



2016-2017 SCHOOL YEAR

## Licensing Forms

### STUDENT INFORMATION

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

Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Allergy or Health Alerts \_\_\_\_\_

### EMERGENCY CONTACTS/PICK-UP AUTHORIZATIONS

Only authorized individuals will be allowed to take your child from the facility. Please list here any individuals that may be contacted in an emergency, and allowed to take child from the facility.

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

3. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

4. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

5. Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### MEDICAL INFORMATION

Primary Insurance Information: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

1. Physician' Name and Phone: \_\_\_\_\_

2. Dentists Name and Phone: \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_

## DEVELOPMENTAL HISTORY

Walked at \_\_\_\_\_ mos

Began talking at \_\_\_\_\_ mos

Stage of toilet training:

\_\_\_ Not yet

\_\_\_ Interested in the potty (may enjoy trying or learning about the potty. May have gone on occasion with assistance. May also begin recognizing and verbalizing a dirty or wet diaper)

\_\_\_ I'm learning (Is at the beginning stage of holding it and verbalizing that they need to use the potty. Many accidents still may happen)

\_\_\_ Almost there (Can usually wait for routine bathroom times, knows how to verbalize the need to use the bathroom, however may have an accident still, especially while engaged in play)

\_\_\_ Mastered! (Rarely has an accident, self-sufficient in the restroom)

Has your child had any of these specific illnesses? Circle all that apply and specify dates.

Chicken Pox	Asthma	Rheumatic Fever
Hay Fever	Diabetes	Epilepsy
Whooping cough	Mumps	Poliomyelitis
Measles (Rubeola)	Measles (Rubella)	Other (specify)

Child's Normal Sleep Times:

Asleep around: \_\_\_\_\_ pm

Awake around: \_\_\_\_\_ am.      Wakes up on own?      Or      Wakes up by parent/alarm?

Naps from \_\_\_\_\_ to \_\_\_\_\_.

Child's Normal Dietary Routines:

Breakfast time: \_\_\_\_\_

Normal food eaten: \_\_\_\_\_

AM Snack? \_\_\_\_\_

Lunch time: \_\_\_\_\_

Normal food eaten: \_\_\_\_\_

PM Snack? \_\_\_\_\_

Dinner time: \_\_\_\_\_

Normal food eaten: \_\_\_\_\_

Is your child able to feed themselves? \_\_\_\_\_

Any eating problems? \_\_\_\_\_

Does your child drink a bottle or use a pacifier? \_\_\_\_\_

Parents Evaluation of child's personality \_\_\_\_\_

How does your child get along with other children? \_\_\_\_\_

Describe any special problems/fears/needs: \_\_\_\_\_

Has your child ever been evaluated for the following? If yes, explain on a separate sheet of paper and provide reports.)

Learning Differences                      No \_\_\_ Yes \_\_\_                      Behavioral Problems    No \_\_\_ Yes \_\_\_

Psychiatric/Psychosocial Problems    No \_\_\_ Yes \_\_\_                      Visual Problems                      No \_\_\_ Yes \_\_\_

Hearing Problems                      No \_\_\_ Yes \_\_\_                      I.Q.                      No \_\_\_ Yes \_\_\_

Does the applicant take prescribed medication or need any special medical attention    No \_\_\_ Yes \_\_\_

If so, explain:

Condition \_\_\_\_\_ Medication \_\_\_\_\_