# JCC Early Childhood Center
# Enrollment Record

## Personal Data

Child's Name (last, first)_____ Nickname _____

Home Address (include city, zip) _____ Phone _____

Date of Birth _____ Sex _____ Hebrew Name _____

Parent 1 Name _____ Address _____

Email _____Occupation _____

Parent 2 Name _____ Address _____

Email _____Occupation _____

## Home Environment

Siblings (please give names and ages)_____

Other adults living in your home (please give relationship to child) _____

Parent 1 Religious affiliations and interests _____

Parent 2 Religious affiliations and interests _____

Primary language of child _____ Parents' _____

Which parent can read and write English? _____Parent 1 _____Parent 2

## Birth History

Did you have any difficulties during your pregnancy? _____

Was your child either premature or very late? _____

Did your child require any special medical care or prolonged hospitalization at birth?
_____

Anything else your child's teacher needs to know? _____

## Developmental History

At what age did your child……

Sit alone _____, Crawl _____, Walk alone _____, Say first words ____,

What were they? _____, Say first sentence _____, Feed

self with a spoon ____, Drink from a cup _____, Toilet Mastery _____

## Child's Physical Record

Serious Illness _____

Are the any medical issues your child's teacher needs to know about? _____

_____

## Allergies and Medications

Seasonal (i.e. hay fever, goldenrod, etc.)_____

Skin _____ Insects _____ Medications _____

Food _____

If so, what effect so they have on your child? _____

_____

Do you have an allergy action plan? _____ yes _____no **(PLEASE PROVIDE COPY)**

*Severe food allergies; should be discussed with Peretz & teachers in the classroom.*

Does your child take medication regularly? _____yes _____no

If so, please describe the nature of the medication, condition, any reactions to the medication, i.e. drowsiness, thirst, etc. _____

_____

Will your child take medication during the day while at the Center? _____yes ___no

## Emotional Record

What are the child's fears and how does s/he react to them? _____

_____

_____

How does your child sooth him/herself? _____

Behavior Management, what form do you use? _____

## Social Record

Does your child prefer to play with children __own age, __younger, __ older, __adults

Active or quiet play preferred? _____

Leader or follower? _____

Has s/he every been away from parents? _____ For what reason? ____

_____

Does your child have separation anxiety? _____

How is it best handled? _____

Has your child been in child care before? ___babysitter/nanny, __ family day care,

__child care center

## Additional Information

Note below any items which you feel may affect your child in any way; i.e. remarriage of parents, adoption of sibling, illness in family, separation from parents for long periods, etc. Any information given is confidential and purely optional. It is primarily for the purpose of understanding and helping your child. _____

_____

_____

_____

Special Needs: ( please describe any points in which the child needs help, i.e. discipline, food difficulties, behavior, etc.) _____

_____

_____

**Children 2 and under answer next two sections, all others skip to last section**

## Sleep

Has your child shown any sleeping problems? _____ yes _____ no

If yes what kind? _____

How long does your child typically sleep at night? _____

What is your child's sleeping pattern for the day? A.M. _____ P.M._____

Do you have any special ways of helping your baby go to sleep? _____ yes _____no

If yes, what are they? _____

Does your baby usually cry when going to sleep? _____

If yes, how long? _____

Does your baby sleep in his or her own bed? _____ yes _____ no

If no, with home? _____

Do you use a pacifier? _____ When _____

## Nutrition

Has your child had any feeding problems? _____ yes _____ no

Does your child have a good appetite and show interest in food? _____ yes _____no

Can your child eat crackers or cereal at school for snack? _____ yes _____no

What is your baby's current feeding schedule? _____

Is your baby:  Breast fed _____ Bottle fed _____