



# Cook County Child Care Center Admission Form

## **Child Information:**

Child's Name (First, Last, Middle): \_\_\_\_\_ Preferred name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age at Admission: \_\_\_\_\_

Address (include P.O. Box): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

## **Parent Information:**

Parent/Guardian Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_ Cell

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: Check box if same as child  \_\_\_\_\_

Work Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address of Employment: \_\_\_\_\_

## **Parent/Guardian 2 Information:**

Parent/Guardian Name: \_\_\_\_\_ Relation to child: \_\_\_\_\_ Cell

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: Check box if same as child  \_\_\_\_\_

Work Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address of Employment: \_\_\_\_\_

## **Emergency Contact Information (other than parent/guardians. Two contacts required)**

(1) Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

(2) Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

## **Names of other persons authorized to remove the child from the site:**

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Child Health Insurance Information**

Is the child covered by insurance?  Yes or  No.

Carrier or Plan Name \_\_\_\_\_ Plan ID number: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Name of Clinic: \_\_\_\_\_ Address/Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Dentist Phone: \_\_\_\_\_

Name of Clinic: \_\_\_\_\_ Address/Phone: \_\_\_\_\_

Authorization is hereby given to the child care provider to obtain emergency medical care or treatment in the event of an emergency.  Yes or  No

If physician above is unavailable, I authorize another licensed physician to treat my child  Yes or  No

**Medications:** For medications that need to be administered, please complete a Medication Administration Record.

**Food, Allergies, and Restrictions**

List all allergies and reactions to medications, food, animals, environment and any other. None

\_\_\_\_\_

List any food restrictions (examples: meat, dairy, gluten, seafood, eggs, nuts, other) None

\_\_\_\_\_

Description of child's eating habits and expectations you have of the provider regarding eating: \_\_\_\_\_

\_\_\_\_\_

**General Health history Questions:**

Recent illness, injury, or infectious disease  Yes or  No

Chronic or recurring illness or condition  Yes or  No

Ever been hospitalized/surgery  Yes or  No

Wear glasses/contacts/protective eyewear  Yes or  No

Diabetes?  Yes or  No

Asthma?  Yes or  No

History of head injury  Yes or  No

Ever been knocked unconscious  Yes or  No

Ever passed out/dizziness or chest pain from exercise  Yes or  No

Ever had a seizure  Yes or  No

History of cardiac abnormality  Yes or  No

Frequent ear infections  Yes or  No

Frequent Headaches  Yes or  No

Ever been treated for ADD or ADHD  Yes or  No

Mental health issues or emotional difficulties?  Yes or  No

**Explain any yes answers:** \_\_\_\_\_

\_\_\_\_\_

**Restrictions/Adaptations/Routines**

Description of child's sleeping habits and expectations you have of the provider regarding sleeping: \_\_\_\_\_

\_\_\_\_\_

Description of child's toileting habits and expectations you have of the providers regarding toileting:

\_\_\_\_\_

\_\_\_\_\_

Description of any individual child care program plan needs or special needs or accommodations for the child:

Description of child's communication habits: \_\_\_\_\_

Effective methods for comforting your child:: \_\_\_\_\_

My child is best at: \_\_\_\_\_

My child most enjoys: \_\_\_\_\_

My child least enjoys: \_\_\_\_\_

My child may need help with:

Methods of positive discipline that work best with my child: \_\_\_\_\_

Backgrounds and Interests: \_\_\_\_\_

Way in which family prefers to communicate with the program (email, phone, face to face, etc) \_\_\_\_\_

Any other family routines or other information that is important to know about my child: \_\_\_\_\_

Days and hours of scheduled attendance:

(Half day AMs include breakfast) (Half day PMs include snack) (Full-day includes breakfast, lunch, and snack)

Monday	Tuesday	Wednesday	Thursday	Friday

**Parent/Guardian Signature:**

\_\_\_\_\_  
We the undersigned hereby agree to abide by the arrangements and authorizations so stated above.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date