

**Teays Valley Child Development Center  
4345-B Teays Valley Road  
Scott Depot, WV 25560  
(304)757-9165**

**APPLICATION FOR ENROLLMENT**

Child's Name \_\_\_\_\_ Birth-date \_\_\_\_\_  
Home Address \_\_\_\_\_  
Telephone \_\_\_\_\_ Present age \_\_\_\_\_ Male/Female (circle one)  
Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Cell/Pager# \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_  
Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Cell/Pager# \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_  
Custody of Child \_\_\_\_\_

**EMERGENCY CONTACTS**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Physician's Address \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_  
Preferred hospital where child may be treated: \_\_\_\_\_

Names of persons authorized to pick child up from center, including parents/guardian (child will not be allowed to leave with any other person without written authorization from the responsible parent or guardian):

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Name \_\_\_\_\_ Telephone \_\_\_\_\_

Time child will usually be picked up: \_\_\_\_\_

**CONFIDENTIAL CHILD ASSESSMENT FORM**

**General Information:** Family Name \_\_\_\_\_ # of persons in home \_\_\_\_\_  
Father \_\_\_\_\_ age \_\_\_\_\_ Mother \_\_\_\_\_ age \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_

**Family and Household:**

Children in order of birth (including this child):

Name	Age	Grade in School	Health	Living?
1.				
2.				
3.				
4.				
5.				
6.				

Others in household (show relationship):

Name	Relationship
1.	
2.	
3.	
4.	

**HEALTH**

**Pregnancy and Birth History:**

Previous Pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_ Stillbirths \_\_\_\_\_  
Delivery: Normal \_\_\_\_\_ Premature \_\_\_\_\_ (how much) \_\_\_\_\_ Caesarian \_\_\_\_\_  
Health of Mother during pregnancy \_\_\_\_\_  
Complications during pregnancy \_\_\_\_\_  
Complication during birth \_\_\_\_\_

**GENERAL HEALTH:**

Any diseases that 'run' in the family? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, describe \_\_\_\_\_  
\_\_\_\_\_

**Is this child subject to:**

	OFTEN	SELDOM	NEVER
Colds - upper respiratory infections			
Constipation			
Convulsions			
Diarrhea			
Fever - 103 or above			
Headaches			
Stomach ache			

Operations (give date and description) \_\_\_\_\_

Injuries (give date and description) \_\_\_\_\_

Describe any difficulties observed with this child's:

Hearing \_\_\_\_\_ Vision \_\_\_\_\_

Other \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Birth weight \_\_\_\_\_ Birth-date \_\_\_\_\_

Illnesses or complications during newborn period: Yes \_\_\_\_\_ No \_\_\_\_\_ If so, describe \_\_\_\_\_

**PAST ILLNESSES: Check those the child has had and give approximate date:**

ILLNESS	X	DATE	ILLNESS	X	DATE
Asthma			Mumps		
Chicken Pox			Poliomyelitis		
Diabetes			Rheumatic Fever		
Epilepsy			Rubeola (10 day Measles)		
Hay Fever			Whooping Cough		
Measles (Rubella)			Other		

Is child allergic to any foods? \_\_\_\_\_ If so, please list: \_\_\_\_\_

Is child allergic to any medications? \_\_\_\_\_ If so, please list: \_\_\_\_\_

Has child ever been separated from parents or guardians for any length of time? \_\_\_\_\_

Describe experiences and the child's reactions and adjustments: \_\_\_\_\_

Is there anything in particular that frightens this child? \_\_\_\_\_

Has this child had any upsetting experiences such as divorce of parents, death in family, frequent or recent moves, etc? \_\_\_\_\_

What were the child's reactions? \_\_\_\_\_

### ROUTINES

**Rating:** As a rule, is your child's appetite: good \_\_\_\_\_, fair \_\_\_\_\_ or poor \_\_\_\_\_.

Does he/she eat alone or with the family? \_\_\_\_\_ Can he/she feed himself completely? \_\_\_\_\_ List any foods your child is not allowed to eat \_\_\_\_\_

Usual meal times: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

**Sleeping:** How many hours does your child sleep at night? \_\_\_\_\_

Time child gets up in the morning \_\_\_\_\_ Does child have a bed of their own? \_\_\_\_\_

Sleeps alone? \_\_\_\_\_ Takes naps daily? \_\_\_\_\_ Length of nap \_\_\_\_\_

**Elimination:** Training started for bladder control at what age? \_\_\_\_\_ Bowel control? \_\_\_\_\_

Is control established in day time? \_\_\_\_\_ During the night? \_\_\_\_\_

How does child indicate need for urination? \_\_\_\_\_ Bowel movement? \_\_\_\_\_

### Self-Help:

CAN CHILD?	Do Alone	Needs Help	CAN CHILD?	Do Alone	Needs Help
Dress			Comb/brush hair		
Undress			Brush teeth		
Wash hands/face			Tie shoes		
Toilet			Put toys away		

### ACTIVITIES

Does your child prefer playing alone? \_\_\_\_\_ With other children? \_\_\_\_\_

List names of favorite playmates: \_\_\_\_\_

Does child get along well with family children? \_\_\_\_\_ Parents? \_\_\_\_\_ Other children? \_\_\_\_\_

Has child attended any children groups? Day Care \_\_\_\_\_ Preschool \_\_\_\_\_ Sunday School \_\_\_\_\_

Vacation Bible School \_\_\_\_\_ Other \_\_\_\_\_

**Check the methods of control, discipline, teaching you find most effective with this child.**

	Bribing		Demonstrating	Other recommended methods:
	Coaxing		Depriving of pleasure	
	Praising		Preparing child in advance	
	Reasoning		Redirection	
	Rewarding		Speaking in a firm voice	
	Time-out		Suggesting	

Plan for care when child is ill? \_\_\_\_\_

Reasons for requesting Center care? \_\_\_\_\_

\_\_\_\_\_

Does your child attend Church/Sunday School? \_\_\_\_\_ Where? \_\_\_\_\_

Other information you feel might be helpful in working with your child in the center? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Director \_\_\_\_\_ Date \_\_\_\_\_

FOR CENTER USE: Date of Admission \_\_\_\_\_ Date of Discharge \_\_\_\_\_