JOSIAH'S CHRISTIAN ACADEMY

- ⇒ Enrollment Form
- ⇒ Emergency Information
- ⇒ Emergency Medical Treatment Form (blue card)
- ⇒ Transportation Form
- ⇒ Permission Form
- ⇒ Photographs
- ⇒ Lotion & Cream Permission
- ⇒ Child's Information Record (5 pages)
- ⇒ Medical Form

Josiah's Christian Academy
Enrollment Form

Child's Name _____ Male _____ Female_____

(Last , First, Middle)

Address _____ Birth date _____

(Number Street)

_____Phone _____

(City State Zip)

Childcare needed: Days: _____Hours: _____

Parent's Name _____Occupation _____

Employer _____Phone ( )_____

Employer Address _____

Parent's Name _____ Occupation _____

Employer _____ Phone ( ) _____

Employer Address _____

Other children in family: (Give names, ages, and birthdates)

_____

_____

Other people living at home (names and relationship to child)

_____

_____

Has child had previous group experience? Please explain:

_____

_____

When do you wish your child to begin? _____

Josiah's Christian Academy offers equal opportunity enrollment to all children without regard to race, color, religion, sex, age, national origin or disability.

Signature _____ Date _____

Josiah's Christian Academy
Transportation Form

Each family will be expected to make whatever arrangements are necessary to transport their own children to and from the Josiah's Christian Academy. I therefore assume full responsibility for my child in route to and from the Josiah's Christian Academy center.

_____ _____

Signature of Parent or Legal Guardian Date

Josiah's Christian Academy
Permission Form

I hereby grant permission for my child to use all of the play equipment and participate in all the activities of the center, and to leave the Josiah's Christian Academy center under the supervision of a staff member on walks or planned field trips*.

_____ _____

Signature of Parent or Guardian Date

*Parents will be notified about any field trips in advance.

Josiah's Christian Academy
Emergency Information/Contact Form

Child's Name: _____

Address: _____

Home Phone: _____

Parent's Name: _____

Daytime Phone: _____

Email Address: _____

Parent's Name: _____

Daytime Phone: _____

Email Address: _____

Other persons to be contacted in case of illness or emergency and who are also authorized to remove child from the Center:

Names Phone Numbers

1. _____

2. _____

3. _____

4. _____

Doctor's Name _____ Phone Number_____

Dentist's Name _____ Phone Number_____

Please list allergies: _____

_____

Please list any special medical instructions: _____

_____

_____

_____

PARENT SIGNATURE_____DATE _____

Josiah's Christian Academy
Photo Permission Form

From time to time we take photographs of the children at the Center. We often hang these photos in the Center to share the children's projects and activities with our families. We also occasionally use the photos for publicity. Please sign the form below and return it with your packet. Let the director know if you have any questions.

I give permission to Josiah's Christian Academy to take photographs of my child, _____ at the Center and to use the photographs for display at the Center or for publicity purposes.

_____ _____

Signature of Parent or Guardian Date

Josiah's Christian Academy
Child's Information Record

Family & Social History

Name of Child _____Nickname_____
Date of birth_____ Sex_____ Home phone_____
Address _____
Parent (or Guardian)_____Business phone _____
Business Address _____
Parent (or Guardian)_____Business phone_____
Business Address _____

Marital Status of Parent(s):

Single____Married____ Living together_____ Divorced_____ Separated_____
Remarks: _____

_____

Custody/Visiting Arrangement_____

_____

If child is adopted:
Age at adoption_____ Does child know he or she is adopted? _____
Was the child adopted from another country? _____Which country? _____
Brothers & Sisters of Child:
Name_____Age_____
Name_____Age_____
Name_____Age_____
Name_____Age_____
Name_____Age_____

Other members of the household (include relationship & age)

_____

_____

_____

Who cared for the child up until now? _____

_____

Has child had group experience?_____Where?_____
What are the child's favorite indoor play activities? _____

_____

Outdoor activities? _____
Is your child right or left-handed? _____
Does child have any special fear that you are aware of? _____
Does child have any speech problems? _____

_____

Child's Information Record

Does child have any other problems we should be aware of? _____

_____

What method(s) of behavior control is used in your home? _____

_____

_____

_____

How would you describe your child's personality? _____

_____

_____

How does your child react to new situations? _____

_____

_____

Health History

What illnesses has the child had? At what age?

Chicken Pox _____/_____ Scarlet Fever_____/_____ Diabetes_____/_____

Mumps_____/_____ Measles_____/_____ Hepatitis_____/_____

Other_____/_____

Does child have frequent colds? Explain_____

_____

Tonsillitis? _____Earaches? _____

Stomach aches? _____Does child vomit easily? _____

Does child run high fevers easily? _____

Has child had any serious accidents? Explain_____

_____

Has child had any surgery or been hospitalized for any reason? Explain

_____

_____

Is child allergic? _____ If so, how does it usually manifest itself?

Asthma_____ Hay Fever_____ Hives_____

Other_____

Do you know what allergy is cause by? _____

_____

What is the necessary treatment for child's allergic reaction? _____

_____

Does your child have a history of asthma and if he/she does how is it handled?

_____

_____

Child's Information Record

Has your child ever had a seizure? _____ If yes, what was the cause _____

_____

Has child ever been to dentist? _____

Has child had vision tested? _____ Does child wear corrective lenses? _____

Hearing tested? _____ Does child wear corrective shoes? _____

Does your child take any medication daily? If yes, what is it and why is it taken?

(Please include daily vitamin) _____

_____

_____

Are there any medical problems we should be aware of or any problems that would restrict child's activities? _____

_____

_____

Sleeping

What is your child's present sleeping schedule? _____

_____

_____

What position does your child sleep in most often? _____

_____

_____

How would you characterize your child sleeping? (Deep, restless, etc.)_____

_____

What conditions are necessary for your child to sleep?

rocking chair_____ toy_____

blanket_____ dark room_____

bottle_____ other_____

music_____ other_____

What is your child's mood on awakening? _____

_____

Feeding

Was or is your child breast-fed? _____ If so, for how long or is he/she still being breast-fed? _____

_____

Child's Information Record

If your child uses (d) formula, what type? _____

_____

Have there been any changes? Why? _____

Is your child eating food? _____If so, what kind? _____

_____

Does your child feed himself/herself? _____

What is your child's eating schedule? _____

_____

What are your child's likes & dislikes? _____

_____

Does your child have any dietary restrictions? _____

_____

Diapering/Toileting

Is your child in diapers? _____

Does your child have sensitive skin? _____

Does your child have frequent diaper rash? _____

If so, how do you treat it? _____

Please check which of the following you use:

_____oil _____powder _____ lotion _____other (specify)

_____

Does your child have regular bowel movements? _____

How many does he/she have per day? _____

Do you have any concerns about your child's elimination system? If so, explain: _____

_____

_____

_____

Have you begun toilet training? _____

If trained, at what age was he trained?

urine_____ bowels_____

How have you approached toilet training? _____

_____

_____

_____

Word child uses for urination? _____

Word child uses for bowel movements? _____

Child's Information Record

Other Parent Comments:

_____

_____

_____

_____

_____

_____

_____

Parent or Guardian Signature _____ Date_____