210 South 5th Street
Sundance, WY 82729
(307) 283-2682
kidprintsinc@gmail.com

CHILD ENROLLMENT FORM

Today's Date: _____ Date of Enrollment: _____

Child's Name: _____

Child's Nickname (if applicable): _____Child's Date of Birth: _____Sex: _____

If Pregnant, Due Date: _____ If Pregnant, Start Date:_____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Parent/Legal Guardian #1 Name: _____ Relationship to Child: _____

Home Address (if different from above): _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address:_____

In order to receive electronic newsletters and other electronic communication please provide your email address.

Parent/Legal Guardian #2 Name: _____ Relationship to Child: _____

Home Address (if different from above): _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address:_____

In order to receive electronic newsletters and other electronic communication please provide your email address.

Name of Siblings: _____ Age _____

_____ Age _____

_____ Age _____

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CHILD HABIT INFORMATION

Child's Name: _____

EATING HABITS *Check all that apply*

Infants (Birth to 12 months): ☐ Breast ☐ Formula ☐ Combination
Toddlers (1 to 2 years): ☐ Baby Food ☐ Solid Food ☐ Feeds Self ☐ Needs Assistance
Children (2 and up):

Child's favorite foods: _____

Child's least favorite foods: _____

Child eats with: ☐ Fingers ☐ Spoon/Fork

Child drinks with: ☐ Bottle ☐ Sipper Cup ☐ Regular Cup

Please list any additional comments regarding your child's eating habits that you feel the caregivers should be aware of:

_____

_____

_____

SLEEPING HABITS *Check all that apply*

Infants

Do you wrap your infant? ☐ Yes ☐ No

How does your infant fall asleep? ☐ Rocking ☐ Holding ☐ On their own ☐ Story ☐ Music

Toddlers

Does your toddler sleep with a special toy and/or blanket? ☐ Yes ☐ No

Does your toddler fall asleep on his/her own? ☐ Yes ☐ No

Children

Does your child nap? ☐ Yes ☐ No

If yes, does your child sleep with a special toy and/or blanket? ☐ Yes ☐ No

Please list any additional concerns regarding your child's sleeping habits that may affect his/her day?

_____

_____

_____

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RESTROOM HABITS

Infants (Birth to 12 months):

Does your child have frequent diaper rashes? ☐Yes ☐No

If yes, what do you use to treat the rashes? _____

Children

Is your child toilet trained? ☐Yes ☐No

If yes, how does your child communicate that he/she needs to use the restroom? _____

_____

Please list any comments regarding your child's restroom habits that you feel the caregivers should be aware of:

_____

MEDICAL INFORMATION

Child's Name: _____ Child's Date of Birth: _____ Sex: _____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

List any medical conditions of which Kid Prints, Inc. should be aware, including, but not limited to, frequent illnesses, injuries or hospitalizations: _____

_____

_____

LIST ANY KNOWN ALLERGIES, INCLUDING FOOD AND MEDICATION ALLERGIES: _____

_____

_____

_____

Is your child currently taking medications? ☐Yes ☐No If yes, what?_____

Does your child receive therapeutic services in a developmental center or school ☐Yes ☐No

If yes, please check which services:

☐ Occupational therapy ☐Physical therapy ☐Speech Therapy

☐Behavior therapy ☐Psychological/Counseling services

Mobility: (check any that apply)

☐Walks ☐Uses wheelchair ☐Wears adaptive shoes

☐Uses cane ☐Uses walker ☐Does not move self

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☐ Crawls

Would your child be able to evacuate the building without assistance? ☐ Yes ☐ No

Communication: (check any that apply)
☐ Wears glasses ☐ Wears hearing aides ☐ Lip reads
☐ Uses light board or other adaptive device ☐ Uses sign language or hand signals

EMERGENCY CONTACT INFORMATION

Child's Name: _____ Child's Date of Birth: _____ Sex: _____

Parent/Legal Guardian Name #1 _____ Phone: _____

Parent/Legal Guardian Name #2 _____ Phone: _____

In the event of an emergency, I hereby authorize Kid Prints, Inc. to contact the following person(s) if I cannot be contacted:

Emergency Contact Name #1 _____ Phone: _____

Emergency Contact Name #2 _____ Phone: _____

Emergency Contact Name #3 _____ Phone: _____

Emergency Contact Name #4 _____ Phone: _____

<u>Health insurance information:</u>

Company Name: _____

Company Address: _____

Name of Policy Holder: _____ Policy Number _____ Group: _____

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AUTHORIZATION FOR MEDICAL TREATMENT

I authorize the hospital and attending physicians to submit claims to the above named company and hereby assign benefits directly to this company. I understand that I am financially responsible to providers of service for charges not covered by any insurance payments.

I, _____ hereby give permission to Kid Prints, Inc. to obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is _____ _____ and date of birth is _____ should the need arise. It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians/dentists may be taken. I further hereby consent to transportation of the above named child to the nearest or most appropriate health care facility.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

NON-PRESCRIPTION MEDICATION ADMINISTRATION

Child's Name: _____ Child Date of Birth: _____

ADMINISTER	MEDICATION	BRAND
YES NO	*Baby Wipes	
YES NO	Band Aids	
YES NO	Neosporin, Bacitracin, or Similar Ointment	
YES NO	*Bactin or Similar First-Aid Spray	
YES NO	*Sunscreen	
YES NO	*Insect Repellant	
YES NO	*Non-Prescription Ointment (Such as A&D, Desitin, Vaseline)	
YES NO	*Tylenol/Acetaminophen	
YES NO	*Motrin/Ibuprofen	
YES NO	*Other – please specify:	

**Must be provided by the parent/guardian*

I hereby request Kid Prints, Inc. to administer/apply one or more of the above medications in accordance with the directions on the container as needed. I release Kid Prints, Inc. from any liability for administering these preparations.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date