Bright Horizons.

FORM

Child Information Form

Child's Name: _____ Primary Language: _____

Child's Address: _____
Street City/Town Zip Code

Place of Birth: _____ Date of Birth: ____/____/____

Child's Schedule: MON _____ TUE _____ WED _____ THU _____ FRI _____

Parent/Guardian Information

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Home E-mail Address: _____ Home E-mail Address: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Home Phone: _____

Others in Family Relationship: _____

Parent/Guardian Business Information

Company Name: _____ Company Name: _____

Address: _____ Address: _____

_____ _____

Business Phone: _____ Business Phone: _____

E-mail Address: _____ E-mail Address: _____

Medical Information

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____ Race: _____ Gender ☐M ☐F

Identified Allergies: _____

Identifying Marks: _____

Health Insurance Provider: _____

Physician/Dentist Information

Name of Physician/Clinic: _____ Phone: _____

Physician Address: _____
Street City/Town Zip Code

Date of Child's Last Physical **(WA State Only)**: _____

Name of Dentist: _____ Phone: _____

Dentist Address: _____
Street City/Town Zip Code

Parent/Guardian Signature: _____ Date: _____

FOR CENTER USE: Center: _____ Date of Admission_____ Age of Admission: _____

Date Registration Fee Rec'd:_____ Discharge Date: _____ Director's Initials: _____

Bright Horizons **Informed Consent**

Child's Name: _____

Access

I will have access to the center without notice when my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

Child Release

For a child's safety, Bright Horizons will release a child only to parent(s)/legal guardian(s) or to the third parties I authorized below. Parents/guardians are required to provide a current copy of any relevant Custody Order. Third party pick-up is subject to the following rules:

- At least two people other than the parents/guardians must be listed and designated as emergency contacts by checking the corresponding box below. Emergency contacts will be contacted if parents/guardians cannot be reached.
- If the person picking up is listed below, but does not pick up the child regularly, I will notify the center **verbally, in advance**. Verbal authorization is not permitted for any person not listed on this form.
- If the person picking up is **NOT** listed below, I must notify the center/school **in writing, in advance**. (Note: In RI, parents/guardians must also provide notice in person and in writing.)
- Photo identification will be required if the third party does not pick up the child regularly or is unknown to the staff member releasing the child.

THE FOLLOWING PEOPLE (WHO ARE NOT PARENTS/GUARDIANS) ARE AUTHORIZED TO PICK UP MY CHILD.

_____
NAME

_____
ADDRESS

_____
CITY/TOWN/STATE/ZIP CODE

_____
RELATIONSHIP TO CHILD

_____ _____
DAYTIME PHONE CELL PHONE

_____
E-MAIL

CONTACT IN THE EVENT OF AN EMERGENCY? ☐ YES ☐ NO

_____
NAME

_____
ADDRESS

_____
CITY/TOWN/STATE/ZIP CODE

_____
RELATIONSHIP TO CHILD

_____ _____
DAYTIME PHONE CELL PHONE

_____
E-MAIL

CONTACT IN THE EVENT OF AN EMERGENCY? ☐ YES ☐ NO

Bright Horizons will not release a child to anyone who appears impaired. If an impaired person attempts to pick up your child, pick-up will be refused and we will attempt to contact the other parent/guardian or authorized persons. If alternative arrangements cannot be made, the local child protective services agency and/or the local police will be called, as required by state licensing.

Walk Permission

Weather permitting, children may go on walks supervised by staff in the surrounding area. Infants and young toddlers are transported in a buggy or stroller. Children may be taken to the areas listed below, which are not part of our licensed premises.

_____

_____

☐ I give permission for my child to participate in walks.

Preschool and school-age children may take field trips. A separate **Field Trip Permission Slip**, describing the activity, will be sent home for signature.

Photography & Video Permission

Bright Horizons takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner. Bright Horizons regularly takes photographs and videos of children enrolled. They may be shared with you and other families in a variety of ways: on the Bright Horizons website, via email, through *My Bright Day®*, on *Teaching Strategies®* Gold (TSG), on a posting in the center, or in a parent newsletter. They may also be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. Additionally, they may be used for other center, general business, and marketing purposes, including online. Bright Horizons retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment.

☐ I give permission for Bright Horizons to take photographs and videos of my child and use these materials as described above.

☐ I give permission for Bright Horizons to take photos and videos of my child and to only use those pictures for curriculum purposes, documenting my child's progress (TSG, My BrightDay) and communication with me and other families.|

Child Illness

If my child becomes ill, I will be called. I may be required to to pick up my child as soon as possible (within 90 minutes at most). A child must remain out of the center until he/she is symptom free for 24 hours, unless a doctor's note is provided which states that the child is 1) not contagious; and 2) can participate in group care. The Family Guide contains Bright Horizons' full Child Illness Policy, including protocols for contagious illnesses.

Children's Injuries

If my child sustains a minor injury during care, I will receive an Occurrence Report when I pick-up describing the incident. I will be contacted immediately if the injury produces any swelling, is on the face or head, or requires medical attention.

Emergency Medical Care

If emergency medical attention is needed for my child, _____ , the center will attempt to contact me or the emergency contacts listed (if I cannot be reached). I authorize Bright Horizons to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility, or to _____my preferred facility, if possible.

Staff is trained in pediatric first aid and CPR and I authorize staff to administer the same. My child's health information may be viewed by staff, on a need to know basis, and state licensors for compliance.

_____

CHILD'S HEALTH INSURANCE PROVIDER

_____

NAME OF INSURED

_____

POLICY NUMBER

Family Guide Acknowledgement

By signing below, I acknowledge and agree that: 1) in addition to this Informed Consent, I received the Bright Horizons Family Guide or client equivalent, as well as any center-specific information and relevant state policies; 2) it is my responsibility to read and familiarize myself with all these materials and address any questions with center management; and 3) I will abide by these materials.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Annual parent/guardian review and signature is required by Bright Horizons. If any changes are necessary, a new form will be completed.

_____ _____

PARENT/GUARDIAN SIGNATURE REVIEW DATE

_____ _____

PARENT/GUARDIAN SIGNATURE REVIEW DATE

_____ _____

PARENT/GUARDIAN SIGNATURE REVIEW DATE

Bright Horizons.
Early Education & Preschool

ORIGINAL: CHILD'S FILE 11/2018 DUPLICATE: PARENT/GUARDIAN COPY

Parental Agreements with Child Care Facility

The _____ agrees to provide day care for
(Name of Facility)
_____ on _____ _____ a.m. to _____ p.m.
(Name of Child) (Days of Week)
from _____ to _____.
Month Month

My child will participate in the following meal plan (circle applicable meals and snacks):

Breakfast
Morning Snack
Lunch
Afternoon Snack
Evening Snack
Dinner
Bedtime Snack

Before any medication is dispensed to my child, I will provide a written authorization, which includes: date; name of child; name of medication; prescription number; if any; dosages; date and time of day medication is to be given. Medicine will be in the original container with my child's name marked on it.

My child will not be allowed to enter or leave the facility without being escorted by the parent(s), person authorized by parent (s), or facility personnel.

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.

The facility agrees to keep me informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child.

The _____ agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

I authorize the child care facility to obtain emergency medical care for my child when I am not available.

I have received a copy and agree to abide by the policies and procedures for
_____.
(Name of Facility)

I understand that the center will advise me of my child's progress and issues relating to my child's care as well as any individual practices concerning my child's special needs. I also understand that my participation is encouraged in facility activities.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Facility Administrator/Person-In-Charge)

Authorization to Dispense External Preparations

590-1-1-.20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give _____, permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

_____ Baby Wipes

_____ Band-aids

_____ Neosporin or similar ointment

_____ Bactine or similar first aid spray

_____ Sunscreen

_____ Insect Repellent

_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)

_____ Baby Powder

Other (please specify) _____

_____ _____

Parent/Guardian Signature Date

*center should maintain in child's file

Bright Horizons

FORM

Topical Applications Administration-Permission

Child's Name_____

I understand that **topical applications**, such as **ointment, lotion, lip balm, diaper cream/spray*, or cornstarch/cornstarch powders** can be applied only as a preventive measure. Where required by licensing, application to open, oozing sores or continued use on a persistent diaper rash requires a Medication Authorization Form signed by me and my child's physician.

*Aerosol sprays are not allowed.

I understand that the topical ointment provided by me must:

- be appropriate for use on a child;
- be applied according to instructions on the label
- be labeled with the child's full name; and
- be handed to a staff member and not left in a diaper bag or cubby.

I give my permission for the staff at Bright Horizons to apply:

- _____
- _____
- _____

as needed from: _____/_____/_____ to: _____/_____/_____ (not to exceed one year).

_____ _____

(Parent/Guardian Signature) (Date)

Bright Horizons

FORM

Sunscreen and Insect Repellent - Permission

Sunscreen and insect repellent should be applied to a child at least once at home to test for any allergic reaction. Aerosols, sprays and combined sunscreen/insect repellents are prohibited.

Sunscreen must provide UVB and UVA protection with an **SPF of 15 or higher**.
Sunscreen **may not** be used on infants under **6 months** of age, unless parent permission below is granted.

Insect repellent may only be used if recommended by public health authorities or requested by a parent/guardian. The repellent must contain a concentration of **30% DEET or less.** Insect repellant **may not** be used on infants under **2 months** of age. Oil of lemon eucalyptus and para-methane products may not be used on children under the age of three.

All sunscreen and insect repellent provided by a parent/guardian must be:

- provided in the original container;
- clearly labeled with the child's full name;
- within the expiration date;
- appropriate for the age of the child; and
- free of nut ingredients.

Complete one of the following:

I **give** Bright Horizons permission to apply (*name of sunscreen*) _____ and/or (*name of insect repellent*) _____ when outdoor conditions warrant and consistent with package instructions (subject to any special instructions below) to my child, _____ from _____/_____/_____ to _____/_____/_____ (not to exceed one year).

I **do not** give Bright Horizons permission to apply ☐ sunscreen and/or ☐ insect repellent to my child, _____. I do not hold Bright Horizons Children's Centers LLC responsible for my decision and understand that my child may be sunburned/bitten as a result. I understand that **I should provide protective clothing including a hat, lightweight long sleeve shirt and pants** instead, to protect my child from sun exposure and insects during outdoor activities.

Special Instructions

Sunscreen:

_____

Insect Repellent:

_____

_____ _____

(Parent/Guardian Signature) **(Date)**

Bright Horizons

FORM

Allergy Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Allergen	Treatment/Substitution
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Type of allergy transmission/trigger: ☐ Ingestion ☐ Contact ☐ Inhalation

Note: Do Not Depend on Antihistamines or Inhalers to treat a SEVERE reaction. USE EPINEPHRINE.

Extremely Reactive to the Following Foods_____; therefore:

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**

☐ **If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.**

For the following signs of a *mild* allergic reaction administer: _____

_____

☐ **Skin:** Hives: Mild Itch

☐ **Nose:** Itchy, Runny, Sneezing

☐ **Stomach:** Mild Nausea/Discomfort

☐ **Mouth:** Itchy

☐ **Other:** _____

For any of the following signs of a *SEVERE* allergic reaction or a combination of symptoms from different body areas, give EPINEPHRINE and CALL 911. If prescribed and directed, give other medications (antihistamine/inhaler). Lay person flat. *If breathing is difficult or vomiting, place on side, or sit up.*

☐ **Mouth:** Significant Swelling of Tongue and/or Lips

☐ **Heart**: Pale, blue, faint, weak pulse, dizzy

☐ **Throat:** Tight, hoarse, trouble breathing/swallowing

☐ **Lungs:** Short of Breath

☐ **Skin:** Many hives over body, widespread redness

☐ **Stomach:** Repetitive vomiting, severe diarrhea

☐ **Other:** Feeling something bad is about to happen; anxiety, confusion

Other Medication Instructions: _____

_____

Bright Horizons

FORM

Prescribed Medications/Dosage

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Potential Side Effects of Medication: _____

_____

Potential Consequences to Child if Treatment is Not Administered: _____

_____

Staff Training

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____ _____

_____ _____

_____ _____

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed note from the child's physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s) ; or be exposed to the item(s); nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen.

_____ _____

Physician Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Director/Principal Signature Date

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.

For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization form.

Bright Horizons.
Early Education & Preschool

FORM

Suspected Allergy/Food Intolerance Form

This form is to be completed by the parent/guardian when the parent/guardian suspects their child may be allergic to a product or has a food intolerance; however, has not received a medical diagnosis or a health care plan from the child's medical provider.

Note: If the suspected allergy or food intolerance is medically diagnosed, a Health Care Plan completed and signed by the child's medical provider is required (provided by the center).

Child's Name:_____Child's Date of Birth_____

My child has a: ☐ **suspected allergy** ☐ **food intolerance to:**

_____ _____
_____ _____
_____ _____

I suspect /am concerned my child may be allergic for the following reasons:

☐ No previous exposure ☐ Family history

☐ Previous reaction (please explain/date of reaction): _____

_____

_____

☐ Other: _____

_____

I understand that Bright Horizons requires the most up to date information regarding my child's suspected allergy/food intolerance. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen.

_____ _____
Parent/Guardian Signature Date

This form must be updated annually or whenever there is any change in treatment or the child's condition changes.

To eliminate the suspected allergy or food intolerance and allow your child to eat the suspected item(s) while at Bright Horizons, please complete the following.

I_____, acknowledge that my child no longer has a suspected allergy to_____and may now be served this item(s) while at Bright Horizons.

_____ _____
(Signature of the Parent/Guardian) (Date)

Bright Horizons

FORM

Asthma Health Care Plan

Name of Child: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

The following information should be completed by the child's health care provider.

Severity: ☐ Mild ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Check All Triggers		
☐ Cleaning Products	☐ Exercise	☐ Pet Dander
☐ Colds/Flu	☐ Food	☐ Smoke
☐ Cut Flowers, Grass, Pollen	☐ Odors/Fragrances	☐ Sudden Temperature Change
☐ Dust Mites	☐ Ozone Alert	
☐ Other:		

Suggested classroom strategies to support this child's needs: _____

_____

_____

Specific Medical Information:

Medication to be administered:* ☐ Yes ☐No If yes, medication to be administered and potential side effects:_____

_____

_____

**For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization form.*

Potential consequences to child if treatment is not administered: _____

_____

_____

Staff Training Needs: _____

_____

_____

Additional Emergency Procedures/Instructions (including when 911 should be called):

_____

_____

_____

GO (Green Zone)

If the child:	**What to do:**	**Medication:**
• Is breathing regularly • Has no coughing or wheezing • Can engage in active play	• Allow current activity	• "As needed medication" not needed • Regular medication to be given as ordered

CAUTION (Yellow Zone)

If the child has:	**What to do:**	**Medication**
• Early signs of a cold (runny nose,	• Cease current activity	• Administer the "As needed

sneezing) • Exposure to a known trigger • Coughing • Mild wheezing • Chest tightness	• If the child is outdoors bring inside • Observe breathing before and after the treatment (15 minutes)	medication" per the Medication Authorization Form and follow directions for use • Monitor breathing status if no improvement follow the steps for the DANGER (Red Zone)

DANGER (Red Zone)

If the child's asthma worsens and any of the following apply:	**What to do:**	**Medication:**
• The medications are not helping within 15-20 minutes of administration. • Breathing is becoming hard and fast • Nose (nostrils) open wide • Ribs are showing • Lips, fingernails or mouth area are blue or blue gray in color • Trouble walking or talking	• Call 911 • Stay with the child—Stay calm • Ancillary staff notify the parent/guardian • Accompany the child to ER • Complete an Occurrence Report within 24 hours	• Medication available has already been given with no relief • Notify EMS staff regarding the type of medication and the time it was given.

Staff Training

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____ _____

_____ _____

_____ _____

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child Bright Horizons cannot delete a health care diagnosis which has previously been documented unless we have a signed note from the child's physician stating that the condition no longer exists; nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's health. I also understand that for the safety of my child, my child's photograph and health information will be posted in the classrooms and kitchen.

_____ _____

Physician Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Director/Principal Signature Date

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.

INFANT PERSONAL CARE PLAN
DEVELOPMENTAL HISTORY FORM

Today's Date: _____ Date of Enrollment/Transition: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Date of Last Physical (for WA State only): _____

What would you like us to call your child?: _____

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Name of Person Completing Form: _____

Primary Caregiver: _____

Classroom: _____

FAMILY INFORMATION

In the columns below list the names of family members residing with the child. Please include siblings, extended relatives, and pets. For each person listed provide the name the child uses to address that individual and include ages of siblings.

Name	How child addresses this individual?	Age

Please list the words used in your language corresponding to the words in English. Include additional words in the blank columns if needed.

I'll take good care of you	
I see that you are crying	
Let's change your diaper	
I like your smile	
It's time for your bottle	
Time to eat	
Time for your nap	
Mommy will be back	
Daddy will be back	

If parental custody is shared, describe the custody arrangements: _____

Please tell us about cultural family customs, rituals, or traditions that will help us make your child's experience more meaningful, including languages spoken at home: _____

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM

CHILD'S NAME: _____

DEVELOPMENTAL HISTORY

Age Child Began: Sitting: _____ Crawling: _____ Standing: _____ Walking with support: _____

Walking independently: _____ Cooing: _____ Babbling: _____

Saying audible words: _____ Saying 2 or 3 simple sentences: _____

Do you have developmental concerns about your child? _____

_____

_____

_____

How does your child communicate his/her needs? _____

_____

_____

_____

CHILD'S HEALTH

List medications regularly taken and conditions requiring them: _____

_____

_____

_____

Describe serious illnesses or hospitalizations: _____

_____

_____

_____

Describe special physical conditions, disabilities, allergies, or concerns: _____

_____

_____

_____

Does your child have a special need? _____

_____

_____

_____

Explain special services and accommodations, which are different from those provided by the center's routine program (i.e. exercises, equipment, materials, or special services personnel): _____

_____

_____

_____

Note: For documented medical allergies an Allergy Health Care Plan completed by the child's medical provider is required.

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM

CHILD'S NAME: _____

NUTRITION PRACTICES AND ROUTINES

How is your child fed? Check all that apply: Breast: ☐ Bottle: ☐ Cup: ☐

In the corresponding row, provide your child's feeding details.

	Brand	Amount	Preferred time of day given
Formula/Milk			
Breast Milk			
Juice			

If your baby is exclusively breast fed, please outline your daily plan: _____

_____

_____

_____

If your baby is breast fed or receiving expressed breast milk, how can we support you?_____

_____

_____

_____

List special dietary requests, and restrictions: _____

_____

_____

_____

Have solid foods been introduced? Yes ☐ No ☐ If yes, please identify: _____

_____

_____

_____

Food likes and eating preferences: _____

_____

Child Eats With: Spoon: ☐ Fork: ☐ Fingers: ☐

Child is Fed in: Highchair: ☐ In Arms: ☐ Bouncy Seat: ☐ Other: _____

Preferred time of day to feed child: ☐ A.M. ☐ A.M. ☐ P.M. ☐ P.M.

Additional Information: _____

_____

_____

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM

CHILD'S NAME: _____

SLEEPING ROUTINES

Pre-nap routines/rituals: _____

_____

_____

_____

Number of naps daily: ___ **From:** _____ **To:** _____ **From:** _____ **To:** _____ **From:** _____ **To:** _____

Preferred sleep position*: _____

At home child sleeps in (Check all that apply: Bassinet: ☐ Crib: ☐ Bed: ☐

Child's typical waking behavior/routine: _____

_____

_____

Special sleeping concerns: _____

_____

_____

Note: Bright Horizons places infants to sleep on their backs in crib unless a waiver has been signed by the parents and the child's physician, stating that the child should be placed in a position other than on his/her back and if allowed by the state licensing agency. Following the recommendation of the American Academy of Pediatrics, soft items such as bumpers, stuffed animals (including pacifiers with a stuffed animal attached), blankets and quilts are not allowed in cribs. The use of sleep or swaddle sacks are recommended for naptime; however, there may be restrictions on the use of and type of these by the state licensing agency.

COMFORTING CHILD

Position child prefers to be held: _____

Security object (if any):_____ Name child uses for object/when needed: _____

_____

_____

Does your child use a pacifier? Yes ☐ No ☐ If yes, when: _____

Describe how adults can comfort your child? _____

_____

_____

DIAPERING/TOILETING ROUTINES

Please check which type of diapers you will provide: disposable: ☐ cloth: ☐

Words used for urination: _____

Words used for bowel movement: _____

_____

_____

INFANT PERSONAL CARE PLAN - DEVELOPMENTAL HISTORY FORM

CHILD'S NAME: _____

SOCIAL RELATIONSHIPS

Has your child had any experience with group care? If yes, please describe: _____

How does your child react to new situations and new children and adults? _____

Has your child had previous child care experience? If yes, explain how it met, or did not meet, your expectations? _____

Child's favorite toys and activities: _____

Does your child have any fears? Explain: _____

ADDITIONAL PERTINENT INFORMATION

To help us care for your child as an individual, please explain your parenting philosophy: _____

Is there additional information you feel is important for the staff to know about your child or family? _____

What do you as a family, hope to get out of this child care experience? _____

Infant Personal Care Plan - Developmental History Form

CHILD'S NAME: _____

Sections of this Personal Care Plan will be updated every 3 months or sooner if requested by a parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	
Date of Change:		Parent Initials:		Staff Initials:	