



APPLICATION FOR CHILD CARE SERVICES

Date: _____ Desired Start Date: _____

Parents' Names: _____ Daytime Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

I may be contacted at the following email address: _____

Are you currently receiving Childcare Assistance? No: Yes:

If yes, Think Small: CCAP: County Case Number: _____

There is a \$50 application fee per child at the time of enrollment for which you are financially responsible.

Job Counselor Name: _____ Phone #: _____

County Worker's Name: _____ Phone #: _____

| Child's Name | Birth Date | Sex of Child | Type of Care Needed? | Does Your Child Have Special Needs or Allergies? |
|--------------|------------|--|--|--|
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Full-time Toddler <input type="checkbox"/> Full-time Preschool | |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Full-time Toddler <input type="checkbox"/> Full-time Preschool | |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Full-time Toddler <input type="checkbox"/> Full-time Preschool | |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Full-time Toddler <input type="checkbox"/> Full-time Preschool | |

| Child's Race (check all that apply) | Child's Ethnicity (check all that apply) |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic/Latino State of MN required: <input type="checkbox"/> Somalian <input type="checkbox"/> Hmong <input type="checkbox"/> Other _____ |

Has your child had a preschool screening? No: Yes: If yes, please provide a copy

Documentation Required for Enrollment:

- Medical Card
- Birth Certificate
- Immunization Record (updated)
- Physical Completed
- Proof of Assistance (if applicable)
- Meet My Child (attached)
- Emergency Information Form with name, address and phone number of at least 2 emergency contacts (attached)

How did you hear about our Center?

- Parent Peer Navigator
- Flyer/Brochure
- Word of Mouth
- Website
- Friend/Acquaintance - _____
Referral's Name

Approval Date: _____ Initials: _____
 Classroom: _____
 Authorization Received: _____
 Start Date: _____
 Orientation Tour Date _____
 Intake Meeting Date _____

Meet My Child

New Student/Classroom _____ **Room Transfer/Classroom** _____

Name: _____ **Date of Birth:** _____

Parents/Guardian: _____ and _____

Is this your child's first child care experience? YES NO

Other members of the household:

_____ Relation to Child/Family _____

_____ Relation to Child/Family _____

_____ Relation to Child/Family _____

Custody: _____

Parents spend days at:

Guardian Work School Home Other _____

Guardian Work School Home Other _____

HEALTH:

Weighed ____ lbs. ____ oz. at birth Any complications at birth? _____

Generally healthy? YES NO Hospitalizations for: _____ When: _____

| Special Conditions | Treatment |
|--|-----------|
| Allergies to: | |
| Asthma: | |
| Seizures when: | |
| Rashes: | |
| Does your child have an Individual Education Plan and/or receiving special services? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| Other: | |

Parents have concerns about: (please check all that apply)

Vision Hearing Development Speech Growth Behavior
 Other _____

Toilet Training:

Totally Independent _____

Needs some help _____

Just started _____

Words used by child to refer to toileting:

Urination _____

Bowel Movements _____

PERSONALITY:

The best words to describe this child: (please circle all that apply)

| | | | | | |
|-------------|---------------------|-------------|---------------|-------------|------------|
| Calm | Happy Friendly | Independent | Shy | Observer | Fearful |
| Active | Easily Angered | Assertive | Affectionate | Cooperative | Submissive |
| Adventurous | Needs Encouragement | Quiet | Learns Easily | | |

Other words that describes your child: _____

What would you like to tell us about your child: _____

How is your child best comforted: (please check all that apply)

Held Left Alone Talked to Sung to Redirect to another activity

Other comforting techniques your child responds to: _____

Activities your child enjoys: (please check all that apply)

Reading Music Dramatic Play Physical exercise Other _____

What would you like your child to learn at the Center? _____

Does your family eat meals together? YES NO **Meals at the Center are served "family style".**
Please tell us how meals in your family are served. This information will help us help your child adjust to new dining experiences. _____

CULTURE:

Language spoken at home is: _____

No pork products are served at the Center. What other foods does your child not eat? _____

Please check if your family observes/recognizes these holidays:

Federal Holidays: New Years Christmas Thanksgiving

Festival/Events: Valentine's Day St. Patrick's Day Halloween Birthdays

Other values/customs/beliefs/etc. that the Center/Classroom should know about:

PARENT PARTICIPATION

What would you like to share with the classroom/program? Check all that apply

Willing to go on field trips Classroom Helper Help with Family Fun Nights
 Share with the classroom what type of work you do Hobby/Craft _____
(What is it?)

Parent Advisory (Requirement of scholarship parents)

Your Choice _____
(What is it?)

EMERGENCY INFORMATION

Start Date: _____ Classroom: _____

Child's Name: _____ DOB: _____ Sex: M F Age: _____

Address: _____ County: _____
(Street Address including apt. #) (City) (State) (Zip code)

Parents Place of Employment/School: _____

Parent 1: _____

Phone numbers Primary () _____ Secondary () _____ Additional () _____
Check type of phone: Home Work Cell Home Work Cell Home Work Cell

Address: _____ County: _____
(Street Address including apt. #) (City) (State) (Zip code)

Last 4 digits of parent's Social Security Number. _____ (used to verify parent identity when authorization for pickup is done by phone)

Parent 2: _____

Phone numbers (Circle **Primary**, **Secondary** or **Additional** Phone#)

Phone numbers Primary () _____ Secondary () _____ Additional () _____
Check type of phone: Home Work Cell Home Work Cell Home Work Cell

Address: _____ County: _____
(Street Address including apt. #) (City) (State) (Zip code)

People authorized to take children from CDC and who may be called in an emergency unless otherwise specified:

Alternate 1: _____ Relationship to Child _____

Phone numbers Primary () _____ Secondary () _____ Additional () _____
Check type of phone: Home Work Cell Home Work Cell Home Work Cell

Address: _____ County: _____
(Street Address including apt. #) (City) (State) (Zip code)

Alternate 2: _____ Relationship to Child _____

Phone numbers Primary () _____ Secondary () _____ Additional () _____
Check type of phone: Home Work Cell Home Work Cell Home Work Cell

Address: _____ County: _____
(Street Address including apt. #) (City) (State) (Zip code)

Alternate 3: _____ Relationship to Child _____

Phone numbers Primary () _____ Secondary () _____ Additional () _____
Check type of phone: Home Work Cell Home Work Cell Home Work Cell

Address: _____ County: _____
(Street Address including apt. #) (City) (State) (Zip code)

Alternate 4: _____ Relationship to Child _____

Phone numbers Primary () Secondary () Additional ()
Check type of phone: Home Work Cell Home Work Cell Home Work Cell

Address: _____ County: _____
(Street Address including apt. #) (City) (State) (Zip code)

Doctor/Clinic: _____ **Insurance Info:** _____

Address: _____ Phone: () _____

Hospital Name: _____

Address: _____ Phone: () _____

Allergies: _____ **Meds:** _____ **Dietary Allergies:** Yes No

Dentist: _____

Address: _____ Phone: () _____

- I give permission to Wilder Child Development Center to take whatever emergency measures they judge necessary for the care and protection of my child while under their supervision.
- In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit (911).
- I understand that in some medical situations, the staff will need to contact the local emergency unit before calling the parent. They will try all emergency contacts listed.
- I agree to make written notification if any of the above statements are to be canceled or if any phone numbers or addresses change.
- My child has permission to go on neighborhood walks within one half mile of the Center.
- I give staff at Wilder Child Development Center permission to use lip balm, suntan lotion, and mosquito repellent on my child at their discretion. I will provide these products for my child. I realize products must be non-aerosol.
- I give Wilder Child Development Center staff permission to use diaper ointments or wipes (which I will provide) for diapering my child. If not available, I give permission to use petroleum jelly (Vaseline).
- I give Wilder Child Development Center staff permission to use hand sanitizer on my child's hands.
- I give Wilder Child Development Center staff permission to use scented lip balm (back of the hand only).
- I give Wilder Child Development Center staff permission to use hand/body lotion on my child.

Signature: _____ **Date:** _____

Please return forms to:
911 W Lafond Ave., St. Paul, MN 55104,
fax to 651-280-3600,
or email to childcare.applications@wilder.org