



Crittenton Center

Helping Families Shine

Application for Child Care Services Central Campus Site

CHILD'S PERSONAL INFORMATION:

Date _____

Last _____ First _____ Middle Initial _____

Sex _____ Date of Birth _____ SS# _____

Race _____ Language _____ Religion _____

Street Address _____

City _____ State _____ Zip _____ Home Phone _____

Referred By _____

If child does not use his/her LEGAL first name, list the name he/she will be using:

PARENT/LEGAL GUARDIAN PERSONAL INFORMATION:

Mother's Name _____ DOB _____ SS# _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Race _____ Language _____ Religion _____

Place of Employment _____

Hours worked per week _____

Student (circle one) Part-time Full-time Grade _____

Father's Name _____ DOB _____ SS# _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Race _____ Language _____ Religion _____

Place of Employment _____ Hours worked _____

Student (circle one) Part-time Full-time Grade _____

Is there a custody problem that we should be aware of? Yes No

If yes, please explain _____



Legal Guardian/Custodian (if other than parent) _____
Relationship to child _____ DOB _____ SS# _____
Address _____ City _____
State _____ Zip _____ Home Phone _____ Work Phone _____
Race _____ Language _____ Religion _____
Place of Employment _____
Hours worked per week _____
Student (circle one) Part-time Full-time School _____

SIBLINGS/OTHERS LIVING IN THE HOUSEHOLD (if applicable):

1. Name _____ Date of Birth _____ Relationship to Child _____
2. Name _____ Date of Birth _____ Relationship to Child _____
3. Name _____ Date of Birth _____ Relationship to Child _____
4. Name _____ Date of Birth _____ Relationship to Child _____

Significant others in child's life _____

If English is not the primary language spoken by your child, please list other language spoken _____

If there are certain events/holidays that your child should not be a part of due to religious reasons, please explain: _____

PLAY, SOCIALIZATION, AND EMOTIONAL DEVELOPMENT:

1. What other type of child care experience has your child had (if any) ?
 None Other _____
2. Do you regard your Infant/Toddler as affectionate? Yes No
If yes, to whom? _____
3. Does your Infant/Toddler usually accept new people easily? Yes No Unsure
4. Is your Infant/Toddler usually happy? Yes No
5. What nervous habits does your Infant/Toddler exhibit (if any)? _____
8. Does your Infant/ Toddler have any fears? Yes No
If yes, what are they? _____



PHYSICAL DEVELOPMENT/HEALTH HISTORY

1. Does your Infant/ Toddler have any food dislikes or eating problems? Yes No
If yes, please explain: _____
2. What is your Toddler usual waking time? _____AM Usual bedtime? _____PM
3. Does your Toddler currently nap at home? Yes No Approximate length of nap _____
4. What is his/her attitude about going to bed or taking a nap? _____
5. Does your infant/ toddler have any physical handicaps/impairments? Yes No
If yes, please explain: _____
6. Does your infant/toddler have any ongoing health conditions or problems? Yes No
If yes, please explain: _____
7. Does your child take any medication? Yes No
If yes, please list medication name and reason for taking: _____
8. Does your child have allergies? Yes No
If so, list allergens and typical reaction to these: _____
9. Illnesses your child has had: Chicken Pox Measles Scarlet Fever
 Mumps Other _____

BEHAVIOR:

Please place a check mark in the space provided that you feel describes your child...(If Applicable)

- Sad Attentive Fearful Quiet Shy
 Overactive Affectionate Withdrawn Happy Unresponsive Enthusiastic
 Moody Loving Cheerful Sensitive Other _____

Please give any further information, which you feel would help us better understand your child _____



SCHEDULING:

Please check the days of the week that your child would attend the child care center:

- Monday Arrival Time: _____ AM PM Departure Time: _____ AM PM
- Tuesday Arrival Time: _____ AM PM Departure Time: _____ AM PM
- Wednesday Arrival Time: _____ AM PM Departure Time: _____ AM PM
- Thursday Arrival Time: _____ AM PM Departure Time: _____ AM PM
- Friday Arrival Time: _____ AM PM Departure Time: _____ AM PM

CARE PLAN

Baby's Name _____

Birthday _____

Bottles and Cereal:

Type of Bottles: _____

How often between feedings? _____

Do we prepare the bottles? _____

How many ounces per bottle? _____

What type of milk does your baby drink: Formula _____ . Breast _____ Milk _____

Is your baby eating cereal? _____

How often is cereal given? _____

How is the cereal prepared? _____

How much cereal? _____

Does your baby eat jar baby food? _____

How much? _____

Does your baby eat table food? _____

NAP:

If your baby does not sleep on his/her back, do you have a doctor's note? _____

How often does your baby nap? _____

Any special ways to get your baby to sleep? _____

Baby's will be feed on demand, should your baby be awoken for a bottle for any reason? _____

Does your baby use a pacifier? _____



Diapers:

Your baby will be changed as needed.

Do you use diaper cream? _____ What brand? _____ At each changing? _____ -

Other:

Can your baby be placed in a swing? _____

In an Exersaucer (no more than 20 minutes per day)? _____

In a bouncy seat? _____

Parent/Guardian Signature:

_____ Date: _____

