling good.

WHEN YOUR CHILD IS SICK:

1. HAVE PLANS FOR BACK UP CHILD CARE.
2. TELL YOUR CAREGIVER WHAT IS WRONG WITH YOUR CHILD, EVEN IF YOUR CHILD STAYS HOME.

