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: _____
Date of Birth: _____ Telephone Number: _____
Address: _____
Are both parents residing at home? Yes No Number of people residing in the home: _____
Mother's Name: _____ Does she work: Yes No
Business Address: _____ Business Phone: _____
Father's Name: _____ Does he work: Yes No
Business Address: _____ Business Phone: _____
Number of Hours Employed: Mother: _____ Father: _____

BROTHERS AND SISTERS:

Name	Date of Birth	Name of School Attending

EMERGENCY PHONE NUMBERS:

Name	Address	Phone Number

Has child had previous day care placement? No Yes Where? _____
Reason for requesting placement: _____
The following people are permitted to pick up my child from the day care center:
1. _____ 3. _____
2. _____ 4. _____

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 allergies? No Yes: _____
_____
4. Is there any recurring illness that your child is prone to? No Yes: _____
_____
5. Any special instructions if the child becomes ill? No Yes: _____
_____
6. Where have you taken your child for medical care? Which Hospital? _____

Doctor	Address	Phone Number

7. Should we take the child to the hospital if needed? No Yes Which Hospital? _____
8. Has your child seen a dentist? No Yes If yes, how are his/her teeth? _____
9. Is your child completely toilet trained? No Yes If no, please explain current progress: _____
_____

continued

FOOD

1. Are there any dietary restrictions for your child? _____

_____

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 an easy or troublesome toddler? _____
   - How? _____
3. Has 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: _____ Toy:_____
   - 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: _____ Do you use: Oil Powder Lotion

Current feeding schedule: _____

_____ Length of time this schedule in use: _____

Any feeding problems? _____

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:_____