Appendix D
Child Application

Head of Household:	**Date of Birth:**
Child Information	
Child's Name:	**Date of Birth:**
Child's Preferred Name:	
This child lives with:	Relationship:

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

Parent/Guardian Address: ______________________
City State Zip

Primary Phone Number: ______________________

Parent/Guardian Address: ______________________
City State Zip

Primary Phone Number: ______________________

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 ☐ Pre-School

☐ Other: ______________________

What hours are you needing child care? ______________________

Do you have a child care subsidy authorization? ☐Yes ☐No

If yes, have you provided proof of documentation? ☐Yes ☐No

Child's Development

Do you or others have concern about your child's overall health and development? ☐Yes ☐No

Who has expressed concerns? ______________________

☐ Primary Care Physician ☐ Medical Provider ☐ Early Childhood Provider ☐ Family Member ☐ Other (Specify)

If yes, describe concerns: ______________________

Does your child have a documented disability, a certified IEP/IFSP or need assistive services? ☐Yes ☐No

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: ____________

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

What does your baby drink? ☐Breast Milk ☐Formula (Specify Brand) ☐Milk ____________

What does your baby eat?:

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 Coverage Included? ☐Yes ☐No

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

Current Immunizations Required at Time of 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 while in care? ☐Yes ☐No

If yes, what is the name of the medication? ____________

Why does your child take the medication? ____________

Parent/Guardian's Signature: ____________ Date: ____________

Print Parent/Guardian's Name: ____________