



Date looking for coverage to start: _____
 Student # _____ (OFFICE USE ONLY)
 Program: _____ (OFFICE USE ONLY)

APPLICATION FOR ENROLLMENT

Name of Child: _____ Today's Date: _____

Address: _____ Home Phone #: _____
street city state zip

Child's Date of Birth: ___/___/___ Age in Months if Under 3 ___ Gender: ()BOY ()GIRL

What Days Would You Like Your Child To Attend?

- | | | |
|---------------------------|---------------|---------------|
| () Monday through Friday | () Full Time | () Part Time |
| () Monday | () Full Day | () Half Day |
| () Tuesday | () Full Day | () Half Day |
| () Wednesday | () Full Day | () Half Day |
| () Thursday | () Full Day | () Half Day |
| () Friday | () Full Day | () Half Day |

Has Your Child Attended Any Other Child Care Programs? _____

If yes, Please Specify:

Names / Ages of Your Other Children: _____

Mother's Name: _____ Age: _____ Marital Status: _____

Mother's Address (If Different From Child): _____

Mother's Employer: _____ Hours of Employment: _____ - _____

Name & Address of Employer: _____

Work Phone # _____ Cell Phone # _____ Home Phone # _____

Mother's Email Address: _____

Father's Name: _____ Age: _____ Marital Status: _____

Father's Address (If Different From Child): _____

Father's Employer: _____ Hours of Employment: _____ - _____

Name & Address of Employer: _____

Work Phone # _____ Cell Phone # _____ Home Phone # _____

Father's Email Address: _____

Does Your Child Have Any Special Medical Problems?

- Allergies
- Nosebleeds
- Speech Problems
- Unusual Sleeping Habits
- Special Diet: (Special Form available in the office)

Other Special Needs?

DISPOSITION

How does your child react when you leave them? _____

What is your child's normal disposition? _____

Does your child have any negative habits? _____

Are there any restrictions to play or activities? _____

Any speech / hearing /vision problems? _____

Has you child had any communicable diseases?

If so, when?

Is your child prone to any illness (such as headaches, tummy aches, etc.)?

How is your child most easily settled? _____

What are your child's favorite activities?

EATING

What are your child's favorite foods? _____

What are your child's least favorite foods? _____

Does your child eat with utensils? Which one(s)? _____

SLEEPING

What time does your child wake up? _____

What is their mood when they wake up? _____

What time does your child go to sleep at night? _____

What is their mood when they are put to bed? _____

Does your child sleep through the night? _____

Where (on what) does your child sleep? _____

Does your child take a nap? If yes, when? _____

How do you put your child to sleep? _____

PERSONALITY TRAITS

Has your child had experience playing with other children? _____

How does your child show when he/she is:

Afraid? _____

Happy? _____

Angry? _____

Tired? _____

Sick? _____

OFFICE USE:
LAST NAME _____ FIRST NAME _____ TOUR: () YES () NO
DATE APPLICATION RECEIVED: ____/____/____
INITIAL CONTACT DATE: _____
ENROLLMENT DATE: _____ DISENROLLMENT DATE: _____

How does your child feel about daycare? _____

Are there any recent traumatic events that have occurred within your life that could affect your child?

If yes, what?

Does your child have any special toys, blanket, etc.?

POTTY TRAINING

Is your child is potty trained?

Can he/she be relied upon to indicate bathroom needs? _____

Does your child have any fears relating to potty training?

Does your child have any accidents? When? _____

What word does your child use for:

Bowel movements? _____

Urination? _____

Soiled Diaper? _____

GENERAL

How Were You Referred To Little Saints Academy? _____

What do you expect from childcare?

Do you have any talents or hobbies you are willing to share with the children at Little Saints Academy?

PARENT / LEGAL GUARDIAN SIGNATURE

DATE

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