

**Teays Valley Child Development Center**  
**6442 Teays Valley Road**  
**Scott Depot, WV 25560**  
**(304)757-9165**

**APPLICATION FOR ENROLLMENT - EXTENDED CARE/SUMMER PROGRAM**

Child's Name \_\_\_\_\_ Birth-date \_\_\_\_\_ Grade \_\_\_\_\_

Home Address \_\_\_\_\_

Telephone \_\_\_\_\_ Present age \_\_\_\_\_ Male/Female (circle one)

Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cell/Pager# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cell/Pager# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

Custody of Child \_\_\_\_\_ Email \_\_\_\_\_

School Name \_\_\_\_\_ Telephone # \_\_\_\_\_

**EMERGENCY CONTACTS**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Physician's Address \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Preferred hospital where child may be treated: \_\_\_\_\_

Names of persons authorized to pick child up from center, including parents/guardian (child will not be allowed to leave with any other person without written authorization from the responsible parent or guardian):

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

**CONFIDENTIAL CHILD ASSESSMENT FORM**

**General Information:** Family Name \_\_\_\_\_ # of persons in home \_\_\_\_\_  
Father \_\_\_\_\_ age \_\_\_\_\_ Mother \_\_\_\_\_ age \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_

**Family and Household:**

Children in order of birth (including this child):

Name	Age	Grade in School	Health	Living?
1.				
2.				
3.				
4.				
5.				
6.				

Others in household (show relationship):

Name	Relationship
1.	
2.	
3.	
4.	

**HEALTH**

**Pregnancy and Birth History:**

Delivery: Normal \_\_\_\_\_ Premature \_\_\_\_\_ (how much) \_\_\_\_\_ Caesarian \_\_\_\_\_

Health of Mother during pregnancy \_\_\_\_\_

Complications during pregnancy \_\_\_\_\_

Complication during birth \_\_\_\_\_

Any other pregnancy information needs relayed \_\_\_\_\_

**GENERAL HEALTH:**

Any diseases that 'run' in the family? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, describe \_\_\_\_\_

\_\_\_\_\_

**Is this child subject to:**

	OFTEN	SELDOM	NEVER
Colds - upper respiratory infections			
Constipation			
Convulsions			
Diarrhea			
Fever - 103 or above			
Headaches			
Stomach ache			

Operations (give date and description) \_\_\_\_\_

Injuries (give date and description) \_\_\_\_\_

Describe any difficulties observed with this child's:

Hearing \_\_\_\_\_ Vision \_\_\_\_\_

Other \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Birth weight \_\_\_\_\_ Birth-date \_\_\_\_\_

Illnesses or complications during newborn period: Yes \_\_\_\_\_ No \_\_\_\_\_ If so, describe \_\_\_\_\_

**PAST ILLNESSES: Check those the child has had and give approximate date:**

ILLNESS	X	DATE	ILLNESS	X	DATE
Asthma			Mumps		
Chicken Pox			Poliomyelitis		
Diabetes			Rheumatic Fever		
Epilepsy			Rubeola (10 day Measles)		
Hay Fever			Whooping Cough		
Measles (Rubella)			Other		

Is child allergic to any foods? \_\_\_\_\_ If so, please list: \_\_\_\_\_

Is child allergic to any medications? \_\_\_\_\_ If so, please list: \_\_\_\_\_

Has child ever been separated from parents or guardians for any length of time? \_\_\_\_\_

Describe experiences and the child's reactions and adjustments: \_\_\_\_\_

Is there anything in particular that frightens this child? \_\_\_\_\_

Has this child had any upsetting experiences such as divorce of parents, death in family, frequent or recent moves, etc? \_\_\_\_\_

What were the child's reactions? \_\_\_\_\_

Child's known developmental needs: \_\_\_\_\_

### ACTIVITIES

Does your child prefer playing alone? \_\_\_\_\_ With other children? \_\_\_\_\_

List names of favorite playmates: \_\_\_\_\_

Does child get along well with family children? \_\_\_\_\_ Parents? \_\_\_\_\_ Other children? \_\_\_\_\_

Has child attended any children groups? Day Care \_\_\_\_\_ PreK \_\_\_\_\_ Sunday School \_\_\_\_\_

Vacation Bible School \_\_\_\_\_ Other \_\_\_\_\_

### Check the approaches to learning your child demonstrates.

	Initiative and Curiosity
	Engagement and Persistence
	Reasoning and Problem Solving
	Invention and Imagination
	Other:

### Check the methods of control, discipline, teaching you find most effective with this child.

	Bribing		Demonstrating	Other recommended methods:
	Coaxing		Depriving of pleasure	
	Praising		Preparing child in advance	
	Reasoning		Redirection	
	Rewarding		Speaking in a firm voice	
	Time-out		Suggesting	

List any concerns you may have for your child: \_\_\_\_\_

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List any goals you may have for your child: \_\_\_\_\_

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Plan for care when child is ill? \_\_\_\_\_

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Reasons for requesting Center care? \_\_\_\_\_

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Days care is needed: M T W TH F Time of day care is needed: \_\_\_\_\_

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Does your child attend Church/Sunday School? \_\_\_\_\_ Where? \_\_\_\_\_

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Other information you feel might be helpful in working with your child in the center? \_\_\_\_\_

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**Permission (circle one)**

I authorize TVCDC to apply sunscreen to my child that I will supply.      **Yes No**

I give permission to TVCDC to use video/photographs in school activities, for news, stories,  
website, or for advertising purposes.      **Yes No**

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Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Director \_\_\_\_\_ Date \_\_\_\_\_

FOR CENTER USE: Date of Admission \_\_\_\_\_ Date of Discharge \_\_\_\_\_