Shirley’s Mother Goose

Preschool & Daycare Center

**Child Data Sheet**

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:**

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Name:

Home Address:

**Cell Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ ZIP:

Mother’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours:

Father’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours:

Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Withdrawal:

**Emergency Contact Information**

Name of person to call if parents cannot be reached

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ ZIP:

Is this person authorized to take child from center? □ Yes □ No

List all other adults who are authorized to take child from center:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| *Name Relationship* |  | *Name Relationship* |  | *Name Relationship* |
|  |  |  |  |  |
| *Phone #* |  | *Phone #* |  | *Phone #* |
|  |  |  |  |  |
| *Address* |  | *Address* |  | *Address* |
|  |  |  |  |  |
| *City State Zip* |  | *City State Zip* |  | *City State Zip* |

**Medical Information**

Child’s physician or emergency treatment facility

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ State:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Mother/Father/Guardian) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Child’s Name) do hereby give my consent to the director of Mother Goose, or his/her duly representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parent(s)/guardian cannot be reached. Consent is also given for the director or his/her duly appointed representative to transport said child for emergency medical treatment, if the parent(s)/guardian cannot be reached.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Does your child have health insurance? □ Yes □ No

**Immunizations**

*Please provide a copy of your child’s immunization record.*

□ Verified by Health Department Record □ Physician’s Record □ Other

**Disease History**

□ Measles □ Mumps □ German Measles □ Chicken Pox □ Whooping Cough

Tuberculosis: (□ Yes □ No) Frequent Ear Infections: (□ Yes □ No)

Frequent Throat Infections: (□ Yes □ No) Defective Heart: (□ Yes □ No)

Other:

**Child Developmental Needs**

Physical or emotional issues child might have:

Spec. Food Needs: Formula \_\_\_\_\_\_\_\_\_\_ Diabetic Diet \_\_\_\_\_\_ Allergies

Spec. Issues: Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Allergies (Non-food)

Temper Tantrums \_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_Frequent Colds

Biting \_\_\_\_\_\_\_\_\_\_\_ Sun Sensitivity \_\_\_\_\_\_\_\_\_\_\_\_\_Seizures

Fainting Spells \_\_\_\_\_\_\_\_\_\_\_ Bed Wetting \_\_\_\_\_\_\_\_\_\_ Other

Requires help in: Dressing (Y/N) Undressing (Y/N) Toileting (Y/N) Eating (Y/N) Washing Hands (Y/N)

Toilet trained? (Yes/No) Words used in toileting:

Favorite: Games \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Toys \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Foods

Siblings (Yes/No) If Yes, name(s):

Type of child care used before:

Other information:

**Parental Conference**

I, the parent/guardian of this child, understand that I may ask for a conference with the caregiver(s) as needed. Additionally, the caregiver(s) may request a conference as needed.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Additional comments: