Smart Kids'
Child Development Center

PROVIDING QUALITY CHILD CARE FOR INFANTS AND CHILDREN-12 YEARS

Date of Application_____ Date of enrollment_____
Name of Child_____ Date of Birth_____
Address_____ Zip code_____

FAMILY INFORMATION

Mother Guardian's Name_____ Home Phone_____
Address_____ Zip Code_____
Place of Employment_____ Business Phone_____
Father Guardians Name_____ Home Phone_____
Address_____ Zip Code_____
Place of Employment_____ Business Phone_____

Email Address:_____

INFORMATION ABOUT CHILD

Please give any information concerning your child, which will be helpful in his or her experience in a group setting (such as play, eating and sleeping habits, special likes or dislikes, fears).

_____
_____
_____

CHILD'S LEARNING STYLE

Please give any information about your child's learning style, learning disabilities, dyslexia, color blindness, hearing, sight, or other concerns.

_____
_____
_____

EMERGENCY CONTACTS AND PICK –UP AUTHORIZATIONS

Name	Address	Phone	Relationship
Name	Address	Phone	Relationship
Name	Address	Phone	Relationship

EMERGENCY CARE INFORMATION

Does your child take medication? Yes_____ No_____. If yes, please explain

_____
_____

Does your child have any allergies? Yes____ No____. If yes please explain:

_____
_____

ILLNESS

- Circle recurring problems that your child may have:

Speech Needs Asthma Allergies Dietary Restrictions Chronic or Recurring Illnesses
Operations or Serious Illnesses:_____ (date/s)_____ _____
Last Visit to Check: vision:_____ hearing:_____ speech:_____

- Circle the following illnesses that your child has had:

Chicken Pox German Measles Mumps Red Measles Rheumatic Fever

DOCTOR INFORMATION

Name	Address	Office Number

HOSPITAL PREFERENCE

Name	Address	Office Number

DENTAL CARRIER

Name	Policy Number

INSURANCE CARRIER

Name	Policy Number

IN CASE OF EMERGENCY WHEN PARENT CANNOT BE REACHED, PLEASE NOTIFY:

Name	Address	Telephone	Relationship
Name	Address	Telephone	Relationship

I agree that the operator may authorize the physician/dentist of his/her choice to provide emergency care in the event neither I nor the family physician/dentist can be contacted immediately.

Signature of Parent/Guardian_____ Date_____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or child's parent, guardian, or full time custodian. Provisions will be made for adequate and appropriate rest and outdoor play.

Signature of Operator_____ Date_____

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DOCUMENTATION OF RECEIVING THE SMART KIDS' PARENT HANDBOOK

I, _____, have reviewed the parent handbook and received a copy. I understand that as a parent at this center, I shall acknowledge and respect all of the rules and standards noted in the handbook. I understand that in the event any changes are made to the existing policies, I will be notified in writing at least 30 days prior to the official adoption of the rules and standards by the center.

Parent's Signature: _____ Date: _____

Director's Signature: _____ Date: _____