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|---|--|--|----------|------------------------|---|---------------------------------------|------|---------------------------------|------|--|------------|--|
| Child's name (last, first, middle): | | | | | Name called: | | Age: | | Sex: | | Birthdate: | |
| Father's name (last, first, middle): | | | | | Driver's license #: | | | Please circle one: Dr. Mr. | | | | |
| Address (street, city, state, zip): | | | | | Home phone (please indicate which # to call first): | | | | | | | |
| Place of Employment: | | | | Work phone/cell phone: | | | | Email Address: | | | | |
| Mother's name (last, first, middle): | | | | | Driver's license #: | | | Please circle one: Dr. Mrs. Ms. | | | | |
| Address (street, city, state, zip): | | | | | Home phone (please indicate which # to call first): | | | | | | | |
| Place of Employment: | | | | Work phone/cell phone: | | | | Email Address: | | | | |
| Person(s) authorized to pick-up child other than parent (name, address, phone, driver's license#): | | | | | | | | | | | | |
| Person(s) to contact in emergency (should both parents be unavailable): | | | | | | | | | | | | |
| Program in which child will be enrolled: Infants Pre-Toddlers Toddlers Pre-school Partial Day Private School After-school | | | | | | | | | | | | |
| Time: from ____ to ____ | | | | | | Numbers of days each week: M T W Th F | | | | | | |
| Beginning Date: | | | | | | | | | | | | |
| Private Physician: | | | Address: | | | Phone: | | | | | | |
| Hospital: | | | | | | | | | | | | |
| Public/Private School Attending: | | | | Address: | | | | Phone: | | | | |
| <input type="checkbox"/> His/Her immunization record is on file at the school and all required immunizations and/or Tuberculosis test are current. Vision and Hearing screening records are also on file. | | | | | | | | | | | | |

Authorizations:

I hereby authorize Stepping Stones to share all health information regarding my child with all relevant Stepping Stones employees, and I authorize Stepping Stones to share my contact information for classroom directories.

Parent/Guardian Signature

Date

Personal Profile

| | |
|---|---------|
| Height: | Weight: |
| For educational purposes, please identify the ethnicity, religion, and language of your family: | |
| Please share any other pertinent family information: | |
| With whom does your child live (circle one or both): Mother Father | |
| Brothers (name and age): | |
| Sisters (name and age): | |
| Brothers and sisters not living with child: | |
| Name of anyone that cares for child other than parents: | |
| Other people child sees frequently: | |
| If child attended another child care center, please name: | |

Personal History

| | | |
|--|-----|----|
| Does your child have a history of: Vision impairment or eye infection? | Yes | No |
| Hearing impairment or ear infection? | Yes | No |
| Speech problems? | Yes | No |
| Does your child need any special help (i.e., Speech therapy)? | | |
| Has your child ever been tested for learning disabilities or developmental delays? | | |
| Does your child have any special fears? | | |
| Does your child have a room alone? Yes No If no, who shares room: | | |
| Any medication prescribed for long-term continuous use: | | |
| Existing illness (i.e., Asthma): | | |
| Previous serious illness/injury? | | |
| Hospitalization during the past 12 months? | | |
| Does your child have any allergies? | | |

I hereby authorize Stepping Stones to post any necessary

ry allergy information in my child's classroom.

Parent/Guardian Signature

Date

Child's Play Experience

How much time does your child spend outdoors?

Some ways your child plays at home:

Some favorite toys:

Some favorite foods:

Does child have playmates of similar age?

Fun things you do together:

How often do you read to your child?

Habits

Relate any pertinent information concerning:

Toilet habits:

Sleep and nap habits:

Eating habits and difficulties:

Behavior habits (thumb-sucking, tantrums, etc.):

Attitude

What is your child's attitude toward himself?

How does he react when not getting his way?

What problems does your child have that concern you most?

List methods of discipline used:

What do you feel are his special abilities/capabilities?

In what ways do you expect our program to help your child?

Comments

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Parent/Guardian Signature

Date

