Praise Kidz Korner Child Development Center
Child Application

Child's legal name	Date of Birth	□Boy □ Gi
Does your child respond to a nickname? □No □Yes *If yes, state nickname*		
Mother's name	Phone #	
Father's name	Phone #	
In what language do you and your child communicate at home?		
Stepmother/Stepfather name(s)		
Primary caregiver relationship to child		
List others living in child's household Name Age Relationship Name Age Relationship Name Age Relationship Name Age Relationship Name Age Relationship		

DAYCARE/HOMECARE EXPERIENCE:
Former child care or home day care child attended *Please include length of time and age at attendance*
Reasons for leaving previous care
Did your child like attending child care/home day care? □Yes □No *If "No", please explain*
HEALTH HISTORY:
Does your child have any chronic or debilitating illness? *(ex. Asthma, diabetes, etc.)* □Yes □No *If "Yes", please explain:*
Does your child have allergies? *Please include seasonal, environmental, and food allergies* □Yes □No *If "Yes", how are they treated/managed?*
Does your child have any speech, hearing or visual problems? □Yes □No *If "Yes", please explain:*
SLEEPING HABITS: Infant/Toddler/Preschool Students

Child's bedtime: Normal Naptime:	Problems with nightmares? □Yes □No Sleep through the night? □Yes □No	Bedwetting? □Yes □No Pacifier use? □Yes □No
Does child have comfort toy at bedtime? *(ex. Special blanket or stuffed toy)* □Yes □No *If "Yes", please describe:*		
Does your child have problem sleeping for bed time or nap time ?		
Has your child slept in a pack-n-play or on a mat /cot before? □Yes □No *If "Yes", please indicate which one:*		
Child's favorite activities:		

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Does child have opportunities to play with other children? □Yes □No
Does your child have any special needs? *Medical, developmental, social, mental health, etc.* □Yes □No *If "Yes", please explain:*

Infant/Toddler Students: *Write N/A if not yet accomplished*			
Solid Food □Yes □No Walking □Yes □No Roll over □Yes □No Sitting up □Yes □No	Pulling up □Yes □No Drink from cup □Yes □No Standalone □Yes □No	Sleep through night □Yes □No Say words □Yes □No Climb stairs □Yes □No	Crawling □Yes □No Use Spoon □Yes □No Toilet trained □Yes □No

What are you most hoping that your child takes from the childcare experience?
Does your child have an IEP? □Yes □No *If "Yes", please provide us with a copy so that we can provide the best possible learning environment for your child*