

# Kids Choice

## Intake Form

*Please have completed and handed into Director min. 48 hours prior to start date.*

Start Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(First, middle, last)

Guardian 1 Name: \_\_\_\_\_ Guardian 2 Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Hours of Work: \_\_\_\_\_ Hours of Work: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Common Law \_\_\_

### **PART ONE:**

1) Emergency Contact Persons: Other than Parents: Must supply two contacts.

1. Name: \_\_\_\_\_ 2. Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Does the child feel comfortable with this person? \_\_\_\_\_ Does the child feel comfortable with this person? \_\_\_\_\_

Mode of Transportation: \_\_\_\_\_ Mode of Transportation: \_\_\_\_\_

2) Authorized Persons to whom Child may be released:

*(Other than emergency contacts)*

1. \_\_\_\_\_ 2. \_\_\_\_\_

Please phone if this child is to be picked up by someone other than you.

Is there anyone **NOT ALLOWED** access to your child?

1. Name: \_\_\_\_\_ 2. Name: \_\_\_\_\_

Relationship to child \_\_\_\_\_ Relationship to child \_\_\_\_\_

IF this person did appear, how is your child likely to react?

IF this person did appear, how is your child likely to react?

(Happy, sad, excited, frightened withdrawn, etc.)

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\_\_\_\_\_  
Are there any problems with this person that we should be aware of?

\_\_\_\_\_  
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\_\_\_\_\_  
If no access is allowed, do you have A court order? YES\_\_\_ NO\_\_\_

\_\_\_\_\_  
If no access is allowed, do you have a court order? YES\_\_\_ NO\_\_\_

**(If you have any court order, we MUST have a copy of it on file.)**

3) **If Divorced or Separated:**

How long has this been? \_\_\_\_\_

Does your ex-spouse have contact with your child? \_\_\_\_\_

How is you child likely to react the day BEFORE and the day AFTER contact?

\_\_\_\_\_  
Does your child understand the situation? \_\_\_\_\_

4) Are there other adults who are important in your child's life? \_\_\_\_\_

5) Any special family circumstances that we should be aware of?

6) Are there any other children in the family?

Name: \_\_\_\_\_ Age: \_\_\_\_\_ M F Live with: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ M F Live with: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ M F Live with: \_\_\_\_\_

During the day are they in: School \_\_\_\_\_

Daycare \_\_\_\_\_

Family Day Home \_\_\_\_\_

Other \_\_\_\_\_

**PART TWO: HEALTH INFORMATION**

*(a copy of this portion will be supplied to room staff prior to start date)*

ALBERTA Health Care Number: \_\_\_\_\_

Child's Physician \_\_\_\_\_ Address: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

1. Is your child's immunization up to date? Yes \_\_\_\_ No \_\_\_\_ (please provide a copy with intake form for child's file. If No, please state reason why (e.g. Religion, personal beliefs, etc.) \_\_\_\_\_

2. Is your child able to totally participate in an active daycare program, including Outdoor play? Yes \_\_\_\_ No \_\_\_\_

3. Does your child have any physical handicap, which we should be aware of?

\_\_\_\_\_ If Yes, please state \_\_\_\_\_

Are there any special medical requirements? \_\_\_\_\_

4. Does your child have any speech problems? Yes \_\_\_\_ No \_\_\_\_

If Yes, is child going to therapy? \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone number: \_\_\_\_\_

5. How is your child's general health? \_\_\_\_\_

Is your child on any daily medication? \_\_\_\_\_

Does he/she take this willingly or is there a special routine for administering the medication? \_\_\_\_\_

*\*Any medications or herbal remedies that need to be administered by child care staff require a medication form.*

6. History of Illness (dates if possible):

MUMPS \_\_\_\_\_ THROAT INFECTIONS \_\_\_\_\_

MEASLES (red) \_\_\_\_\_ TONSILITIS \_\_\_\_\_

MEASLES (German) \_\_\_\_\_ EYE SIGHT PROBLEMS \_\_\_\_\_

CHICKEN POX \_\_\_\_\_ HEARING PROBLEMS \_\_\_\_\_

SCARLET FEVER \_\_\_\_\_ CRONIC DIARRHEA \_\_\_\_\_

CONVULSIONS (with fever) \_\_\_\_\_ FREQUENT COLDS \_\_\_\_\_

CONVULSIONS (w/o fever) \_\_\_\_\_ FRACTURES \_\_\_\_\_

CROUP \_\_\_\_\_ EARACHES \_\_\_\_\_

PNEUMONIA \_\_\_\_\_ CONGENITAL DEFORMITIES \_\_\_\_\_

OPERATIONS \_\_\_\_\_ BRONCHITIS \_\_\_\_\_

RINGWORM \_\_\_\_\_ IMPETIGO \_\_\_\_\_ SALMONELLA \_\_\_\_\_

\*ECZEMA \_\_\_\_\_ What triggers the Eczema \_\_\_\_\_

\*ASTHMA \_\_\_\_\_ What triggers the Asthma \_\_\_\_\_

**7. ALLERGIES and or dietary restrictions:**

Food \_\_\_\_\_

Medical \_\_\_\_\_

Other \_\_\_\_\_

How does your child react when in contact with said allergen? \_\_\_\_\_

What immediate first aid should be undertaken? \_\_\_\_\_

- Is your child toilet trained? Yes\_\_\_ No \_\_\_\_\_ Partially \_\_\_\_\_
- Are there special words used for Bowel Movement\_\_\_\_\_ Urination \_\_\_\_\_
- Does your child dress him/her self? Yes\_\_\_ No\_\_\_\_\_ Needs Help \_\_\_\_\_
- Do you celebrate birthdays in your family? Yes \_\_\_\_\_ No\_\_\_\_\_ Any special celebration or cultural belief? \_\_\_\_\_
- Does your child sleep in a CRIB \_\_\_\_\_ or a BED \_\_\_\_\_
- Does your child have naps in the MORNING \_\_\_ AFTERNOON \_\_\_\_.  
For how long? \_\_\_\_\_
- What is your child's USUAL bedtime? \_\_\_\_\_ Night time sleep habits \_\_\_\_\_
- Does your child have a bottle at home? Yes\_\_\_ No\_\_\_ On a regular basis \_\_\_\_\_ Just at bedtime or naptime \_\_\_\_\_ When under stress \_\_\_\_\_
- Does your child wear diapers? Yes\_\_\_ No\_\_\_ Naptime\_\_\_ Bedtime\_\_\_  
Daily \_\_\_\_\_
- BEDWETTING? Yes\_\_\_ No\_\_\_
- How does your child react to INJURY/ILLNESS? \_\_\_\_\_
- What is your usual method of discipline? \_\_\_\_\_
- What is your child's usual reaction when disciplined? \_\_\_\_\_
- What are your child's Food Preferences? \_\_\_\_\_
- Food Dislikes? \_\_\_\_\_
- Is he/she willing to try new foods? \_\_\_\_\_
- General Eating Habits: FORK\_\_\_\_\_ SPOON \_\_\_\_\_ KNIFE \_\_\_\_\_  
CUP \_\_\_\_\_ BOTTLE \_\_\_\_\_ Feeds self \_\_\_\_\_ Needs assistance \_\_\_\_\_
- How is your child likely to react upon initial separation from you? \_\_\_\_\_
- General Concerns re: health or behavior \_\_\_\_\_

**PART THREE:** *(a copy of this portion will be supplied to room staff prior to start date)*

1. What is your child's favorite toy? \_\_\_\_\_
2. Does your child have a security Blanket \_\_\_\_\_ Toy \_\_\_\_\_  
Thumb sucking \_\_\_\_\_
3. What activities does your child enjoy doing when playing alone? \_\_\_\_\_  
\_\_\_\_\_
4. What activities does you child enjoy doing when playing with others?  
\_\_\_\_\_
5. Does your child have much contact with other children? Yes \_\_\_ Often \_\_\_  
No \_\_\_ Minimal \_\_\_\_\_
6. Does your child enjoy other children? Yes \_\_\_ No \_\_\_  
Or does your child prefer adult company? Yes \_\_\_ No \_\_\_
7. What types of activities do YOU enjoy doing with your child? \_\_\_\_\_  
\_\_\_\_\_
8. Does your child enjoy outdoor play? Yes \_\_\_ No \_\_\_
9. Does your child enjoy: Music \_\_\_ Sand \_\_\_ Water \_\_\_ Table Activities \_\_\_  
Looking at Books \_\_\_ Dressing Up \_\_\_ Helping Out \_\_\_ Being read to \_\_\_  
Any others? \_\_\_\_\_
10. Does your child have any fears? Yes \_\_\_ No \_\_\_  
Please describe the fear and how he/she is likely to react. \_\_\_\_\_  
\_\_\_\_\_
11. Has your child had previous day care experience? Yes \_\_\_ No \_\_\_  
If Yes, Please describe experience \_\_\_\_\_  
If No, what were your previous child care arrangements? \_\_\_\_\_  
\_\_\_\_\_
12. Does your child have any sensitive situations? (eg. Toileting in front of others;  
having someone other than you change his/her diaper; being 'left out' of  
play by other children, etc.) \_\_\_\_\_  
\_\_\_\_\_
13. Does your child have any tendencies to wander off from you or run away? If  
yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Please write any other comments that you may have regarding the care of your  
Child or any goals that you would like your child to work on \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART FOUR:**

**IMMUNIZATION:**

Please sign below if your child's immunization records are up to date and supply a photocopy for your child's file.

**PARENTAL PERMISSION**

I \_\_\_\_\_ give permission for my child \_\_\_\_\_  
\_\_\_\_\_ to go on walks around the neighborhood. I also give  
my permission for my child to play in the neighborhood and in the attached  
playgrounds under the supervision of the staff of Kids Choice.

**RE: PERMISSION TO SEEK MEDICAL ATTENTION**

In case of a medical emergency, I understand that every effort will be made to contact the parent/legal guardian of my child.

In the event of emergency or medical situation that neither parents/legal guardian can be contacted, I give my permission to the staff of Kids Choice to seek medical attention in whichever way they believe to be appropriate. I agree to be responsible for any costs that may be incurred from any such action taken.

I give permission to the staff of Kids Choice to complete the Nipissing Developmental Screen. The individual result will remain confidential and be discussed with the parents.

Yes  No

Parents Signature \_\_\_\_\_

Date \_\_\_\_\_