

**Jefferson Avenue Childhood Development Center**  
**793 Jefferson Avenue**  
**Rochester, NY 14611**  
**(585) 436-0454 (tel)**  
**(585) 529-5713 (fax)**

**ADMISSION APPLICATION**

Child Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Employer/School \_\_\_\_\_ Phone # \_\_\_\_\_

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

**Give the name of 2 people that can be contacted in case of emergency and who are at home during the hours your child is in day care. \*\*NOTE - I agree that in case of an accident or injury emergency medical care may be given in the event I or Person(s) designated below cannot be reached.**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

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

**List the name of those (other than parent, guardian) who you give the Center consent to pick up your child/children. \*\*NOTE - It is your responsibility to call the Director or Teacher first and the child must be picked up from the office. The person(s) must have valid identification.**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

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

**MEDICAL INFORMATION**

Child's physician: \_\_\_\_\_ Phone # \_\_\_\_\_

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

Date of last ***complete physical***: \_\_\_\_\_ Where? \_\_\_\_\_

Date of last dental appointment: \_\_\_\_\_

Check-up or dental work? \_\_\_\_\_

Is your child current with his/her immunization schedule? \_\_\_ Yes \_\_\_ No

Type of medical coverage: (submit a copy of your child's health insurance card)

Blue Cross & Blue Shield # \_\_\_\_\_

Preferred Care # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Other # \_\_\_\_\_

Does your child have any ***ongoing health conditions that limit his/her activities***? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

Does your child take ***any prescription medications*** now? \_\_\_ Yes \_\_\_ No

If yes, please list all and explain: 1) \_\_\_\_\_ 2) \_\_\_\_\_

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***(You must sign along with your child's doctor a medication administration form)***

Is your child allergic to any medications? \_\_\_ Yes \_\_\_ No If so, please list: \_\_\_\_\_

During the past 12 months has your child had any illnesses or problems that required treatment or hospitalization? \_\_\_ Yes \_\_\_ No If so, please explain: \_\_\_\_\_

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Please check if your child has ever had any of the following:

\_\_\_ Asthma \_\_\_ Wears glasses \_\_\_ Sickle cell \_\_\_ High lead level

\_\_\_ Six or more ear infections \_\_\_ Hyperactivity \_\_\_ Counseling

Can your child follow directions from others, without repeating the direction? \_\_\_ Yes \_\_\_ No

If no, please explain why \_\_\_\_\_

**FEEDING INFORMATION**

Does your child have any known allergies to food? \_\_\_ Yes \_\_\_ No

If yes, please explain \_\_\_\_\_

What reactions do they have? \_\_\_\_\_

Any dislikes for certain foods? \_\_\_ Yes \_\_\_ No What? \_\_\_\_\_

Can your child feed his/her self? \_\_\_ Yes \_\_\_ No

Is your child still on the bottle? \_\_\_ Yes \_\_\_ No What kind of milk? \_\_\_\_\_

**BIRTH INFORMATION**

Was there any trouble with labor and or delivery? \_\_\_\_\_

Did your child have any problems in the hospital after birth? \_\_\_\_\_

During pregnancy did the mother smoke or drink alcohol? \_\_\_ Yes \_\_\_ No

Was your child breast-fed? \_\_\_ Yes \_\_\_ No

How much did your child weigh at birth? \_\_\_\_\_

**DEVELOPMENT INFORMATION**

Please check the following if your child can:

\_\_\_ Tie his/her shoe \_\_\_ Button clothes \_\_\_ Cut with scissors \_\_\_ Interact well w peers

\_\_\_ Recognize his/her name and things \_\_\_ Wait to take a turn \_\_\_ Follow your rules

\_\_\_ Easily adjust to a change in routine \_\_\_ Get upset easily \_\_\_ Ask questions

\_\_\_ Knows the colors red, blue, yellow \_\_\_ Balance on one foot \_\_\_ Run/Jump/Hop

\_\_\_ Sit up \_\_\_ Crawl \_\_\_ Walk without assistance \_\_\_ Feed self \_\_\_ Potty trained

\_\_\_ Sit for more than 15 minutes \_\_\_ Write their name \_\_\_ Can work independently

Does your child need extra help with his/her behavior, social or emotional functioning?

\_\_\_ Yes \_\_\_ No If so, please explain: \_\_\_\_\_

Does your child have a set bedtime? \_\_\_ Yes \_\_\_ No Time:\_\_\_\_\_ What time do they awake? \_\_\_\_\_

How much television does your child watch per day? (morning/evenings) \_\_\_\_\_

How often do you read to your child? \_\_\_\_\_

Does your child have brothers or sisters? If so how many and their ages: \_\_\_\_\_  
\_\_\_\_\_

Is this your child's first experience with childcare in a center? \_\_\_ Yes \_\_\_ No

Who cared for your child before they came to this Center? \_\_\_\_\_

Is your child left or right handed? \_\_\_\_\_

What is your child's reaction when you leave? \_\_\_\_\_

How does your child display anger? \_\_\_\_\_

Is your child toilet trained? If so at what age? \_\_\_ Yes \_\_\_ No \_\_\_\_\_

Is your child prone to skin rashes? \_\_\_ Yes \_\_\_ No

Has your child had any problems with hearing or speech? \_\_\_ Yes \_\_\_ No

So that we may provide your child the necessary support to succeed in our programs we need the following information.

**Language**

What language is spoken at home? ( ) English ( ) Other \_\_\_\_\_

What language does your child understand? ( ) English ( ) Other \_\_\_\_\_

What language can your child read and or write? ( ) English ( ) Other \_\_\_\_\_

( ) Does not read ( ) Does not write

**Holiday Celebration**

So that we are culturally sensitive and respect your families religious belief please list holidays you celebrate.

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**OTHER INFORMATION**

Would you be interested in participating in our parent's group?  Yes  No

Would you be willing to volunteer at the Center?  Yes  No (escort a field trip, "Annual Kids Day", holiday celebrations, share a talent or skill)

Do you consent to any hearing, speech, behavioral or emotional assessments and testing for your child?  Yes  No If yes you will need to complete a form.

**\*NOTE - The Center can provide services to you and your family with the support of outside agencies (Rochester Hearing and Speech, Visiting Nurse Services, Rochester City School District and others)**

Is there any other information you wish to share with us? \_\_\_\_\_

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**We Have An Open Door Policy**