



### Child's Application (Infant)

Full Name of Child: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Child's DOB: \_\_\_\_\_ Name the child goes by: \_\_\_\_\_

Is the child related to the primary caregiver? ☐ No ☐ Yes – Relationship: \_\_\_\_\_

Child's school (if applicable): \_\_\_\_\_  
Name Address Phone

Email Address: \_\_\_\_\_

### Parents/Custodial Parents:

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Address: \_\_\_\_\_

City State Zip

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employment: \_\_\_\_\_

Work Address: \_\_\_\_\_

City State Zip

Work Phone: \_\_\_\_\_

Work Hours: \_\_\_\_\_

City State Zip

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employment: \_\_\_\_\_

Work Address: \_\_\_\_\_

City State Zip

Work Phone: \_\_\_\_\_

Work Hours: \_\_\_\_\_

### Transportation Plan:

Please list any other adults to whom your child may be released or are authorized to provide transportation for your child.

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**Emergency Contact Information:**

1. Name of person, other than the childcare provider, authorized to act for parent in an emergency.

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City State Zip

Place & Address  
of Employment/School: \_\_\_\_\_  
City State Zip

Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Alternate Phone Numbers (cell): \_\_\_\_\_

2. Name of person, other than the child care provider, authorized to act for parent in an emergency.

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City State Zip

Place & Address  
of Employment/School: \_\_\_\_\_  
City State Zip

Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Alternate Phone Numbers (cell): \_\_\_\_\_

3. Name of person, other than the child care provider, authorized to act for parent in an emergency.

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City State Zip

Place & Address  
of Employment/School: \_\_\_\_\_  
City State Zip

Work Phone: \_\_\_\_\_ Work Hours: \_\_\_\_\_

Alternate Phone Numbers (cell): \_\_\_\_\_

**Physician Contact Information:**

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

**Background Information:**

Other Children in the Family	Date of Birth	School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Experiences with Others:**

Who does your child interact with people at home? \_\_\_\_\_

Does he/she play with children from other families? \_\_\_\_\_ How? \_\_\_\_\_

Does he/she do tummy time? \_\_\_\_\_

Is the entire family together for any time during the day? \_\_\_\_\_

### Eating Habits: Bottle Schedule

How often does your infant eat? What time breakfast? \_\_\_\_\_ Lunch? \_\_\_\_\_ Dinner? \_\_\_\_\_

Between-meal Snacks? \_\_\_\_\_ Does the child hold him/her bottle? \_\_\_\_\_

Is the child eating table food? \_\_\_\_\_

Are there anything food/eating restrictions? \_\_\_\_\_

Food Allergies: \_\_\_\_\_

### Sleep Habits:

Sleep in crib: \_\_\_\_\_ Shares room with: ☐ Other Children ☐ Parents

At night sleeps from \_\_\_\_\_ to \_\_\_\_\_ Average Hours of Sleep Per Night: \_\_\_\_\_

Naps from \_\_\_\_\_ to \_\_\_\_\_ Average Hours of Naps: \_\_\_\_\_

Attitude toward going to sleep: \_\_\_\_\_

If there is difficulty, how is this handled? \_\_\_\_\_

Habits associated with going to sleep? \_\_\_\_\_

### Diapering Habits:

How often do you change the child diapers? \_\_\_\_\_

Can the child take them off? \_\_\_\_\_ Time of bowel movement? \_\_\_\_\_ Regular? \_\_\_\_\_

Constipated? \_\_\_\_\_

What words do you use for:

Urinating: \_\_\_\_\_ BM: \_\_\_\_\_

### Speech and physical Growth:

The child cry: ☐ Very Little ☐ Sometimes ☐ All the time ☐ Not at All

Does anyone read to the child? \_\_\_\_\_ How regularly? \_\_\_\_\_ does the child creep? \_\_\_\_\_

Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_ Which of the following words would you use to describe the child (check all that apply): ☐

active ☐ quiet ☐ thin ☐ average weight ☐ heavy ☐ tall ☐ average height ☐ short ☐ friendly ☐ unfriendly

Is there any other information you think we should have about the child? \_\_\_\_\_

### Ongoing Medical Care:

Does the child have any medical diagnosis that requires ongoing care? \_\_\_\_\_

If yes, explain what type of care is administered at home and by whom? \_\_\_\_\_

Are you requesting that this care be provided at the facility? ☐ Yes ☐ No If yes, describe the care required: \_\_\_\_\_

(Request a doctor's statement for any specified requests for care at the facility).

### Parent Declarations:

I received a summary of the licensing requirements.

I do hereby authorize emergency medical care for my child (a limited power of attorney may be required for military dependents).

I visited the facility prior to enrolling my child. Pre-enrollment Visit Date: \_\_\_\_\_

I received a copy of the child care facility's policy statement or handbook, and payment contract, and I have signed their copy, verifying by receipt my understanding and agreement of their content.

I authorize the agency to transport my child as specified in the transportation plan section (see page 1).

\_\_\_\_\_  
Signature of Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

Date of Child's Withdrawal: \_\_\_\_\_ Reason for Withdrawal: \_\_\_\_\_

This form/information shall be maintained for one year after date of disenrollment.

Information on this form shall be updated annually or as needed to ensure the protection of the child.

Date of last update with parent's initials:
