



D.H.C.D. CHILD CARE PROGRAM

Application for Child Care Services

Family Name _____ Date of Application _____

Child's Name _____ Nickname (if used) _____

Age _____ Date of Birth _____ Birthplace _____

Home Address _____ Phone Number _____

Father's Name _____ Address _____

Employer _____ Address _____

Phone _____ Hours _____

Mother's Name _____ Address _____

Employer _____ Address _____

Phone _____ Hours _____

Person authorized to call for child _____

Is there anyone who may not pick up the child? _____

Hours of care needed from _____ to _____ No. of Days _____

Members of Household:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason Day Care is needed _____

Income: Mother _____ Father _____

SS# _____ SS# _____

PERSONAL HISTORY

Type of Birth Normal [] Premature [] Complicated []

Age began sitting _____ Crawling _____ Walking _____

Is he/she a good climber? _____ Does he/she fall easily? _____

Age began talking _____ Does he/she speak in words? _____ or sentences? _____

Does he/she have any difficulties in speaking? _____ Other language? _____

Special words to describe needs? _____

HEALTH

What arrangements can you make for child's care during illness? _____

Doctor's Name _____

Address _____ Phone _____

What communicable diseases has child had? Measles (Big Red) _____ Measles (3 Day) _____

Mumps _____ Chicken Pox _____ Whooping Cough _____ Other _____

Any serious illness or hospitalization _____ Hospital Preferred _____

Any physical disabilities _____ any known allergies (asthma, hay fever, insect bites, medicines etc.) _____

How many colds has your child had this past year? _____

How does the child react to an elevated temperature? _____

Special instructions if child becomes ill _____

Are any medications given regularly? _____

Has the doctor ever prescribed aspirin? _____

EATING HABITS

Is the child usually hungry at mealtime? _____ Between meals? _____

What are his/her favorite foods? _____

What foods are refused? _____

What eating problems does the child have? _____

Any food allergies? _____ Does the child eat with a spoon? _____ fork? _____ hands? _____

TOILET HABITS

Can the child be relied upon to indicate his bathroom wishes? _____

What word is used for urination? _____ bowel movement? _____

Does the child need to go more frequently than normal for his/her age? _____

Is he/she frightened of the bathroom? _____ Does he/she have accidents? _____

How does he/she react to them? _____

Does the child need help with toileting? _____

When was toilet training started? _____ When accomplished? _____

Was the child easy or difficult to train? _____ Does the child wet his/her bed at night? _____

SLEEPING

What time does the child go to bed? _____ Awaken? _____ Is he/she ready for sleep? _____

Does he/she have own room? _____ Own bed? _____ Does he/she walk or cry out at night? _____ What does he/she take to bed with him/her? _____

What is his/her mood on awakening? _____ Does he/she take naps? _____
(from when _____ to _____)

SOCIAL RELATIONSHIPS

Has he/she experience in playing with other children? _____ By nature, is he/she friendly? _____ Aggressive? _____ Shy? _____ Withdrawn? _____

How does he/she get along with brothers and sister? _____ Other adults? _____

With what age child does he/she prefer to play? _____

Do you feel he/she will adjust easily to the day care situation? _____

Does he/she enjoy being alone? _____ How does he/she relate to strangers? _____

Does he/she demand a lot of adult attention? _____ What makes him/her mad or upset? _____

How does he/she show his/her feelings? _____

What do you find is the best way of handling him/her? _____

Who does most of the disciplining? _____

Is he/she frightened by any of the following? Animals? _____ Tall people _____ Rough children _____ Loud noises _____ Dark _____ Storms _____

Anything else? _____ Favorite toys and activities at home _____

Does he/she like to be read to? _____ Listen to music? _____ Any experience with clay? _____
Scissors? _____ Easel painting? _____ finger painting? _____ blocks _____
Water play _____

COMMENTS

In what particular ways can we help your child this year? _____

Residency Verification

Verified by: _____
Position at _____
Visited? Yes _____ No _____
Date Verified _____

Income Verification

Verified by: _____
Position at _____
Source of Verification _____
Date Verified _____

Birthday Verification

Verified by _____
Position at _____
Document source _____
Date Verified _____