

IMAGINATION STATION

IMAGINATION STATION EXPRESS

CHILD REGISTRATION FORM

Child's Name: _____ Nickname(s): _____

Birthday: _____

Do you receive assistance with the payment of your bill? _____

If yes, which program assists you? _____

Mother's name: _____ Father's name: _____

Soc. Security #: _____ Soc. Security #: _____

Home address: _____ Home address: _____

Home phone #: _____ Home phone #: _____

Mother's DOB _____ Father's DOB: _____

Driver's License# _____ Driver's License # _____

Mom's place of employment: _____ Work phone#: _____

Dad's place of employment: _____ Work phone #: _____

Custody/Visitation Arrangements: _____

Health of child

(Physical examination within the last year is required for admission to the center)

Date of last complete exam: _____ Current state of health: _____

Physician's name: _____ Phone #: _____

Please describe any chronic illnesses: _____

Please describe any accidents or surgeries your child may have had? _____

Does your child get frequent colds? Yes () No () Earaches? Yes () No ()

Sore throat? Yes () No () Stomach aches? Yes () No () Fevers? Yes () No ()

Please list any medications the child is currently taking (including Asthma and ADHD medications): _____

Does your child use an inhaler for any reason? Yes () No ()

Does your child have any special medical, physical, social or emotional needs that the staff should be aware of? _____

Does your child have an IEP? Yes () No ()

Please list any known or suspected allergies (including allergies to food): _____

Developmental level

Is the child fully responsible for his/her own toileting during the day? Yes () No ()

Is the child fully responsible for his/her own toileting at night? (no pull-ups/diapers)
Yes () No () if not, what does he/she need? _____

Does the child use a bottle during the day? Yes () No () To go to sleep? Yes () No ()

Does the child use a pacifier? Yes () No () If yes when? _____

(The Anchorage Municipal Code section 16.55.400 E: states that an infant shall be held by a caregiver for each bottle feeding, unless the child can hold their own bottle. We will not put a child to bed with a bottle or sippy cup for any reason at any time.)

Has the child been in a day care setting before? Yes () No ()

How many other children at a time is your child accustomed to being around? _____

Has the child ever been asked to leave another center or home day care? Yes () no ()

If yes, why? _____

What fears, if any, does the child have? _____

Any nervous habits? _____

Does the child eat without any help? Yes () No () Does your child use a high chair at home?
Yes () No ()

Does the child take an afternoon nap? Yes () No () Approximate length: _____

Does the child use a crib to sleep in at home? Yes () No ()

What time does your child go to bed at night and wake up in the morning? _____

What does your child eat for breakfast? _____ Lunch: _____

_____ Dinner: _____

How much television does your child watch a day? _____

Are any other languages besides English spoken in your home? Yes () No () If so what are they?

How high can the child count? _____ Can he/she say the ABC's? _____

What form of behavior management do you use at home? _____

Does your child accept correction easily? Yes () No ()

TODDLERS/PRE-SCHOOL AGED CHILDREN

Do you feel your child speaks clear? Yes () No ()

Can strangers understand your child speaks? Yes () No ()

Does your child play well alone? Yes () No ()

Does your child play well with others? Yes () No ()

	<u>YES</u>	<u>NO</u>
Does he/she: say the ABC's?	___	___
use scissors?	___	___
share effectively?	___	___
interact with other children?	___	___
color with crayons?	___	___
recognize colors?	___	___
recognize shapes?	___	___
recognize written letters?	___	___
write with a pencil?	___	___
use glue or paste?	___	___
speak clearly?	___	___
tie his/her own shoes?	___	___

INFANTS

	<u>YES</u>	<u>NO</u>
Does he/she: roll over?	___	___
sit up unassisted?	___	___
crawl?	___	___
pull to a stand?	___	___
take steps by him/herself?	___	___
feed him/herself with a spoon?	___	___
drink from a sippy cup?	___	___

Is your child eating veggies? Yes () No () Fruits? Yes () No () Meats? Yes () No ()
Solids? Yes () No () Cereals Yes () No () If so what types? _____

