# CHILD INFORMATION FORM

Our center's staff needs your help to understand and plan for your child. Please fill out the following form and return it to the center before enrollment.

Today's Date:_____________

Child's Name: ________________________________________________

First Middle Last

Child's Preferred Name: _______________________ Sex: F_____ M_____

(First, Middle or Nickname)

Birthdate:______________________________Age:____________________

Child Lives with: Both Parents Together: _____ Mother:_____ Father:____
Shared Custody: _____ Other: _____

Languages (other than English) Spoken at Home: ___________________________

Other Members of the Family Living At Home:
(brothers, sisters, grandparents, etc....)

| Name | Age | Relationship | Name Used By Child |
|---|---|---|---|
| ______________ | ___ | __________ | _________________ |
| ______________ | ___ | __________ | _________________ |
| ______________ | ___ | __________ | _________________ |

Has Your Child Been In A Preschool Setting Before? ___Yes ___No
Please List Previous School/Daycare Situations Your Child Has Been Exposed To Prior To This Application: ______________________________

____________________________________________________________

What Is The Reason For Switching Schools? (Please Attach Additional Sheets If Necessary.)

____________________________________________________________

(Please complete both sides)

How Did You Hear About Planet Kids at Wellington? ____________________
______________________________________________________________________

Why Did You Choose Planet Kids at Wellington? ________________________
______________________________________________________________________

Does Your Child Take A Nap? _______________ How Long?_______________
Describe Your Child's Appetite: Always Hungry:_____ Eats At Mealtimes:______
Snacks All Day:_____ Never Hungry:_____ Has To Be Coaxed To Eat: _______
Are There Any Foods Your Child May Not Eat? __________________________
______________________________________________________________________
(Due To Religious Customs, Etc.....) If So Please List:____________________
______________________________________________________________________
______________________________________________________________________

## Medical History

___ Yes ___No 1. Any concerns about general health? (sleeping, eating, weight, etc?)
___ Yes ___No 2. Any allergies (food, insects, medication, etc...?)
___ Yes ___No 3. Any specific illness, behavioral or social/emotional problems?
___ Yes ___No 4. Any problems with speech, vision or hearing?
(glasses, contacts, hearing aids, or ear tubes?)
___ Yes ___No 5. Any prescription medication? (daily or occasionally?)
___ Yes ___No 6. Any hospitalization, operations or major illness (specify problem)?
___ Yes ___No 7. Any significant injury or accident (specify problem)?

Please Explain If Yes Was Answered To Any Questions
above:_______________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Please List Any Additional Information About Your Child That You Feel Would Be Helpful To Our Staff While Caring For Your Child:
(afraid of lightening, costumed characters, toilet terms, etc...)
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

(Please complete both sides)