



DREAM TOO

INFANT / TODDLER ENROLLMENT APPLICATION

CHILD INFORMATION

Child Name:		
Date of birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Phone:
Age:	Race:	Special Needs:
Current address:		
City:	State:	ZIP Code:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:		
Address:		
City:	State:	ZIP Code:
Email:	Phone:	

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	
Relationship to Child:	Phone:
Physician Name:	Phone:
Preferred Hospital:	
Allergies:	

PICK-UP AUTHORIZATION

Name	Phone

CONSENT TO EMERGENCY FIRST AID & TRANSPORTATION

In the event of an emergency, I hereby give permission for my child to be given emergency treatment by a staff member at DREAM TOO. I also give permission for my child to be transported by ambulance to an emergency center for treatment and agree to hold DREAM TOO and its employees harmless.

Parent Signature:	Date:
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CONSENT TO MEDICAL TREATMENT

In the event that I cannot be contacted immediately, medical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician, and hold DREAM TOO and its employees harmless.

Parent Signature:	Date:
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MEDIA RELEASE

With my signature below, I give permission for DREAM TOO to photograph my child for the purpose program advertisement for the DREAM TOO website and program bulletins recruitment, newsletters and media that promote student and program success.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Parent Signature:	Date:
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What position does your child like to be in while bottle feeding?

What position does your child like to be in while being burped?

Has your child been introduced to solids? Yes No

If yes, what identify: _____

What foods does your child like/dislike? _____

SLEEP

Describe your child's sleep routine (include naps & lengths of naps):

Does your child usually cry when going to sleep? Yes No

Where does your child normally sleep? _____

DIAPERING

What type of diapers does your child use? _____

Describe your child's diapering routine (include double diapering, liners, creams, powders etc.)

Is your child prone to diaper rash? Yes No Treatment: _____

SOCIAL/EMOTIONAL DEVELOPMENT

Describe your child's temperament: (i.e. colic, likes to cuddle)

What signs does your child give of being hungry, tired or overstimulated? (i.e. pulls at ears, rubs eyes):

Does your child separate easily from you? Yes No

Please comment:

Is your child afraid of anything? Yes No

Please comment:

Does your child have a favorite toy, blanket or soother? Yes No

Please identify: _____

What activities does your child enjoy: _____

Please provide any additional information relating to your child that would be helpful in understanding and caring for your child:

Parent/Guardian Signature

Date