

FIRST CHURCH OF GOD NOAH'S ARK DAY CARE & PRESCHOOL
1505 WEST MAIN STREET
GREENEVILLE, TENNESSEE 37743

CHILD'S APPLICATION

Date of Admission _____ Full name of child _____

Child's birth date _____ What does child like to be called? _____

Parents:

Mother's Name _____ Father's Name _____

Address _____ Home Phone _____ Address _____ Home Phone _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Where employed _____ Where employed _____

Work phone _____ Work Hours _____ Work phone _____ Work Hours _____

Transportation Plan:

To insure the safety of your child, please list other adults to whom your child may be released or who are authorized to provide transportation for your child.

Emergency Information:

Name of person, other than parent, authorized to act for parent in an emergency:

_____ Address _____

Home Phone _____ Work Phone _____ Work Hours _____

Name of Physician _____ Office Phone _____ Home Phone _____

Background Information:

Other children in the family:

| <u>Name</u> | <u>Birthdate</u> | <u>School</u> |
|-------------|------------------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Experiences with others:

What are some of the ways in which the child plays at home? _____

Does he/she play with children from other families? _____ How? _____

Does he/she usually get his/her own way with other children? _____ If not, how does he/she react? _____

Is the entire family together for any time during the day? _____ When your child misbehaves, what form of discipline or punishment do you use? _____

Eating Habits:

At what time does the child eat breakfast? _____ Lunch _____ Dinner _____

Between-meal snacks? _____ Does he/she feed himself/herself? _____

What is his/her general attitude toward eating? _____

If he/she refuses to eat, how is this handled and by whom? _____

Favorite foods: _____

Disliked foods: _____

Foods he/she is allergic to: _____

If the child is an infant, use a separate sheet for information about the formula, bottle schedule, etc.

Sleep Habits:

Has room alone _____ Shares with other children _____ Rooms with parents _____

At night sleeps from _____ to _____ Average hours _____

Naps from _____ to _____ Average hours _____

Attitude toward going to bed _____

If there is difficulty, how is this handled? _____

Habits associated with going to bed _____

Does he/she wet the bed _____ At nap time? _____ At night? _____

If so, how is the problem handled? _____

Toilet Habits:

Time at which child is taken to the bathroom _____ Does he/she take himself/herself? _____

Time of bowel movement? _____ Regular? _____ Constipated? _____ Does he/she tell you when

he/she needs to go to the toilet and go willingly? _____ Can he/she manage his/her clothes himself/herself at the

toilet? _____ What word does he/she use for urinating? _____ BM? _____

Speech and Physical Growth:

Does he/she talk well? _____ Fairly well? _____ Not very well? _____ Not at all? _____

Does anyone read to him/her? _____ How regularly? _____ At what age did he/she creep? _____

Crawl? _____ Walk? _____ Would you describe him/her as active or quiet; thin, average weight, heavy; tall, average height, or short; friendly or unfriendly? (Please underline correct description.)

Please list any other information you think we should have about your child: _____

I have received a summary of licensing requirements.
I do hereby authorize emergency medical care:

_____ Date

_____ Signature of Parent(s)