

Children's Corner Learning Center

Registration Forms

Child's Name: _____ **Birthday:** _____

Home Address: _____

Gender: M / F

Mother's Name: _____ **Home Phone:** _____

Address: _____

Place of Employment: _____ **Work Phone:** _____

Email Address: _____ **Cell Phone:** _____

Father's Name: _____ **Home Phone:** _____

Address: _____

Place of Employment: _____ **Work Phone:** _____

Email Address: _____ **Cell Phone:** _____

Family Background

Marital Status of Parents: () Married () Single () Living Together

() Divorced () Step Parent () Foster Parent () Grandparent () Other

Are there any court documents that forbids any family members from seeing or picking up the child? (If yes, we need to have a copy on file) _____

Children's Corner Emergency Information

Child's Name: _____ **Enrollment Date:** _____

Please indicate who are authorized to pick up the child **OTHER THAN PARENTS:**
We are required to have at least two on file. The people you choose will assume responsibility for your child if we are unable to reach you.

Name: _____ **Relationship to Child:** _____

Address: _____ **Work Phone:** _____

Daytime Phone: _____ **Cell Phone:** _____

Name: _____ **Relationship to Child:** _____

Address: _____ **Work Phone:** _____

Daytime Phone: _____ **Cell Phone:** _____

Name: _____ **Relationship to Child:** _____

Address: _____ **Work Phone:** _____

Daytime Phone: _____ **Cell Phone:** _____

Please list all other authorized people that can pick up your child. Include phone numbers and relationship to the child: _____

Emergency Release Form

Child's Name: _____ **Birthdate:** _____

1. PUBLIC RELATIONS: My child has my permission to participate in public relations activities such as newspaper pictures, observations by college students...

Parent's Signature: _____

2. DOCTOR & DENTAL INFORMATION: In case of an emergency a name of your doctor & dentist is required. If you do not have one please sign and we will use the doctor or dentist on call.

Doctor Name: _____ Phone Number: _____

Doctor's Address: _____

Dentist Name: _____ Phone Number: _____

Dentist's Address: _____

Parent's Signature: _____

3. EMERGENCY MEDICAL CARE: The staff are authorized to administer emergency medical care for my child. They also have permission to use the emergency on call services such as an ambulance and emergency room or clinic.

Parent's Signature: _____

4. WOOD TICKS AND SPLINTERS: The staff have my permission to remove splinters and wood ticks from my child if needed.

Parent's Signature: _____

5. PUBLIC HEALTH & DEPARTMENT OF HEALTH

Public Health, The Department of Human Services and The Department of Health will randomly look at your child's file for health and immunizations information and to ensure our center is in compliance for record keeping.

Parent's Signature: _____

6. SUNSCREEN & BUG LOTION: The staff have my permission to apply bug lotion and sunscreen as needed.

Parent's Signature: _____

Tell Us About Your Child

** This is a required document in your child's file**

Child's Name: _____ **Birthdate:** _____

Names and ages of siblings: _____

What name do you want your child to be called? _____

What activities does your child like to do? _____

What are your child's dislikes? _____

Does your child have any specific fears? _____

How would you describe your child's personality? _____

What do you enjoy most about your child? _____

What do you find most challenging with your child? _____

How does your child react when he/she is upset or angry? _____

How does your child like to be comforted or relax? _____

Has your child experienced playing with other children? _____

What have those experiences been? How did your child respond? _____

Infant:

How often does your child take a bottle? _____

What temperature does your child like their bottle? (Please Circle One)

Cold Room Temperature Heated

What type of formula do you use? _____

What type of bottle and nipple do you use? _____

How often does your child need burping? _____

Does your child use a pacifier? Yes No

How often does your child nap? _____

How long does your child nap? _____

How does your child like to go to sleep? (Lay down, rock...) _____

Toddler:

What are your child's favorite foods? _____, _____,
_____, _____, _____.

What is your child's least favorite foods? _____, _____,
_____, _____, _____.

How often does your child nap? _____

How long does your child nap? _____

Does your child need to wear a pull up for naptime? Yes No

Is your child toilet trained for: Urination _____ Bowel Movements _____?

** The answer must be honest so that we are prepared to help your child properly. Answering yes if this is not correct will create more stress for your child then is necessary as they would be expected to perform as you have indicated. Please help us help your child in the best ways possible for the most positive experience for them. **

If your child is a male, does he urinate: _____ Standing _____ Sitting

Does your child tell you when he/she needs to use the bathroom? _____ If yes,
what has your experience been with this issue? _____

If no, what are the signs that he/she displays when needing to use the bathroom?

Preschooler:

What are your child's favorite foods? _____, _____,
_____, _____.

What is your child's least favorite foods? _____, _____,
_____, _____.

How long does your child nap? _____

Is your child toilet trained for: Urination _____ Bowel Movements _____?

** The answer must be honest so that we are prepared to help your child properly. Answering yes if this is not correct will create more stress for your child than is necessary as they would be expected to perform as you have indicated. Please help us help your child in the best ways possible for the most positive experience for them. **

If your child is a male, does he urinate: _____ Standing _____ Sitting

Does your child tell you when he/she needs to use the bathroom? _____ If yes,
what has your experience been with this issue? _____

If no, what are the signs that he/she displays when needing to use the bathroom?

Health Information

Name of Child: _____

Please check if your child has frequent: () Colds () Asthma

() Sore Throats () Strep () Earaches or Infections

() Diabetes () Hearing Challenges () Vision Challenges

() Constipation () Stomach Aches () Headaches

() Loose Stools () Body Temp Higher than Average () Other

Does your child have any **allergies** or **sensitivities** to food or medications? Yes/No
(If your child has a food allergy, we need to have a medical note from their Physician.)

Has your child had any operations? (If yes please explain) _____

Is your child on any medication(s)? (If yes please list) Yes No

Are there any other health related issues we should know about? _____

What age is the home where you live? _____

Has your home been tested for lead paint? _____

Do you speak another language at home other than English? _____ If yes, which language? _____

Are there any special words that would help us communicate with your child?

Are there any cultural practices or holidays you would like us to know about?

Has your child ever been in child care before this enrollment? _____ If yes, please describe the experience for them: _____

** This includes, but not limited to: Center-based, home provider, relatives, friends, ect**

How did you hear about our Children's Corner Learning Center Locations?

If it was a referral by a friend, relative, or current enrolled family, we would like to thank them personally and would appreciate it if you would provide us with their name. _____

What are YOUR expectations for your child's experience with Children's Corner facilities? _____

What specific things would you like your child to experience while attending Children's Corner? _____

Is there anything else you would like us to know? Please feel free to make any comments below. _____

Children's Corner Tuition Contract

Child's Name: _____ Enrollment Date: _____

I will contract my child for the following time block:

Monday – Friday 7:00 am – 4:30 pm _____

Monday – Friday 7:30 am – 5:00 pm _____

Monday – Friday 8:00 am – 5:30 pm _____

I understand that I am responsible for payment of these days even if my child does not attend for a particular day they are contracted for. I also understand that there is a written **TWO-WEEK** notice for discontinuation of care.

I understand that I will be billed every other Tuesday. Payments can be made by Friday, but I understand that I have until the following Friday to pay my bill before a \$25 late fee will be assessed. If payments are continuously late, the account will be turned over to a collection agency and the child will no longer be able to attend and a \$25 fee will be assessed every month until the bill is paid in full.

I have been given the Children's Corner handbook and have read and understand the contents.

I understand by signing this contract, that contracts can be terminated by Children's Corner at will.

***** If families leave Children's Corner for any reason and wish to return, the registration fee will be charged again upon return to any Children's Corner facility.***

Parent's Signature

Date