

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

APPLICATION FOR ENROLLMENT - EXTENDED CARE/SUMMER PROGRAM

Child's Name _____ Birth-date _____ Grade _____
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 _____
School Name _____ Telephone # _____

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 _____

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? _____

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 _____