Program: PT FT T2
Parent Pre-Conf _________
Age Category: I T Pre
Date: ________________

Family Child Development Center
Registration Form

General Information:

Child's Name: ______________________________________ Nickname: ____
Birth date: ____ Gender: Male/Female (Please Circle)
Mother's Name: _____________________________________ Father's Name: ____________________________________
Address: ____ Address: ____
____ ____
Phone: (H)_________________(C)______________________ Phone: (H)__________________(C)_____________________
Mother's Occupation: ________________________________ Father's Occupation: _______________________________
Place of Employment: ________________________________ Place of Employment: _______________________________
Work Hours: _________Work Phone: __________________ Work Hours: ____________Work Phone: ______________

Public School District you reside in: ____
Has your child participated in preschool screening? __________________ When: ____

Child's Physician: ____ Phone: ____
Address: ____
Child's Dentist: ____ Phone: ____
Address: ____
Has your child ever been seen by a physician in a specialty other than family practice or pediatrics? __________________________
Specify: ____
Person to be called in case of emergency/illness when parents are not available (**must list two contacts**)

1. ____
2. ____

(name) (relation) (address) (Phone)

Who brings the child to the Center? ____
Who is authorized to take the child from the Center? ____
____
Is there someone who is specifically **NOT** authorized to take your child from the Center? __________________________________
____

Home Environment:

Mother living? ________ Father living? ________ Both parents at home? _______________________________
If no, please explain living arrangements: ____
If separated or divorced, who has custody of child? ____
Is your child adopted? __________At what age?________Has the child been told? _____________________________________
Is there anything we should know about the adoption?____
Children in family: name: _________________ age: _____ name: ________________ age: _______
name: _________________ age: _____ name: ________________ age: _______
Name/relationship of other adults besides parent(s) living in home:____
Social interests/likes: ____
Definite dislikes: ____
Does your child sleep alone? ___________________ Does she/he nap daily? ______________ Hours: _____________________
Is your child a good eater? _____________________ Any food dislikes? ____

Medical Information:

Has your child had any surgery?_______If so, please explain____
Any past illnesses?_________If so, please explain____
Any medication being routinely given?______If so, please list type and reason prescribed:______________________________
____
What physical problems are present at this time? _______none
Respiratory: Orthopedic: Seizures: Visual: Hearing: Heart: Allergies: Other:
Any food allergies:____Any food restrictions?_____________________________
Does you child currently have a prescription for an epi-pen?____

Social Development:

Has your child had previous child care or group experience? ____________Where? _____________________________________
How long? _________________________ Month/year _________________________
Does your child have playmates? ______ If so, what age/gender?____
How well does she/he get along with other children? ____
Any challenging/difficult behaviors:____
Has your child ever received special education or therapeutic services, or assessment? ___________________________
Describe ____
Social behavior (indicate words best describing your child):

Assertive Reluctant Shy Friendly Cautious Outgoing Aggressive

Communication:

Describe your child's language abilities ____
What is your child's most effective way of communicating? ____

Behavioral/Emotional:

Characteristic behavior (indicate words best describing your child)

Calm	Excitable	Easily angered	Independent	Crying	Happy
Cheerful	Stubborn	Fights often	Gives in easily	Quiet	Active
Whining	Cooperative	Wants own way	Has temper tantrums		

What behavior do you consider most difficult to deal with? ____
____
Describe discipline used at home by mother _________________________ by father ___________________________
Describe any fears your child may have and how you have dealt with them: ________________________________
____
How do you calm/comfort your child? ____

Large Muscle/Motor Development:

What large muscle activities does your child enjoy? ____
Are there any activities your child is cautious about? ____
Any motor concerns you may have? ____
Do you consider your child_______under-active ________average _______over active?
Is your child right _________ or left__________ handed? Or undetermined ___________

Toilet Training:

Is your child bladder trained? ____________________ Is your child bowel trained?___________________________
Child's words for Urinating:________________________Bowel movement:_______________________________________

Special Needs: _____None

Is your child currently, or in the process of being evaluated for a special need?______________________________
Check and describe any special developmental needs your child has that we should be aware of or possible attend to:

Speech/Laguage:	Motor Development:	Self-Help Skills:	Attention Span:
Emotional Development:	Social Development:	Behavioral Problems:	Others:

Indicate if there is anything you want our Child Development Coordinator to observe/assess or address regarding any of the above needs:
____
____
____

Your Expectations:

What do you want most out of your child's Early Childhood experience? ___________________________________
____
____

Are there any specific areas of development, interests, or concerns you want us to be aware of when planning activities for your child's age group? ____
____
____
Any other information about your child you consider important?____
____