

Registration Form

Student's Name _____ Preferred Name _____ DOB _____
 Physical Address _____
 Home Phone _____ Primary Language Spoken at Home _____
 Allergies _____ Start Date _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1:

Name _____
 Mailing Address _____
 City, State, Zip _____
 Cell Phone _____
 Home Phone _____
 Work Phone _____
 Email _____
 Employed By _____
 Work Address _____

Parent/Guardian #2:

Name _____
 Mailing Address _____
 City, State, Zip _____
 Cell Phone _____
 Home Phone _____
 Work Phone _____
 Email _____
 Employed By _____
 Work Address _____

CHILD'S PHYSICAL DESCRIPTION (REQUIRED BY LICENSING)

Eye Color _____ Hair Color _____
 Height _____ Weight _____
 Skin Color _____ Race / Ethnicity _____
 Identifying Marks _____

PARENT'S/GUARDIAN'S AUTHORIZATION OF OTHER PERSON(S) TO WHOM CHILD MAY BE RELEASED

I, _____, authorize the following individuals to pick up my child as needed. I understand that any individuals not listed will not be allowed to pick up unless I provide written permission in advance. **I understand that it is my responsibility to keep this list of Authorized Persons up to date and will make all changes, additions, and deletions in writing by updating this form.**

Name _____	Address _____
Telephone Number _____	Relation to Child _____
Name _____	Address _____
Telephone Number _____	Relation to Child _____
Name _____	Address _____
Telephone Number _____	Relation to Child _____

Signature of Parent/Guardian: _____

Date: _____

First Aid/CPR and Emergency Medical Care Consent Form

Child's Name _____ Date of Birth _____

I authorize the staff at The Children's Workshop, who are trained in the basics of first aid and CPR, to give my child first aid and CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and /or to _____, and to secure necessary treatment for my child.

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

Physician's Address: _____

Child's Allergies: _____ Chronic Health Conditions: _____

Emergency Contacts (In order to be contacted)

Name _____ Address _____
 Telephone Number _____ Relation to Child _____
 Do you give permission for your child to be released to this person? Yes _____ No _____

Name _____ Address _____
 Telephone Number _____ Relation to Child _____
 Do you give permission for your child to be released to this person? Yes _____ No _____

Name _____ Address _____
 Telephone Number _____ Relation to Child _____
 Do you give permission for your child to be released to this person? Yes _____ No _____

Child's Health Insurance Coverage _____ Policy # _____

Parent Name _____ Primary Phone # _____
 Secondary Phone # _____

Parent Name _____ Primary Phone # _____
 Secondary Phone # _____

Parent/Guardian Signature: _____

Date: _____

Developmental History



Child's Name: _____ Date of Birth: _____

This form must be completed prior to the child's first day of enrollment and updated at least annually. Please be thorough when filling out this form - the more information we have about your child, the more individualized education we can provide!

Section I: General Information

Person providing information: _____ Relationship to Child: _____

Please list all people in your child's immediate family:

Name	Relationship to Child	Age	Living in the house?

Please list all other *family or non-family* members who live in the household:

Name	Relationship to Child/Family	Age	Length of time in household?

Language(s) spoken at home (please circle primary language): _____

Please list all locations (city, state) that your child has lived:

- | | |
|----------------------|----------------------------|
| 1. Birthplace: _____ | Age at time of move: _____ |
| 2. _____ | Age at time of move: _____ |
| 3. _____ | Age at time of move: _____ |

Are custodial parents of child currently (please circle): married separated divorced never married

- If separated or divorced, please describe the *legal* custody arrangement: _____

court documents must be provided for us to honor a custody agreement

- If separated or divorced, how do you feel the child has adjusted to the separation/divorce? _____

Are there other adults who have a **significant** part in raising your child? (please check one) YES NO

- If yes, please indicate name, relationship & how child refers to this person (step-parent, grandparent, boy/girlfriend, etc.): _____

Have there been any significant changes in the home over the *last few years* (such as: new marriages, deaths, births, address changes, family separations/divorce, parent job change, death of a pet, etc.) that you believe have affected your child's development or behavior? (please check one) YES NO

- If yes, please describe: _____

Signature of Parent/Guardian: _____ Date: _____

Developmental History



Child's Name: _____ Date of Birth: _____

What do you feel are your child's:

- Greatest strengths: _____
- Personality characteristics: _____
- Areas of concern: _____

Will this be your child's first experience in group child care (please check one): YES NO

- If yes, please provide any information you think will be useful in helping your child feel comfortable at school: _____
- If no, please describe prior child care experience (location, length of time, how did your child adjust, etc.): _____

Section II: Health

Place a check mark next to the current state of your child's health: EXCELLENT GOOD FAIR POOR

Is your child currently taking any medication, including over the counter medications (please check one)? YES NO

- If yes, please list medication, dosages, times and uses: _____

Has your child ever had any of the following?

Name of Condition	Describe details, dates and/or age of onset
Serious Illnesses	
Head Injuries	
Seizures or convulsions	
Surgeries/Hospitalizations	
History of Ear Infections	
Allergies	
Asthma	
Vision Problems or Hearing Problems	
Known Complications at Birth	
Frequent Nightmares and/or Sleep Concerns	
Other	

Signature of Parent/Guardian: _____ Date: _____

Developmental History



Child's Name: _____ Date of Birth: _____

Please describe any other health information we need to know to care for your child: _____

Section III: Developmental Milestones

Please indicate the age or range when your child could perform the following milestones (check ONE box per row):

Milestone	0-3 Months	4-6 Months	7-12 Months	13-18 Months	19-24 Months	2-3 Years	3-4 Years	Other (specify age)	Not Yet Applicable
Sit up without help									
Crawl									
Pull up to stand									
Walk Alone									
Speak First Word									
Speak in Sentences									
Walk Up/ Down Stairs									
Full Bladder Control									
Full Bowel Control									
Run									
Jump in Place									
Pedal a bike									

Describe any speech difficulties your child has and/or any special words he/she uses to describe his/her needs: _____

Please describe any concerns you currently have or have had in the past about your child's development or behavior: _____

Has your child ever received/is your child currently receiving specialized services such as early intervention, an IEP or 504 plan at a public school, speech therapy, etc. (check one) YES NO

If yes, please provide more detail: _____

You must also provide TCW copies of any applicable service plans

Signature of Parent/Guardian: _____ Date: _____

Developmental History



Child's Name: _____ Date of Birth: _____

What do you hope your child will gain from this early education experience? _____

Please describe what behavior management methods (if any) are used at home: _____

Section IV: Daily Schedule

Please use the table below to indicate your child's typical daily schedule:

Time of Day	Description of activity, typical mood, meal, etc.

Section V: Eating Habits

Infants/Toddlers: if your child still uses a bottle does he/she drink (check all that apply): FORMULA BREAST MILK

- If your child drinks formula, please specify brand and any preparation details: _____

Is your child bottle fed (check all that apply): HELD IN LAP IN HIGH CHAIR OTHER: _____

Does your child eat independently with (check all that apply): SPOON FORK HANDS

Toddler/Preschool/Prekindergarten/School Age Children:

Child's favorite foods: _____

Child's refused foods: _____

Is there anything else we need to know about your child's eating habits to properly care for him/her: _____

Signature of Parent/Guardian: _____ Date: _____

Developmental History



Child's Name: _____ Date of Birth: _____

Section VI: Toilet Habits

Children who have not yet toilet learned:

Type of diapers used (check all that apply): DISPOSABLE CLOTH OTHER: _____

Does your child have frequent diaper rash (check one): YES NO

Do you use (check all that apply): LOTION POWDER OIL OTHER: _____

please note, The Children's Workshop cannot use powder in the classroom due to the danger of inhalation

All children:

Are your child's bowel movement regular (check one): YES NO How many does he/she have per day: _____

Does your child have any problems with diarrhea, constipation, frequent urination or reluctance to use the bathroom (check one): YES NO

- If yes, please describe: _____

Section VII: Sleeping Habits

Where does your child sleep (check all that apply)? BED CRIB OTHER: _____

Does your child become tired and/or nap during the day (include when and how long): _____

When does your child go to bed at night? _____ And get up in the morning? _____

Describe any special sleep characteristics or needs (stuffed animal, story, mood on waking, etc.): _____

Does your child sleep in his/her own room (check one): YES NO

- If no, please note who shares the room: _____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep may reduce the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your infant does not usually sleep on his/her back, please contact your pediatrician immediately to discuss best sleeping positions for your baby.

At The Children's Workshop we follow these required safe sleep practices as recommended by the American Academy of Pediatrics. Infants up to twelve months of age will be placed for sleep in a supine position (wholly on their back) for every nap or sleep time. Infants will be placed for sleep in a safe sleep environment; which includes: a firm mattress covered by a tight-fitting sheet in a safety-approved crib and no other items will be placed in the crib occupied by an infant except for a pacifier. Infants may not sleep in a car seat, bouncy seat, infant seat, swing, or any other type of furniture/equipment that is not a safety-approved crib. Soft or loose bedding will be kept out of sleep environments. These include, but are not limited to: pillows, sleep positioning devices, blankets, bibs, etc. Infants will not be swaddled, but rather parent provided one-piece sleepers may be used.

Signature of Parent/Guardian: _____ Date: _____



Family Communication & Media Consent

Family Communication

At TCW, we believe pictures, both still and moving, tell a powerful story of your child's development. We also understand that there are many reasons you may prefer we do not take or share pictures of your child. Our family communication app, Kaymbu, allows us to easily and securely share school updates, progress reports, daily notes, and more with you; please indicate your preferences to receive this communication below:

You may choose to have us keep your cell phone number to receive text messages*, email, or both on file in our system. If you fill in both, you must also check **one** box to indicate which method you prefer. Routine messages will be sent to preferred contact only, and urgent messages will be sent to both.

Parent #1 Name: _____

cell: _____ email: _____

Parent #2 Name: _____

cell: _____ email: _____

The Children's Workshop (circle one) **MAY** or **MAY NOT** (initial here _____) take pictures of my child to be included with these communications **to the people listed above only**.

Feel free to also visit your app store on any mobile device to download the "Kaymbu for Parents" app. You may register using any of the contact information you have listed above.

*standard messaging rates may apply

Media Consent

TCW likes to use pictures, still and moving, to spread the word not only about our own early education programs, but also about the importance of access to high quality childcare for all families. We like to use pictures of the great moments happening at our schools to share this information in the following ways: moments and newsletters to other families, internal newsletters and resources to our educators and staff, informational material for incoming families, on our website and blogs, newspapers and magazines (print and digital), social media outlets, and at conferences. Indicate below if we may use your child's pictures, still or moving, for these purposes.

In all cases, pictures are for internal or promotional use only and will never be shared beyond these uses or without express parental consent as indicated below. By signing your consent to allow TCW to use pictures of your child, you acknowledge your understanding that neither you nor your child will receive remuneration for your voluntary participation or future use of pictures, still or moving.

yes, TCW **may** use pictures of my child as described above (Initial here: _____)

no, TCW **may not** use pictures of my child as described above (Initial here: _____)

Parent/Guardian Signature: _____

date

If you have questions about this form, please email info@childrensworkshop.com



Transportation Plan

Child's Name: _____

Date of Birth: _____

Section I: Arrival and Departure to/from Home

The Children's Workshop does not provide transportation to or from a child's home at the beginning or end of our program day. Parents/Guardians are expected to provide or arrange safe transport to and from the program on days when their child is enrolled. Children will only be released from the program to a parent/guardian or to an individual, who is 18 years of age or older, who is authorized, in writing, by the parent/guardian to pick up the child and whose identity can be verified by a government issued form of identification.

I, _____, acknowledge that I understand it is my responsibility to maintain a written
Parent/Guardian Name

list of individuals, other than myself, who are authorized to pick up my child from The Children's Workshop. I further acknowledge that The Children's Workshop does not provide transportation to or from my child's home at the beginning or end of the program day and that I am responsible for providing, or arranging another responsible adult to provide, this transportation safely and in accordance with all state or federal laws.

Parent/Guardian Signature: _____

Date: _____

Section II (School Age Programs Only): Before and After School Transportation

The Children's Workshop provides safe transportation to and from local schools for elementary and middle school students. Please check with your School Director for our full transportation policies and availability of transportation at your child's elementary or middle school. All vans and buses operated by The Children's Workshop are inspected, registered, insured, and operated in accordance with applicable state and federal laws and regulations. To utilize our transportation, you must complete the permission form below.

I, _____, give permission to The Children's Workshop to transport my child,
Parent/Guardian Name

_____, to and/or from, _____
Child's Name Name and Address of School

on a van or bus owned or leased by The Children's Workshop. I give my permission for my child to be transported at the following times (check all that apply):

- Before School (from The Children's Workshop to above-named school)
- After School (from the above-named school to The Children's Workshop)
- Neither, my child will be transported to/from the above-named school by the following alternate form of transportation: _____

I/we, for the said child, hereby release The Children's Workshop, its Officers, Directors, and employees from all liability for injury to my child.

Parent/Guardian Signature: _____

Date: _____

Section III: Field Trips & Special Activities

On occasion, The Children's Workshop will provide safe transportation to and from enrichment activities and/or age-appropriate destinations in the community. Parents/Guardians will always be notified in advance of the date/time/location/cost/transportation method of such trips and will be required to give specific written permission on a separate consent form. Participation in any field trip or special activity is always optional.



The Role of Child Care Health Consultants

Child Care Health Consultants are licensed health professionals with education and experience in community health and child care. Child Care Health Consultants and child care staff work together to promote healthy and safe environments for children. Through onsite and telephone consultation, health education, and technical assistance, Child Care Health Consultants work with individual child care facilities to help create environments that best support the healthy growth and development of young children.

Child Care Health Consultants:

- assess the health and safety needs and practices in the child care facility,
- review safe medication administration practices,
- develop strategies for inclusion of children with special care needs,
- establish and review health policies and procedures,
- manage and prevent injuries and infectious diseases,
- connect families with community health resources, and
- provide health education for staff members, families and children.

Please note that Child Care Health Consultants are not direct care providers and should not be considered part of your child's direct care team. The Children's Workshop employs a team of Child Care Health Consultants to assist all of our schools; Health Consultants are not on premises at every school 100% of the time, nor should their advice or information they share be relied upon solely – parents should always consult their child's pediatrician or health care professional.

I acknowledge that I have received, read, and understand this information and I understand the role of the Child Care Health Consultant at The Children's Workshop. I hereby give permission for the Child Care Health Consultants employed by The Children's Workshop to access my child's file including immunization records, physical exam, and medication administration information.

Child's Name _____

Guardian Initial _____

Release of Information

I _____ give my permission to _____, at
Parent's Name Pediatrician or Practice Name

(_____) _____ to release the following to The Children's Workshop for patient
Phone Number

Childs Name

Immunization Record X

Verbal Communication X

Lead Level X

Yearly Physical X

Medication Instructions X

Other X

Signature: _____

Date: _____