The Country Day School of Colts Neck
93 Route 34
Colts Neck, New Jersey 07722
732-252-8908
countrydaycn@aol.com

ENROLLMENT APPLICATION

Child's name _____ Date of birth _____

Expected start date _____ Male or female _____

Child's age in months on start date _____

Home address _____

E-mail _____ Home phone number _____

Parent Information

Mother's name _____ Cell phone no. _____

Employer's name/address_____

Employer's phone no. _____

Father's name _____ Cell phone no. _____

Employer's name/address _____

Employer's phone no. _____

Marital status ___married ___separated ___divorced ___single ___widowed

If there is an issue regarding custody, please provide The CDSCN with a court order.

PEDIATRICIAN CONTACT INFORMATION

Name of Pediatrician _____ Phone number _____

Address _____

EMERGENCY MEDICAL RELEASE FORM

In the event of an emergency when medical treatment is immediately necessary, I/we give permission to The CDSCN to authorize emergency treatment for my child. For this purpose, I/we give permission to release my child's medical information to emergency medical personnel.

Mother's signature _____ *Date* _____

Father's signature _____ *Date* _____

Please attach a current copy of your child's immunization records. If his or her immunizations are not up to date in accordance with the recommended schedule, please attach an explanation from your child's physician.

Emergency Contacts – please list in order

In the event of an emergency, when we are unable to reach a parent or guardian, please list the person(s) you authorize The CDSCN to release your child to. ***Please note that we will require this person to present a photo ID if he or she is not familiar to our staff.***

1) Name _____ Relationship _____ Phone _____

2) Name _____ Relationship _____ Phone _____

3) Name _____ Relationship _____ Phone _____

Please list any other person(s) whom you authorize to pick your child up from The CDSCN.

_____

We want to provide your child with the best care possible. Please help us get to know your child by filling out this questionnaire. Thank you!

Child's name _____ Date of birth _____

FAMILY INFORMATION

Sibling's name: _____ Age: _____

Sibling's name: _____ Age: _____

Sibling's name: _____ Age: _____

Languages spoken at home _____

DAILY ROUTINES

EATING

Do you consider your child to be a good eater? _____ What are some of your child's favorite foods?

_____

IF YOUR CHILD HAS ANY FOOD ALLERGIES, LIST THEM HERE AND EXPLAIN ANY REACTIONS IN DETAIL.

_____

If you will be providing us with an epi-pen or any other allergy treatments, please list them here and complete an "Individual Permission for Medication or Health Care Procedure" Form.

_____

If there are any foods that you do NOT want us to offer your child, please list them here.

_____

Does your child eat with his or her hands, a spoon or a fork? _____

Does your child drink from a bottle, sippy cup or a regular cup? _____

NAPPING

Please describe your child's usual bedtime routine (including what time and where he or she usually sleeps.)

_____

_____

How do you know that your child is sleepy?

_____

_____

Does your child nap? _____ If yes, for how long? _____

TOILETING

Does your child wear underwear, a diaper or Pull-ups during the day? _____ For naps? _____

Do you have any concerns about your child's toileting habits? If yes, please explain.

_____

PLAY

What are your child's favorite toys, objects or songs?

_____

Does your child enjoy playing with others? _____ Does your child like to play alone? _____

HEALTH

Does your child have any health problems? _____ If yes, please explain.

_____

Does your child take any medications regularly? _____ If yes, please list. _____

Does your child have frequent ear infections? _____ Rashes? _____

Do you have any concerns about your child's health? _____ If yes, please explain.

_____

Does your child have any non-food allergies? _____ If so, to what? _____

Explain reactions in detail

_____

Please note that if your child requires any medication while in our care, you must complete an "Individual Permission for Medication or Health Care Procedure" Form.

DEVELOPMENT

GENERAL DEVELOPMENT

Do you have any concerns about your child's hearing and/or vision? _____ Speech and language development? _____ Overall development? _____

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever attended a preschool or childcare center? _____

How does your child respond in group situations?

_____

How would you describe your child's temperament or personality? _____

Does your child use a special comforting item such as a blanket or a stuffed animal? _____
If so, what is it? _____

GOALS

What goals do you have for your child while attending The CDSCN?

_____
_____
_____

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

_____
_____
_____

Thank you for completing this questionnaire. Please contact us if you have any additional concerns or comments.

Our mission at The CDSCN is to provide a safe, nurturing environment where every child receives outstanding, individualized care. As our students reach their developmental milestones, we strive to help them achieve a higher level of thinking that will challenge them, build self-confidence and instill a love of learning.