



203 Dick Buchanan Street
 La Vergne, TN 37086
 (615) 213-0499

4050 Mercy Ct
 Murfreesboro, TN 37128
 (615) 895-4741

Child Application Form

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|--|--|--|--|
| Name of Child: | | | |
| Last Name | | First and Middle Name (s) | |
| Date of Admission (mm/dd/yy) | | | |
| Child's Date of Birth (mm/dd/yy) | | Name the child goes by | |
| Is the child related to the primary caregiver? Yes <input type="checkbox"/> No <input type="checkbox"/> | | Relationship: | |
| Parents/Custodial Parents: | | | |
| Mother's Name | | Father's Name | |
| Home Address | | Home Address | |
| City State Zip | | City State Zip | |
| Home Phone: | | Home Phone: | |
| Cell Phone: | | Cell Phone: | |
| Employment: | | Employment: | |
| Work Address: | | Work Address: | |
| City State Zip | | City State Zip | |
| Work Phone: | | Work Phone: | |
| Emergency Contact Information: | | | |
| 1. Name of person, other than the child care provider, authorized to act for parent in an emergency. | | | |
| Work Address: | | | |
| City State Zip | | Home Phone: | |
| Child's Physician: | | Telephone: | |
| Last Name | | First Name | |
| Address | | | |
| Place & Address of Employment/School: | | Work Address | |
| | | City State Zip | |
| Work Phone: | | Work Hours: | |
| Alternate Phone Numbers (cell): | | | |

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| 2. Name of person, other than the child care provider, authorized to act for parent in an emergency. | | | |
| Work Address: | | | |
| City | | State | |
| Zip | | Home Phone: | |
| Child's Physician: | Last Name | First Name | Telephone: |
| Address | | | |
| Place & Address of Employment/School: | Work Address | | |
| | City | | |
| State | | Zip | |
| Work Phone: | Work Hours: | | |
| Alternate Phone Numbers (cell): | | | |
| 3. Name of person, other than the childcare provider, authorized to act for parent in an emergency. | | | |
| Work Address: | | | |
| City | | State | |
| Zip | | Home Phone: | |
| Child's Physician: | Last Name | First Name | Telephone: |
| Address | | | |
| Place & Address of Employment/School: | Work Address | | |
| | City | | |
| State | | Zip | |
| Work Phone: | Work Hours: | | |
| Alternate Phone Numbers (cell): | | | |
| Physician Contact Information: | | | |
| Name of Physician: | Phone: | | |
| Address | | | |
| City | | State | |
| Zip | | | |
| Background Information: | | | |
| Other Children in the Family | Date of Birth (mm/dd/yy) | School | |
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| Experience with Others: | | | |
| What are some of the ways the child plays at home? | | | |
| Does he/she play with children from other families? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | How? |
| Does he/she react when he/she does not get his/her own way? | | | Yes <input type="checkbox"/> |
| Is the entire family together for any time during the day? | | | Yes <input type="checkbox"/> |

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| Eating Habits: | | | |
| At what time does the child eat: | Breakfast: | Lunch: | Dinner: |
| Between meal snacks: Yes <input type="checkbox"/> No <input type="checkbox"/> | Does the child feed himself/herself: Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| What is the child's general attitude toward eating? | | | |
| If the child refuses to eat, how is this handled and by whom? _____ | | | |
| Food Favorites: | _____ | | |
| Food Dislikes: | _____ | | |
| Food Allergies: | _____ | | |
| If the child is an infant, use a separate sheet for information about the formula, bottle schedule, etc. | | | |
| Sleep Habits: | | | |
| Has own room: Yes <input type="checkbox"/> No <input type="checkbox"/> | Shares room with: | Other Children <input type="checkbox"/> | Parents <input type="checkbox"/> |
| At night sleeps from _____ to _____ | Average Hours of Sleep Per Night: | | |
| Naps from _____ to _____ | Average Hours of Nap: | | |
| Attitude toward going to bed: _____ | | | |
| If there is difficulty, how is this handled? _____ | | | |
| Habits associated with going to bed: _____ | | | |
| Is bed wetting an issue? Yes <input type="checkbox"/> No <input type="checkbox"/> | At nap time? Yes <input type="checkbox"/> No <input type="checkbox"/> | At night? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| If yes, how is the situation handled? _____ | | | |
| Toilet Habits: | | | |
| Time at which child is taken to the bathroom: | | | |
| Can the child take themselves? Yes <input type="checkbox"/> No <input type="checkbox"/> | Time of bowel movement? | Regular? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Constipated? Yes <input type="checkbox"/> No <input type="checkbox"/> | Does the child tell you when he/she needs to go and does he/she go willingly: Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Can he/she manage his/her clothes at the toilet? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| What word does he/she use for: | Urinating: | BM: | |
| Speech and Physical Growth: | | | |
| The child talks: <input type="checkbox"/> Well <input type="checkbox"/> Fairly Well <input type="checkbox"/> Not Very Well <input type="checkbox"/> Not at All | | | |
| Does anyone read to the child? Yes <input type="checkbox"/> No <input type="checkbox"/> | | How regularly | |
| At what age did the child: | Creep? | Crawl? | Walk? |
| Which of the following words would you use to describe the child (check all that apply): | | | |
| <input type="checkbox"/> Active <input type="checkbox"/> Quiet <input type="checkbox"/> Thin <input type="checkbox"/> Average weight <input type="checkbox"/> Heavy <input type="checkbox"/> Tall <input type="checkbox"/> Average height <input type="checkbox"/> Short <input type="checkbox"/> Friendly <input type="checkbox"/> Unfriendly | | | |
| Is there any other information you think we should have about the child? _____ _____ | | | |

Ongoing Medical Care:

Does the child have any medical diagnosis that requires ongoing care? Yes No

If Yes, explain what type of care is administered at home and by whom: _____

Are you requesting that this care be provided at the facility? Yes No . If yes, describe the care required:

(Request a doctor's statement for any specified requests for care at the facility).

Parent Declarations

- I received a summary of licensing requirements.
- I do hereby authorize emergency medical care for my child (a limited power of attorney may be required for military dependents).
- I visited the facility prior to enrolling my child. Pre-enrollment Visit Date: _____ (mm/dd/yy)
- I received a copy of the childcare facility's policy statement or handbook, and payment contract, and I have signed their copy, verifying by receipt my understanding and agreement of their content.
- I authorize the agency to transport my child as specified in the transportation plan section (see page 1)

Signature of Parent(s)/Guardian(s)

Date (mm/dd/yy)

| | | | |
|--|------------|------------------------|--|
| Date of Child's Withdrawal: | (mm/dd/yy) | Reason for Withdrawal: | |
| <ul style="list-style-type: none">• This form/information shall be maintained for one year after date of disenrollment.• Information on this form shall be updated annually or as needed to ensure the protection of the child. | | | |

Date of last update with parent's initials:

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