APPENDIX H
SAMPLE CHILD APPLICATION

Head of Household:	Date of Birth:

Child Information	
Child's Name:	Date of Birth:
Child's Preferred Name:	
Child lives with: __One Parent __Two Parents __Guardian __Shared Custody __Foster Parent	
Do you have custody of the above-listed child? __Yes __No __Shared	
If no, give the legal name of the person having legal custody: _____	
If shared custody, with whom do you share custody: _____	

Contact Information			
Physical Address:			
City:		State:	Zip:
Phone Number:	Type of Phone:	Is this your primary phone number?	Notes and Comments (Specify if this is a Message Phone)
	__Home __Work __Cell	__Yes __No	
	__Home __Work __Cell	__Yes __No	
	__Home __Work __Cell	__Yes __No	

Child Care Information	
Is the child named above currently enrolled in a full time child-care or -education program?	__Yes __No
If yes, what type: __Child Care Center __Family Child Care Home __Relative's Home __Home __Preschool	
__Other: _____	
Are you looking for a child-care or -education program so that you can attend school or work?	__Yes __No
What hours are you needing child care? _____	
Are you on a childcare subsidy?	__Yes __No
If yes, did you bring proof of documentation?	__Yes __No

Child Development

Do you have concerns about your child's overall health and development? __Yes __No

If yes, describe concerns: ______________________________

Who has expressed concerns?

__Primary Care Physician __Medical Provider __Early Childhood Staff

__Family Member __Other (Specify): ______________________________

Does your child have a documented disability, a certified IEP/IFSP, or need assistive services? __Yes __No

If yes, what is the date of the IEP/IFSP: ______________________________

Do you have any concerns about your child's mood or behavior? (For example: excessive crying, aggressive behavior, tantrums, or sexual behavior.) __Yes __No

If yes, describe concerns: ______________________________

Nutritional Information

Does your child have a food allergy? __Yes __No

If yes, what is the allergy to? ______________________________

Describe any reaction: ______________________________

Is your child on a special diet prescribed by a doctor? __Yes __No

If yes, explain: ______________________________

Please list foods not eaten for medical, religious or personal reasons: ______________________________

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Please complete the following two questions only if your child is 0-12 months old.

What does your child eat? __Breast Milk __Formula (Specify Brand): ______________________________

__Milk __Other: ______________________________

Feeding Method? __Breast Fed __Bottle Fed

Child's Name:	Date of Birth:

Medical Home Information	
Physician/Clinic:	Phone:
Dentist:	Phone:
Specialist:	Phone:

Type of Health Insurance: __State Program __Medicaid __Indian __Private __None

__Other: _____

Insurance Provider's Name: _____ Dental Included? __Yes __No

Insurance Policy Number or ID: _____ Insurance Expiration Date: _____

Immunizations Required at Enrollment: _____

Medical History

Has your child ever been hospitalized or had surgery? __Yes __No

If yes, explain: _____

Has your child ever had a serious accident? __Yes __No

If yes, explain: _____

Identify any past or present health conditions your child has had:

__Anemia	__Diabetes	__Asthma
__Hearing Difficulties	__Heart Murmur	__Trouble Chewing or Swallowing
__Wears Hearing Aid	__Sickle Cell Disease	__Frequent Constipation
__Vision Problems	__Allergies	__Frequent Diarrhea
__Glasses Are Prescribed	__Eczema	

Does your child take medications at home? __Yes __No

Will your child need to take medications at school? __Yes __No

If yes, what is the name of the medication: _____

Why does your child take the medication? _____

Birth History
Weight: Pounds:_____ / Ounces:_____ Length:_____ (Inches)
Gestational Age: __Term __Premature (___ Weeks) __More than Two Weeks Overdue
Type of Delivery: __Vaginal __Cesarean __Unknown
Length of Infant's Hospital Stay: __Routine __Non-Routine, Length of Stay:_____
Delivery Location: __Hospital/Clinic __Birthing Center __Home __Unknown
Were there any complications associated with this delivery (pre-term, fetal distress, etc.)? __Yes __No __Unknown
If yes, describe: _____
Did baby have any problems at birth? __Yes __No
If yes, describe: _____
Describe any observable birth defects: _____
Did the mother have any health problems during pregnancy or delivery? __Yes __No
If yes, describe: _____

Parent/Guardian's Signature _____ Date: _____

Print Parent/Guardian's Name _____