

**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: _____

List any goals you may have for your child: _____

Plan for care when child is ill? _____

Reasons for requesting Center care? _____

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

Does your child attend Church/Sunday School? _____ Where? _____

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

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/audio recordings in school activities,
for news, stories, website, or for advertising purposes. **Yes No**

Signature of Parent/Guardian _____ Date _____

Signature of Director _____ Date _____

FOR CENTER USE: Date of Admission _____ Date of Discharge _____