Little Wonders Learning Center & Child Care Inc.
Enrollment Data Form

1. Student Information

Child's Full Name (First, Middle, Last)	**Nickname**
Child's Social Security Number	**Date of Birth** **Sex** **Male ☐ Female ☐**

2.Primary Contacts: (In the event there is any issue regarding custody of the child. Little Wonders Learning Center must be provided with court issued custody papers that clearly describe the custody arrangements. Any person granted custody in such papers may pick up the child at any time. Little Wonders Learning Center cannot legally refuse their right to pick up the child.)

Full Name (first, middle, last)	**Home Phone**
Address City State Zip	
Employers Name Address City State Zip	**Work Phone**
E-Mail Address Drivers' License #	**Work Hours**

Additional / Emergency Contacts: Complete for additional authorized child pick up.

Relationship: Mother☐ Father☐ Neighbor☐ Friend☐ Other☐	**Home Phone**
Full Name (first, middle, last)	
Address City State Zip	**Work Phone**
Employers Name Address City State Zip	**Work Hours**

Additional / Emergency Contacts: Complete for additional authorized child pick up.

Relationship: Mother☐ Father☐ Neighbor☐ Friend☐ Other☐	**Home Phone**
Full Name (first, middle, last)	
Address City State Zip	**Work Phone**
Employers Name Address City State Zip	**Work Hours**

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3. Medical Information

Name of Doctor	**Phone**	**Primary Health Carrier**
Address		**Policy Number**
Dentist	**Phone**	**Preferred Hospital**
Address		
Allergies or outstanding health issues		

4. Enrollment Data

Continued enrollment is not guaranteed. Without prior notice Little Wonders Learning Center may determine that it is in the best interest of the child and for the center that he/she is removed from the program.

5. Sick Policy

This program does not provide care for sick children. To avoid spreading illness to other children, PLEASE DO NOT BRING YOUR SICK CHILD TO THE CENTER. Children should not be brought to the center if they have a fever of 100.4 degrees within the past 24 hours, unexplained rashes, diarrhea, vomiting, continuous non-clear discharge from the nose, or yellow-green discharge from the eye, or a cough bad enough that you would not want your well child around. If the child is out for 3 or more days, please provide a doctors note to return.

6. Financial (Please read, sign and date below)

On occasion Little Wonders Learning Center will have special projects at the center. I acknowledge and will be responsible for any additional costs that may be incurred. PARTICIPATION IN THESE PROJECTS IS VOLUNTARY.

I agree to pay a RETURN CHECK FEE OF $35.00 for any returned checks that I write. Little Wonders Learning Center will have the option to refuse any future checks.

7. Policy and procedure changes

From time-to-time Little Wonders Learning Center may change or alter its policies and procedures. Little Wonders Learning Center reserves the right to undertake these changes without prior notice.

I certify that I have received, read and understand the information contained in Little Wonders Learning Center & Child Care Inc. Parent Handbook and enrollment data form and agree to the terms and conditions set forth therein. I also certify that all information provided is both true and accurate.

Signature of parent/guardian	**Date**	**Please print name**

I have received and reviewed this form for its completeness.

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Signature of center Director	Date	Please print name

HEALTH AND SOCIAL RECORD

Childs Name		
Birth Date	Height	Weight
Parent	Work Phone	Home Phone
Parent	Work Phone	Home Phone
Surrogate	Work Phone	Home Phone
Childs Doctors Name	Doctors Phone	Fax

Has your child ever been in a child care setting? ☐ **YES** ☐ **NO**_____

If so what kind? ☐ **Relatives' care** ☐ **In- home** ☐ **Church** ☐ **Other**_____

Does your child have existing conditions that Little Wonders should be aware of? ☐ **Yes** ☐ **No**

Explain_____

Does your child function at an age-appropriate level? ☐ **Yes** ☐ **No**

Explain_____

Is your child able to walk? ☐ **Yes** ☐ **No Explain**_____

Can your child effectively communicate his or her needs? ☐ **Yes** ☐ **No**

Explain_____

Is your child on a special or restricted diet, or have any food allergies (e.g. peanut butter)?

☐ **Yes** ☐ **No Explain**_____

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Does your child have any non-food allergies that we should be aware of (e.g. bee stings, environmental)?

☐ Yes ☐ No Explain_____

Does your child have any problems at meal time? ☐ Yes ☐ No

Explain_____

Does your child rest in the middle of the day? ☐ Yes ☐ No Explain_____

Can your child use the toilet on their own? ☐ Yes ☐ No

Explain_____

Does your child require any medication, therapy, medical treatment or assessment while in child care? ☐ Yes

☐ No Explain_____

If applicable, may we have copies of your child's IEP, IFSP, written plans and or Special Needs assessments completed by professionals in order to better help your child meet their goals? Yes____ No_____

Please Initial Response.

What are your child's preferences or other information that would help us provide your child with the best possible experience? _____

To the best of my knowledge, the information I have provided and the statements I have made in this health and social record are correct and complete. I understand that withholding or providing false information herein or in connection with the enrollment process may result in immediate disenrollment of my child. I further agree to update the information in this health and social record as circumstances may require.

Signature of Parent/Guardian:	**Date:**