GROUP CHILD CARE DEVELOPMENTAL FORMS

(Please return to Busy Bee Academy as soon as possible.)

Child's Name:	Eye Color:	Skin Color:
Home Address:	Hair Color:	Height:
Telephone:	Sex:	Weight:
Date of Admission:	Age at Admission:	
Date of Birth:	Primary Language:	
Identifying Marks:		
Allergies / special diets:		

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name:	Parent/Guardian Name:
Relationship to child:	Relationship to child:
Home Address:	Home Address:
Home Telephone #: ____________________ Cell Telephone #:	Home Telephone #: ____________________ Cell Telephone #:
Bus. Name:	Bus. Name:
Bus. Address:	Bus. Address:
Bus. Telephone #:	Bus. Telephone #:
Hours at Work:	Hours at Work:

ADDITIONAL INFORMATION:

Child's Physician/Clinic:	
Address:	Phone:
Chronic health conditions:	
Special limitations or concerns:	

______________________________ ____________________

Parent/Guardian Signature **Date**

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care.

CHILD'S NAME __________________________________ DATE OF BIRTH _____________

DEVELOPMENTAL HISTORY

Age began sitting ________ crawling ______ walking _________ talking ____________

Any speech difficulties? ____

Special words to describe needs ____

Language spoken at home _______________________

HEALTH

Any known complications at birth? ____

Serious illnesses and/or hospitalizations:____ Special

physical conditions, disabilities: ____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions:

____

____

Regular medications: ____

EATING HABITS

Special characteristics or difficulties: ____

Favorite foods:__________________________________ Foods Refused: ______________________________

Child eats with hands _________________ spoon ________________ fork ________________________

TOILET HABITS

How does your child indicate bathroom needs (include special words): ___________________________

Is your child ever reluctant to use the bathroom? ____

Does the child have accidents? ____

SLEEPING HABITS

Does your child become tired or nap during the day (include when and how long)? _______________

____

When does your child go to bed at night? ______ and get up in the morning? ___________________

Describe any special characteristics or needs (stuffed animal, story, mood on walking etc) ________

____

SOCIAL RELATIONSHIPS

How would you describe your child:

____

Previous experience with other children/day care:

____

Reaction to strangers:

____

Able to play alone:

____

Favorite toys and activities:

____

Fears (the dark, animals, etc):

____

How do you comfort your child:

____

What is the method of behavior management/discipline at home:

____

What would you like your child to gain from this childcare experience?

____

DAILY SCHEDULE:

Please describe your child's schedule on a typical day.

____

____ Is

there anything else we should know about your child?

____

____________________________________ ____________________________

Parent/Guardian Signature Date

Authorization for Leaving the Premises

I agree to allow Busy Bee Academy to take my child off the premises if an emergency arose. I am aware that I will receive a separate notice and permission slip if there was a trip requiring car or bus transportation. I will make every effort to return the individual trip form. If I forget, this form may be used to grant permission upon verbal consent from me. It is understood that this permission slip will cover walks around the school.

____ ___________________

Parent/Guardian Signature Date

Authorization for use of Photographs and Videotapes

I agree to allow Busy Bee Academy to photograph and video my child for use in our weekly newsletters or in the classroom. These pictures will be used only for educational or information purposes. If we would like to use your child's picture for publicity purposes we will get your signed approval.

____ ___________________________

Parent/ Guardian Signature Date

GROUP CHILD CARE FIRST AID
AND EMERGENCY MEDICAL CARE
CONSENT FORM

Child's Name: ________________________________ Date of Birth: ____________________

I authorize staff in the child care program who are trained in the basics of first aid to give my child first aid when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to__________________________, and to secure necessary medical treatment for my child.

Emergency Contacts (*In order to be contacted*)

1. Name: Address:

Relationship to Child: Phone #:

Do you give permission for child to be released to this person? Yes No

2. Name: Address:

Relationship to Child: Phone #:

Do you give permission for child to be released to this person? Yes No

3. Name: Address:

Relationship to Child: Phone #:

Do you give permission for child to be released to this person? Yes No

____________________________________ ________________________

Parent/Guardian Signature **Date**

Please sign below if you have read and understood everything included in your Busy Bee Academy Parent Handbook such as our inclement weather policy, healthcare policy, behavior management policy, and snack and lunch policy. If you have any questions, please feel free to ask us before signing below.

____________________________________ ________________________

Parent/Guardian Signature **Date**

TRANSPORTATION PLAN AND AUTHORIZATION

CHILD'S NAME:____

MY CHILD WILL ARRIVE AT THE PROGRAM BY:

_____PARENT DROP OFF

_____SUPERVISED WALK (WHO______________)

_____OTHER (DESCRIBE___________________)

MY CHILD WILL DEPART FROM THE PROGRAM BY:

_____PARENT PICK UP

_____SUPERVISED WALK (WHO_______________)

_____OTHER (DESCRIBE___________________)

I give permission for my child to be released from the program at the end of day as stated above and/or I give my permission to the following people to receive my child at the end of the day. **(If no one is authorized, please indicate below by writing "NO ONE")**

1. NAME_______________________________________ RELATIONSHIP______________________________

ADDRESS____ PHONE _______________________________

2. NAME_______________________________________ RELATIONSHIP______________________________

ADDRESS____ PHONE________________________________

3. NAME_______________________________________ RELATIONSHIP______________________________

ADDRESS____ PHONE________________________________

ANY OTHER TRANSPORTATION REQUESTS MUST BE STATED IN WRITING AND MAINTAINED IN THE CHILD'S FILE OR THE ABOVE PLAN MUST BE IMPLEMENTED. THIS PERMISSION IS VALID FOR ONE PROGRAM YEAR FROM THE DATE OF SIGNATURE.

PARENT/GUARDIAN SIGNATURE_______________________________DATE___________________

Dear Physician: ____

(Child's Name)

is enrolled in an early childhood program licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of Child: ________________________________ Date of Birth: ________________

Address: ____ Phone # _________________

Name of Parents: ____

Address: ____

Date of Examination of Child: ____

What is your opinion concerning the child's general health and appearance:

____

____

____

Has this child been screened for lead poisoning? Yes ________ No _________

If Yes, date screened: _______________

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:

____

____

____

Physician's Signature: ____

Date: _________________ Comments: ____

_____________________________________ ________________________

Parent/Guardian Signature **Date**