



# ENROLLMENT FORM



|  |                |  |              |
|--|----------------|--|--------------|
| Facility Name:<br><b>CORNERSTONE KIDS</b>  |                | Director's Name:<br><b>Robin Hull</b>                    |              |
| Child's Name:  | Sex:           | Date of Birth:   | Home Phone # |
| Child's Address:   |                |  |              |
| Date of Admission:<br><b>September 2010</b>  | Withdraw date: | Hours and days in care:<br><b>9:00 a.m. to 2:00 p.m.</b> |              |
| Parent's or Guardian's Name:   |                | Address (if different):                                  |              |
| Phone numbers while child is in care:  |                |  |              |
| <b>Mother</b>  | <b>Father</b>  | <b>Guardian</b>  |              |
| If cannot reach parents, persons to call in emergency (please provide a minimum of 2):   |                |  |              |
| Name   | Relationship   | Phone #  |              |
| 1. _____   | _____          | _____  |              |
| 2. _____   | _____          | _____  |              |
| I hereby authorize the day care facility to allow my child to leave the day care facility ONLY with the following persons:   |                |  |              |
| Name:  | Relationship   | Phone#   |              |
| 1. _____   | _____          | _____  |              |
| 2. _____   | _____          | _____  |              |
| 3. _____   | _____          | _____  |              |
| <b>AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:</b>  |                |  |              |
| In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to: |                |  |              |
| Name of Physician:   | Address:       | Phone:   |              |
| Name of Hospital:  | Address:       | Phone:   |              |
| I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital.   |                |  |              |
| Signature of Parent or Legal Guardian:   |                |  |              |
| Are you affiliated with any church? _____ If so, which one? _____  |                |  |              |
| How did you find out about our program? _____  |                |  |              |

# Family & Social History

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

Nickname: \_\_\_\_\_

Name your child will use at school: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

## MARITAL STATUS OF PARENTS

Married: \_\_\_\_\_ Separated (How long): \_\_\_\_\_ Divorced: (How long): \_\_\_\_\_

Child lives with: \_\_\_ both parents \_\_\_ Mother \_\_\_ Father \_\_\_ Other \_\_\_\_\_

Custody/Visiting arrangements: \_\_\_\_\_

Stepmother's Name: \_\_\_\_\_ (How long?) \_\_\_\_\_

Stepfather's Name: \_\_\_\_\_ (How long?) \_\_\_\_\_

## IF CHILD IS ADOPTED

Age at adoption: \_\_\_\_\_ Does child know that he/she is adopted: \_\_\_\_\_

Remarks: \_\_\_\_\_  
\_\_\_\_\_

## BROTHERS AND SISTERS

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Other members of the household (include relationship and age).  
\_\_\_\_\_

If both parents are away from home during the morning, please state arrangements for child's care when not at school:

\_\_\_\_\_

Has your child had any play group experience? Yes \_\_\_ No \_\_\_ If yes, where? \_\_\_\_\_

Has your child had any Mother's Day Out or Preschool experience? Yes \_\_\_ No \_\_\_ If yes, where? \_\_\_\_\_

Have you had a positive experience leaving your child (separation anxiety)?  
\_\_\_\_\_

What does child say when he/she needs to go to the restroom? \_\_\_\_\_

Is child right or left handed? Right \_\_\_\_\_ Left \_\_\_\_\_

What time does child usually eat lunch? \_\_\_\_\_ Any eating problems? \_\_\_\_\_

Other dietary restrictions? \_\_\_\_\_

What are child's favorite indoor play activities? \_\_\_\_\_

Outdoor activities? \_\_\_\_\_

Does child have any special fears that we should be aware of? \_\_\_\_\_

What method of behavior correction is used in your home? \_\_\_\_\_

What is child's usual reaction? \_\_\_\_\_

Is your child involved in any extra curricular activities (gymnastics, dance, karate, baseball)? If so please list activity with how many days/hours per week.

\_\_\_\_\_

Do you have any family pets? Please list what kinds and names.

\_\_\_\_\_

How would you describe your child's personality (at home and in group settings)?

\_\_\_\_\_

What type of characteristics would you like to see in your child's teacher?

\_\_\_\_\_

What would you like for your child to gain from their experience at Cornerstone this year?

\_\_\_\_\_

\_\_\_\_\_

# Health History of Child

Does your child have any food allergies? \_\_\_\_\_  
(If yes, please provide the office with a complete medical alert form)

Is your child allergic to any insect bites or stings? \_\_\_\_\_  
(If yes, please provide the office with a complete medical alert form)

What illness has your child had?

|                      |            |                  |            |
|----------------------|------------|------------------|------------|
| Chicken Pox: _____   | Age: _____ | Measles: _____   | Age: _____ |
| Mumps: _____         | Age: _____ | Diabetes: _____  | Age: _____ |
| Scarlet Fever: _____ | Age: _____ | Hepatitis: _____ | Age: _____ |

Other: \_\_\_\_\_

Does child have frequent colds? \_\_\_\_\_ Explain: \_\_\_\_\_

Tonsillitis? \_\_\_\_\_ Earaches? \_\_\_\_\_

Stomachaches? \_\_\_\_\_ Does child vomit easily? \_\_\_\_\_

Does child run high fevers easily? \_\_\_\_\_

Has child had any serious accidents? \_\_\_\_\_ Explain: \_\_\_\_\_

Does child have or had:

Asthma \_\_\_\_\_ Hay Fever \_\_\_\_\_ Hives \_\_\_\_\_ Other \_\_\_\_\_

List any other special problems that your child may have, such as seasonal allergies, existing illness, previous serious illness, injuries during the past 12 months, any medication prescribed for long-term continuous use, and any other information which staff should be aware of:

---

---

---

---

---

Parent comments:

**\*\*Please bring a copy of child's shot records. All children must be up to date on his/her shots before entering our Preschool & Mother's Day Out programs**



## PRESCHOOL CHILDREN



Child's name:

---

**ADMISSION REQUIREMENT:** One of the following must be presented to enroll your child to the weekday education program at Cornerstone. A physician's statement is required by the start of school in September.

**PARENT'S STATEMENT:** My child has been examined within the past year by a licensed physician and is able to participate in the day care program.

**Before the start of school in September, I will obtain a physician's statement, a copy of the medical screening form from the EPSDT Program, or a statement from a health service or clinic and will submit it to Cornerstone.**

Signature of Parent or Legal Guardian:

---

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

**DOCTOR'S STATEMENT:** I have examined the above named child within the past year and find that he/she is physically able to take part in the day care program.

Physician's signature:

---

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

## IMMUNIZATION INFORMATION REQUIRED