

Registration Billy Dalwin Preschool of Temple Emunah

Toddler Preschool

Start Date: ____/____/____

Family Information

Child's Name:		Date of Birth ____/____/____ Age ____ (as of 9/1/24)	
Home Address:			
City:		State:	Zip Code:
Eye Color:	Skin Color:	Hair Color:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Allergies:	Height:		Child's Primary Language:
Epi Pen: Y N	Weight:		Languages Spoken at Home:
Identifying Marks:			

*Required Information: Please Print

Guardian Name 1:	Guardian Name 2:
Relationship to Child:	Relationship to Child:
Home Address: Same <input type="checkbox"/>	Home Address: Same <input type="checkbox"/>
Cell Phone:	Cell Phone:
Bus. Phone:	Bus. Phone:
Bus. Name:	Bus. Name:
E-Mail:	E-Mail:
Hours at Work:	Hours at Work:
I give permission to be included in the family Directory. Yes No	Signature:

Parent Signature _____ Registration Date ____/____/____

Parent Signature _____ Start Date 09/01/2024

First Aid and Emergency Medical Care Consent Form

Child's Name:	Date of Birth ____/____/____
I authorize staff of Billy Dalwin Preschool of Temple Emunah to administer first aid to my child when appropriate. <i>*Only staff trained and certified in first aid will administer aid.</i> Initials _____	
I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____ and to secure necessary medical treatment for my child. Signature _____	
Child's Physician/Clinic Name:	
Address:	Phone:
Health Insurance Coverage:	
Policy #:	
Child's Allergies: Y/N	List Allergy: _____ Anaphylactic? Y/N
Describe the reaction:	
Special Diet: _____	
Does your child have a medical alert bracelet/necklace? Y/N <i>*If your child has an anaphylactic allergy, they must have a medical alert bracelet on, when attending Billy Dalwin Preschool.</i>	
Chronic Health Conditions: Y/N If yes, you must complete an <i>IHCP medical plan</i> signed by your physician. Forms are located on our website or requested through the BDPS Office. Please describe the condition(s): Has your child ever had a seizure? Y/N Please describe: Does your child have any physical limitations?	

Parent Signature _____

Date ____/____/____

Emergency Contacts

Please inform Emergency Contacts that they may be called if we cannot reach the child's guardian(s)
We will always try to reach the parent or guardian first.

3 Contacts Required

1. Name:	Relationship to Child:
Address:	Phone:
Do you give permission for the child to be released to this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Name:	Relationship to Child:
Address:	Phone:
Do you give permission for the child to be released to this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Name:	Relationship to Child:
Address:	Phone:
Do you give permission for the child to be released to this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Parent Signature _____

Date ____/____/____

Transportation and Authorization

Child's Name:	Date of Birth ____/____/____
All children arrive and depart under the personal responsibility of the parent/guardian or other authorized individuals.	
I give permission to the following people to receive my child at the end of the day.	
Every child must have at least one person listed other than the guardian(s).	
Signature _____	
How will your child arrive/leave the program? <input type="checkbox"/> Parent Drop Off /Pick UP <input type="checkbox"/> Other Drop Off/ Pick Up	

1. Name:	Relationship to Child:	
Address:		Phone:

2. Name:	Relationship to Child:	
Address:		Phone:

3. Name:	Relationship to Child:	
Address:		Phone:

4. Name:	Relationship to Child:	
Address:		Phone:

5. Name:	Relationship to Child:	
Address:		Phone:

6. Name:	Relationship to Child:	
Address:		Phone:

***Please inform those listed above a photo ID is required at the time of pick up.**

All other permission-to-pick-up requests must be stated in writing and maintained in the child's file.
This permission is valid for one program year from the date of signature

Parent Signature _____ Date ____/____/____

Developmental History and Background Information

Child's Name:	Date of Birth ____/____/____
Any speech difficulties (if yes, please list)?	
Special words to describe needs:	

Health (First-year Students Only).

Any known complications at birth?
Serious illnesses and/or hospitalizations:
Special physical conditions, disabilities:
Regular medications:

Eating Habits

Special characteristics or difficulties:
Favorite foods:
Foods refused:
*Does your child eat with <input type="checkbox"/> spoon, <input type="checkbox"/> fork, <input type="checkbox"/> hands?

Toilet Habits

Are disposable <input type="checkbox"/> diapers or <input type="checkbox"/> pull ups used?	
Is there a frequent occurrence of diaper rash? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a problem with diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe any particular bathroom procedure to be used for your child at the center:	
Is a <input type="checkbox"/> potty chair or <input type="checkbox"/> special child seat, or <input type="checkbox"/> regular seat used at home?	
How does your child indicate bathroom needs (including special words)?	
Is your child ever reluctant to use the bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child have accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Sleeping Habits

*Does your child sleep in a <input type="checkbox"/> crib or <input type="checkbox"/> bed?	
Does your child become tired or nap during the day?	
What time does your child go to bed?	What time does your child wake up?

Developmental History and Background Information

Regulations for licensed childcare facilities require this information to be on file to address the needs of children while in care.

Social Relationships: Please add additional pages if needed.

How would you describe your child:	
Previous experience with other children/daycare:	
Reaction to strangers:	Able to play alone:
Favorite toys and activities:	
Fears (the dark, animals, etc):	
How do you comfort your child:	
What is the method of behavior management/discipline at home:	

What would you like your child to gain from this childcare experience?	

Daily Schedule: Please describe your child's schedule on a typical day.

Is there anything else we should know about your child?

Parent Signature _____

Date ____/____/____

Please Attach Your Most Recent Physical Exam

INCLUDING: IMMUNIZATION, EYE, HEARING AND LEAD TESTS OR FILL OUT THE FORM BELOW

Dear Physician: _____ (Child's Name)

is enrolled at Billy Dalwin Preschool of Temple Emunah a licensed by the Department of Early Education and Care. **The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations, and lead screening under the Department of Public Health's recommended schedules.** A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.
