

Enrollment Questionnaire

Child's Name _____ Nickname _____

Previous Childcare History:

Has your child been in childcare before? _____ If so, please give name, address and phone number of last childcare provider/center:

Name _____ Phone Number _____

Address _____

Dates attended from _____ to _____ Why was care terminated? _____

May I contact them for a reference? _____

Sleeping Habits:

Does your child have a regular bedtime schedule? _____

What time does your child usually go to bed at night? _____

What time does your child usually wake up in the morning? _____

Does your child have trouble sleeping? _____

Night terrors? _____ Trouble going to sleep? _____

Other? _____

If under 18 months, how does your child prefer to sleep (back, stomach, side)? _____

What time(s) and for how long does your child nap each day? _____

Are there any favorite items that your child needs to go to sleep each day (pacifier, pillow, blanket, teddy bear, etc.)? _____

Has your child slept in a pack-n-play or on a mat/cot? _____

What is your child's disposition upon waking (happy, clingy, slow to wake, etc.)? _____

Health History:

Has or does your child have any known health condition? _____

Does your child need regular medication? If so, please explain why? _____

Does your child have any known allergies? _____

Special instructions in case of allergic reaction _____

Has your child had or been exposed to any communicable diseases (chicken pox, measles, mumps, lice, etc.)? If so, please explain and provide dates.

Is your child prone to any common ailments (upset stomach, frequent colds, allergies, ear infections, sore throats, nose bleeds, diaper rash etc.)?

Is there any indication of hearing or vision problems? _____

Does your child have any physical or mental disabilities? _____

Eating Habits:

What are your child's eating habits (frequency and portion)? _____

How often does your child drink during the day (milk, juice, water, etc.)? _____

Does your child have any favorite foods? _____

Does your child dislike any foods? _____

Does your child have a special diet? _____

Are there any foods your child should not be fed? _____

How does your child sit at the table (high-chair, booster seat, etc.)? _____

General Information:

Do you have a back-up caregiver in the event that your child becomes ill and is unable to attend childcare or for provider's holidays, vacations or personal days?

Are you looking for long-term or short-term care for your child? _____

What are your expectations from **MDO** ? _____