

**Forest School**

xxx Rd.

xx, VT 05443

**2015-2016 Admission Form**

(Once your child has been offered a space in the program, please return this form with the signed Enrollment Contract, Immunization Record and appropriate payment)

Date: \_\_\_\_\_ Child's Full Name: \_\_\_\_\_ Age: \_\_\_\_\_

**#1 Family Contact Information**

Name: \_\_\_\_\_ Email: \_\_\_\_\_

**#2 Family Contact Information**

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Please circle all that apply for child's primary caregiver(s):

live together   live apart   single   married   divorced   separated

Who lives with the child (i.e. family member names or nicknames, ages, significant others, siblings, half-siblings, step siblings, pets)?

---



---



---

If a parent does not have custodial responsibility, please attach related documents (i.e. copy of current restraining order, sole-custody decree, divorce decree stating sole custody) and briefly explain below:

---



---

How would you describe your caregiving or parenting style? (circle one)

Strict   Mostly Strict   In the middle   Mostly Flexible   Flexible

How do you identify your family's ethnic background, religion, and primary language(s)?

---



---



---



---

What holidays or other special days do you celebrate or observe?

---



---



---

What are your child's interests, favorite activities, likes and dislikes?

---



---



---



---



---

What do you think your child's strengths are? Fears?

---



---



---



---

How do you expect your child to adjust to Forest School?

Easy adjustment	Shy at first then quick to adjust
Shy at first then slow to adjust	Frightened      Not Sure

Do you have any concerns regarding your child’s success in our program?

---

---

---

---

What goals do you have for your child in this program?

---

---

---

---

Has your child ever been referred for developmental and/or behavioral screenings?

Yes   No

If services were or are being received, please explain below:

---

---

---

---

If applicable, may we contact the Service Coordinator and/or Provider? Yes No  
For children receiving additional support services, we request that you provide a copy of your child’s IFSP/One Plan, IEP, or contact information for the Service Coordinator and Provider(s). By providing us with this information, Forest School educators can better advocate for your child and meet their needs.

Is there anything else you think we should know about your child to help them succeed in our program (i.e. struggles at home, eating habits/diet restrictions, sleeping/napping habits, special words for toileting or body parts etc.)?

---

---

---

---

---

**Please note:** In accordance with VT Licensing Regulations, if you would like educators to provide a medically required special diet, formula or food supplements to your child, we require written instructions from the parent and a registered dietician or a physician.

**All information shared with Forest School is kept strictly confidential and will not be shared without written permission from families and as required by law.**

**Emergency Contact Information** (in the event that Family Contacts cannot be reached)

**#1 Emergency Contact**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Other #: \_\_\_\_\_

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

\_\_\_\_\_

**#2 Emergency Contact**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Other #: \_\_\_\_\_

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

\_\_\_\_\_

**Child Pick-up Authorization**

If you would like anyone else (age 18+) to be able to pick up your child, besides Family Contacts, please provide their information below. The following information must be verified by a Driver's License or State ID card by an educator at the time of pick-up.

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Other #: \_\_\_\_\_

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

---

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Other #: \_\_\_\_\_

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

---

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Other #: \_\_\_\_\_

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

---

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Other #: \_\_\_\_\_

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

---

### **Medical Contact Information**

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

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

---

Child's Dentist: \_\_\_\_\_

Phone #: \_\_\_\_\_

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

---

Hospital Preference: \_\_\_\_\_

Please list any allergies your child has and what might an allergic response look like (i.e. hives, difficulty breathing):

---



---



---

Please explain your child's chronic or acute medical conditions, and any previous or existing serious illness:

---



---



---



---

Please list any prescribed and over-the-counter medications your child takes regularly\*:

---



---

\*If applicable, educators will work with families to document an appropriate medical action plan for children with allergies or existing medical conditions. If you would like us to administer medication to your child while he/she is in our care, please fill out a permission form at school. All medication must be clearly labeled with the child's name and dosage instructions and given directly to the lead educator by an adult. The medication must have an appropriate administration and measuring device.

Please attach necessary documents:

- Copy of child's annual well-care examination
- Evidence of immunization appropriate to your child's age

OR

- An immunization exemption form due to medical, religious, or moral beliefs.