CHILDREN'S SAFE STAY, INC.

DAY CARE AND PRE SCHOOL P.O. Box 152, Sparrowbush, NY 12780

845-858-4923, www.childrenssafestay.com

INFORMATION RECORD

GENERAL INFORMATION	Date:			
Child's Full Name	Nickname:			
	Nickname: Telephone Number:			
Address:	Telephone Number.			
	Number of people residing in the h			
Mother's Name:		Does she work:	Yes	No
Business Address:				
Father's Name:		Does he work:	Yes	No
	Business Phone:			
	Father:			
BROTHERS AND SISTERS:				
Name	Date of Birth	Name of Scho	ol Attend	ing
EMERGENCY PHONE NUMBERS:			 -	
Name	Address	Phone Numbe	er	
Has child had previous day care placement? Reason for requesting placement: The following people are permitted to pick up m				
1				
2				
HEALTH				
1. What childhood illnesses has this child had?				
	Any after-effects?			
2. Has your child had any serious accidents?	No Yes:			
3. Are there any special health problems or allerg	gies? No Yes:			
4. Is there any recurring illness that your child is	prone to? No Yes:			
5 American State and State	IIO No Wasi			
5. Any special instructions if the child becomes i	ll? No Yes:			
6. Where have you taken your shild for madical s	caro? Which Hospital?			
6. Where have you taken your child for medical of	•			
Doctor	Address	Phone Numbe	:1	
7. Should we take the child to the hospital if need	ded? No Yes Which Hospital?			
7. Should we take the child to the hospital if needed? No Yes Which Hospital?				
9. Is your child completely toilet trained?		ress:		
22 , 2 dima de lipidetti tonet transcar	2			

FOOD

2. Any special feeding problems? 3. Any food allergies? LANGUAGE 1. How does your child communicate what he/she wants? Gestures: Words: Sentences: 2. Does your child have any speech problems? MOTOR COORDINATION: 1. Does your child have any problems with motor coordination? Cutting with scissors or coloring? Running, jumping or riding a bicycle? 2. Are there any activities that your child cannot participate in? SOCIAL & EMOTIONAL DEVELOPMENT: 1. Has your child had experience with other children? 2. Was your child had experience with other adults (baby sitters, day care, etc.)? 4. Does your child have any fears? No Yes To what? 5. Generally, what are your child's strengths? 6. What or who are your child's favorite: Person: Food: TV Program: Story: Other: ADDITIONAL INFORMATION FOR BABIES & TODDLERS: Any history of colic? No Yes: Is the baby's skin highly sensitive? No Yes: Frequent diaper rash? No Yes: Length of time this schedule in use: Any feeding problems?	1. Are there any dietary restrictions for your child?				
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Length of time this schedule in use:					
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How has this child been fed? Held in lap High Chair Other:	, •				
Are bowel movements regular?					
Does the child have a "fussy" time? No Yes: What time? When:		When:			