MUSTARD SEED PRESCHOOL
A Mission of Christ Community Church

Deposit Check # _____

Date of Admission: _____

Child Information Form

Identifying Information

Child's Name: _____ Date of Birth _____/_____/_____
First Middle Last

Home Address _____ City _____ St. _____ Zip _____

Name child wants to be called: _____

Age of child on OCTOBER 1, 2018 _____ Days of the week your child will be attending MSP: _____

Gender _____ Approx. Height _____ Approx. Weight _____ Hair Color _____Race (optional) _____

Is the child related to the primary caregiver? Yes _____ No _____ How? _____

Parents/Guardian:

Does child live with mother? ____yes ____no
Mother's Name _____

Email : _____

Primary Phone # _____

Secondary Phone # _____

Home Address _____

_____
City State Zip

Place of Employment _____

Work Address _____

_____
City State Zip

Work Phone:_____

Work Hours: _____

Parents/Guardian:

Does child live with father? ____yes ____no
Father's Name _____

Email : _____

Primary Phone # _____

Secondary Phone # _____

Home Address _____

_____
City State Zip

Place of Employment _____

Work Address _____

_____
City State Zip

Work Phone:_____

Work Hours: _____

Is there another legal guardian for the child? If yes, list name address, phone number and email.

_____

Other Family Information

Brothers and Sister's Names and Ages_____

Others living in household? _____

Family pet's names _____

Please return to MSP with your May deposit by May 1, 2018

(Continued on reverse)

Emergency Contact Information

In case of an emergency or illness, after attempting the phone numbers listed on page 1, please list the names of persons who would be authorized to act on behalf of the parents(s). ***If you move or any of this information changes, please notify the MSP office ASAP with updated information.***

Name _____ Relationship _____

Address _____
Street City State Zip

Primary Phone # _____ Secondary Phone # _____

Name _____ Relationship _____

Address _____
Street City State Zip

Primary Phone # _____ Secondary Phone # _____

Name _____ Relationship _____

Address _____
Street City State Zip

Primary Phone # _____ Secondary Phone # _____

Other than those listed above, please list any person (s) who have permission to pick up your child.

Name _____ Relationship _____

Primary Phone # _____ Secondary Phone # _____

Name _____ Relationship _____

Primary Phone # _____ Secondary Phone # _____

Name _____ Relationship _____

Primary Phone # _____ Secondary Phone # _____

If none, please write "none". _____

Mustard Seed Preschool will not release your child to anyone who is not listed on this form; however you can add names to this list at anytime. If there are individuals who because of special circumstances are NOT allowed to pick up your child at any time, we will need this in writing and given to the Director. If there is a custody issue involved, we also need supporting court documents. MSP will not release a child to any person whose ability to drive or care for the child is impaired by drugs, alcohol or any physical or emotional condition which might in any way jeopardize the safety and well being of the child.

(Continued on next page)

Please help us get to know your child better.

Personal Health /Medical Information

Physician's Name: _____ Physician's Phone Number: _____

Primary Insurance Coverage _____Policy Number _____ Hospital of Choice _____

Primary Insured Relationship to Child _____

Allergy: a medical condition that causes someone to become sick after eating, touching or breathing something that is harmless to most people

List any known allergies that your child may have _____

Do these allergies require immediate medical treatment? _____ Yes _____ No

Are ***any*** of these allergies life threatening? _____ Yes _____ No

If yes, please specify: _____

Have you turned into MSP the Allergy Action Plan from your physician _____Yes _____No _____ Not Yet

Does the child have any medical diagnosis that requires ongoing care? _____

If yes, explain what type of care is administered at home and by whom? _____

Does your child take any medications routinely? _____Yes _____No

If yes, please list _____ Reason for taking _____

Does your child have a history of frequent ear infections? _____

Has your child ever had any surgeries? _____ Yes _____No

If yes, please specify _____

Is there anything in your child's past or current medical history (physical or emotional) about which the school or teacher should know? _____

Are there any special needs or special circumstances in your child's life that would help your child's teacher better understand or help your child? _____

Has your child ever been professionally evaluated for speech, behavior or any type of developmental delay? (If yes, please explain.) _____

Sleep Habits:

Does your child have own room? _____ Share a room with? _____

At night sleeps from _____ to _____ Average hours sleep per night _____

Naps from _____ to _____ Average hours of naps _____

Self-care Information

Does child tell when he/she needs to go to bathroom? _____ Can child manage clothes in the bathroom? _____

Can your child care for himself/herself in the following areas?

_____ Dressing _____ Brushing teeth _____ Going to the bathroom _____ Tying shoes

(Continued on reverse)

Living Habits and Emotional Development

Are there any foods or beverages your child should not be given at MSP? _____

Is your child a picky eater? _____ Does your child eat breakfast? _____

Behavior habits (i.e. biting nails, sucking fingers, tantrums, or biting others):_____

Does your child have any fears? _____ If so, do you know the cause of the fears?_____

What is your child's reaction to strangers? _____

Does your child cry easily? _____ If so why? _____

What thing(s) usually calms your child? _____

Is it easy for your child to be separated from either parent? _____

What types of discipline are used in your home? _____

Speech and Physical Growth

Please choose one of the following:

My child talks: Well _____ Fairly Well _____ Not Very Well _____ Not at All _____

Does anyone read to your child? _____ How regularly? _____

Which of the following words would you use to describe your child (check all that apply):

Active _____ Quiet _____ Friendly _____ Shy _____

Social Habits

Does your child play well with others? _____

Is it hard for your child to take turns? _____

How does he/she react when he/she does not get their own way? _____

Does your child help put away toys after playing? _____

Does your child play well by himself/herself? _____

Does your child help with small household tasks? _____ If so, what? _____

List special interests and toys _____