

Oak Park Early Learning Academy

Child Enrollment Form

Date of Enrollment: _____
Child's First Name: _____ Nickname: _____
Child's Last Name: _____
Date of Birth: _____ Present Age: _____ Gender: ___ M ___ F
Verification Document: _____
Home Address: _____
City: _____ State: _____ Zip: _____



Mother's First Name: _____ Mother's Last Name: _____
Mother's Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employer's Name: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____ Work Hours: _____
Email Address: _____

Check here: To receive Oak Park Kids' FREE email newsletters. Have your child's weekly activity calendar, weekly meal menu & upcoming events delivered straight to your inbox! Plus, discover tips & ideas for creating a fun, learning environment at home.



Father's First Name: _____ Father's Last Name: _____
Father's Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employer's Name: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____ Work Hours: _____
Email Address: _____

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Service Needed Questionnaire:

Are you looking for full-time child care (Monday – Friday)? ____ Yes ____ No

Are you looking for part-time child care? ____ Tuesday/Thursday ____ Monday/Wednesday/Friday

Beginning date needing child care services: _____

Hours needed:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____



About Your Child:

Has your child ever been in child care before? _____

If so, what type? (center, family, ministry daycare) _____

Was it a positive experience? _____

Why are you looking for child care? _____

How does your child feel about daycare and being left by parents? _____

Are there any recent traumatic situations the child has experienced, such as death, divorce, new sibling? _____

What is your child's temperament? i.e. Easy going, hard to please, demanding, assertive, bashful? _____

What time does your child awaken? _____

What time does your child go to sleep at night? _____

Do they sleep through the night? _____

What languages are spoken at home? _____

Are there any siblings? Please name them and specify ages and gender.

First Name: _____ Age: _____ Gender: _____

First Name: _____ Age: _____ Gender: _____

First Name: _____ Age: _____ Gender: _____

First Name: _____ Age: _____ Gender: _____



What You Are Looking For In Child Care:

Please describe the type of child care services that you are looking for to meet your child's needs and your family needs:

Authorized Individuals:

Person(s) authorized to remove your child from Oak Park Early Learning Academy:

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alt. Phone: _____
Relationship to child: _____

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alt. Phone: _____
Relationship to child: _____

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alt. Phone: _____
Relationship to child: _____



Emergency Contacts:

Responsible person(s) who may be called to come for your child in case of illness or other emergency, if you cannot be reached.

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alt. Phone: _____
Relationship to child: _____

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alt. Phone: _____
Relationship to child: _____

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Alt. Phone: _____
Relationship to child: _____

Medical Records:

List the following information to be used in case of an emergency:

Physician's Name: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Physician's Phone Number: _____



Dentist's Name: _____

Dentist's Address: _____

City: _____ State: _____ Zip: _____

Dentist's Phone Number: _____



Child's Health Questionnaire:

A copy of your child's immunizations and current physical will be needed for enrollment.

General state of health: _____

Immunizations up-to-date?: _____

Does your child have any known allergies? _____ If yes, please list: _____

Are you concerned that your child may be prone to any type of allergies? Describe. _____

Does your child have any medical conditions which I should be made aware of? _____

Has your child had any of the following childhood illnesses? Please circle.

- | | | | |
|-------------------------|-----------------|---------------|----------------|
| Constipation | Nose Bleeds | Asthma | Measles |
| Convulsions | Lice | Bronchitis | Mumps |
| Diarrhea | Ringworm | Chicken Pox | German measles |
| Fainting Spells | Skin Rash | Diabetes | Polio |
| Frequent Colds | Stomach upsets | Heart Disease | Scarlet Fever |
| Frequent Ear Infections | Urinary problem | Hepatitis | Tuberculosis |
| Frequent Sore Throats | Worms | Impetigo | Whooping Cough |

Does your child have any speech, hearing or visual problems? _____

Would there be any restrictions to play or activities? Describe. _____

Are there any food restrictions? _____



Anything else that you would like to let me know about?

