

The Little Sage Enrollment Form

Application Date: _____

Please fill out the following form to the best of your ability. If you are filling this out for an infant or soon-to-be-born baby, please be sure to include their birthdate or approx. due date and your contact information.

Child Information:

First Name: _____ Middle Name: _____ Last Name: _____

What name do you prefer us to call your child? _____

Child's Age: _____ Child's Birthday: _____

Address: _____

Parent/Guardian Information:

Parent/Guardian 1:

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

E-mail: _____

Parent/Guardian 2:

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

E-mail: _____

Emergency Contact Information:

Emergency Contact 1:

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

E-mail: _____

Emergency Contact 2:

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

E-mail: _____

Do you have a back-up care provider? _____

Enrollment Questions:

When do you need care? _____

Hours of care needed (we are open from 7:30 am – 5:30 pm):

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Your Child’s Health:

A copy of your child’s immunizations will be needed before attending school. Please fill out the rest to your best knowledge!

How would you describe the general state of the child’s health?

Doctor’s name & office: _____ Phone: _____

Dentist’s name & office: _____ Phone: _____

Are your child’s immunizations up to date? _____

Any known allergies? _____

Please list and describe any allergies/reactions, not yet determined by a healthcare professional, which you may be concerned about: _____

Please list and describe any medical conditions your child has which we should be aware of (including speech, hearing, or visual): _____

Has your child experienced any of the following common childhood illnesses? Check off any that apply.

<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Soiling	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Stomach Upsets	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>	Impetigo	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	Worms	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Frequent Sore Throats	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Ringworm
<input type="checkbox"/>	Lice	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	

Please list and describe your child’s restrictions to play or activities:

About Your Child:

Has your child ever been in childcare before? _____

What type (center, family daycare, grandparent, etc.)? _____

How does your child feel about daycare and being left by his/her parent?

Are there any recent life changing situations the child has been exposed to, such as a death in the family, divorce, new sibling, etc.? _____

What is your normal method of discipline/behavior correction?

What is your child's temperament? Are they easy going, hard to please, demanding, calm, etc.?

If any, what are your child's food restrictions?

What are your child's favorite foods?

What food does your child dislike?

Can your child be relied upon to indicate bathroom wishes? _____

What does your child call bowel movements? _____ Urination? _____

What time does your child awaken? _____ Go to sleep? _____

How do they sleep through the night? _____

Does your child sleep in a bed, a crib, or other? _____

Are there any siblings? Please name them and specify ages and gender.

Name: _____ Age: _____ Gender: _____ Name: _____ Age: _____ Gender: _____

Name: _____ Age: _____ Gender: _____ Name: _____ Age: _____ Gender: _____

What is your child's experience with playing with other children?

What language(s) are spoken at home? _____

Does your child have any security objects (blanket, soother, bottle, toy, etc.)?

What are your child's favorite activities, toys, books, or games?

Is there anything else you would like us to know about your child? Concerns?

Your signature: _____ Date: _____

Relation to child: _____