Children's Developmental Program

FOR OFFICE USE ONLY:

Paid Registration: ____

Days and Times Approved ___________

____

Registration Form

(Individual Registration Fee $75.00 – Family Registration Fee $100)

Child's name: ____

Birthdate: ______________________

Address: ____

____

Home Phone: __________________________

Parents' Names: __________________________

Mother's Employer ______________________ Work No. _____________
Can we contact you at work? ________

Father's Employer ______________________ Work No. _____________
Can we contact you at work? ________

Email Address: ____

Does your family require interpreter services? _____________

Name and Phone Numbers of Emergency Contacts:

1. ____

2. ____

Name, Address, Phone No. of Child's Physician:

____

____

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A United Way Agency

Name, Address, Phone No. of Child's Dentist:

____

____

Is your child on any kind of medication? If yes, please explain:

____

Does your child have any siblings?

Name Sex Age

____

____

How old was your child when he/she:

sat with support? ____________________ sat without support? ____________________

started to talk?____________________ began to crawl? ____________________

began to walk? ____________________ does your child nap? ____________________

Is your child potty trained? ____________ Needs some assistance? ____________________

How does your child express/communicate his wants and needs, excitement and fears?

____

____

Describe your child's personality:

____

What can we do to help with this transition?

____

____

Where did you hear about our program?

____

Days and times requesting: ____

Anticipated Start date: ____