Maple Leaf Children's Center
P.O. Box 148
Thetford, VT 05074
802.785.2074

REGISTRATION FORM Enrollment Date: _____ /_____/_____

- Child's Information

Child's Full Name: _____ Nickname:_____

Home Phone: _____-_____-_____

Home Address: _____

Date of Birth _____/_____/_____ Place of birth: _____

- Family Information

Parent's Marital Status: Single _____ Married _____ Divorced _____ Widowed_____

1) Parent's Name: _____ Home Phone: _____-_____-_____

Home Address: _____ Cell Phone: _____-_____-_____

Email: _____

Employer: _____ Employer Phone: _____-_____-_____

2) Parent's Name: _____ Home Phone: _____-_____-_____

Home Address: _____ Cell Phone: _____-_____-_____

Email: _____

Employer: _____ Employer Phone: _____-_____-_____

3) Was your child adopted: _____ Does your child know they're adopted? _____

4) Other children in the family:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

5) Please list any pets in the family (include their names and type of animal): _____

- Authorized Persons

Emergency Contacts:

Name: _____

Phone: _____-_____-_____

Name: _____

Phone: _____-_____-_____

Other People Allowed to Pick-up:

Name: _____

Phone: _____-_____-_____

Name: _____

Phone: _____-_____-_____

- Child's Developmental History:

Has your child attended another preschool or child care center before? _____

Place: _____ How long: _____

Reason(s) for leaving: _____

Is your child toilet trained? (circle one) Yes No In Training

Does your child have problems with:

_____ chewing, swallowing, eating _____ dressing

_____ walking/running _____ walking up/down stairs

_____ picking up small objects _____ speech/language

Does your child dress and undress their self? _____

What is your child's bedtime? _____ Where do they sleep? _____

Does your child experience difficulty in going to bed? _____

Does your child nap? _____ How long? _____

How does your child get to sleep? (nurses, special blanket or stuffed animal, rocking, listening to a story, etc.) _____

Does your child have any fears we should be aware of? _____

What is your discipline policy at home?

_____

_____

Do you have any special concerns about behavior that we should be aware of? (Please add extra sheet if needed.)

_____

_____

- 3 Child's Medical History:

Child's Physician: _____ Phone: _____-_____-_____

Hospital Preference: _____

Child's Dentist: _____ Phone: _____-_____-_____

Does your child have any medically diagnosed illness or condition, including allergies, ear infections, seizures, etc.? _____

_____

Were there any problems during pregnancy/immediately after birth with your child?

_____

_____

Has your child had any of the following tests?

_____ Developmental _____ Hearing _____ Neurological _____ Psychological

_____ Vision _____ Speech/Language _____Physical Therapy _____ Occupational Therapy

If so, please describe the reason and results: _____

_____

_____

I, hereby give authorization to Maple Leaf Children's Center to obtain emergency medical treatment for my child in case of sudden illness or accident.

Signed: _____ Date: _____

(Parent or Guardian's Signature)