Close To My Heart
Early Childhood Development Center
1740 Van Dyke St N
St. Paul, MN 55109
Phone: 651-487-0001 Fax: 651-487-0007 Cell: 651-307-1492

Infant Enrollment Form

Please circle the days are your child will be attending: **M T W TH F**

Registration Fee: $80.00 **Scholarships are available, a scholarship application must be completed**

Child's Name: _____
Last Name **First Name** **Middle Name** **Nickname**

Date of Birth: _____ **Place of Birth:** _____ **Social Security#:** _____

Male_____ **Female**_____

_____
Home Address **City** **State** **Zip Code**

_____ _____ _____
Home Phone # **Cell Phone #** **Email Address**

Ethnicity ____American Indian or Alaska Native ____Asian or Pacific Islander ____Hispanic
____Black, not Hispanic Origin ____White, not Hispanic ____Other_____(please specify)

Citizenship of student?

A. American Citizen
B. Refugee
C. Status Pending Enrollment
D. Immigrant
E. Student Visa _____
F. Visitor Visa
G. Other _____(please specify)

Language(s) Spoken at Home: _____

School District in which you live in: _____

Last School Attended: _____ **Address:** _____

My child will be transported to and from school by: _____

Parent 1 Name: _____
Occupation: _____
Employer: _____
Work Phone: _____
Email: _____

Parent 2 Name: _____
Occupation: _____
Employer: _____
Work Phone: _____
Email: _____

Parents are: ___Same Residence ___Separated ___Divorced ___Widow/Widower ___Married ___Single

If parents are separated or divorced, who does the child live with: _____

Parent/Guardian Name: _____ **Phone Number:** _____
(please print name)

Parent/Guardian Signature: _____ **Date:** _____

Close To My Heart
Early Childhood and Development Center

Health and Wellness Form

**This information must be filled out for all children.

Child's Name _____
First **Middle** **Last**

Birth Date _____ **Gender Male** _____ **Female** _____

HEALTH CONCERNS: Please check if your child has any of the following.

____ NO HEALTH CONCERNS

____ A.D.H.D./A.D.D.

____ Allergies (to what?)_____

____ Asthma or other breathing problems
Has you child ever been diagnosed by a **doctor** as having asthma? Yes No

____ Bladder problems/Bowel problems (describe) _____

____ Heart Problems (describe) _____

____ Seizures

____ Social/emotional/mental health (describe) _____

Do you have any concerns about your child's development? Yes ( ) No ( ) If yes, please comment: _____
_____
_____

Please comment on any other medical information or special need the child care provider should be aware of:
_____
_____

EMERGENCIES: Does your child have a health problem that could result in an emergency?

If yes, describe: _____
_____

Are there any physical problems at this time?

Respiratory _____ Orthopedics _____ Heart _____
Visual _____ Hearing _____ Allergies _____
Seizures _____ Other _____

Does child have any known health problems? Yes ( ) No ( ) If yes, attach documentation

Check (X) any of the following illnesses the child has had:

( ) Asthma ( ) Earaches ( ) Mumps ( ) Whooping Cough ( ) Bronchitis ( ) Eczema
( ) Pneumonia ( ) Polio ( ) Chicken Pox ( ) Frequent Colds ( ) Croup ( ) Convulsions
( ) Measles ( ) Influenza ( ) Diphtheria ( ) Tonsillitis ( ) Rheumatic Fever
( ) Other _____

Has your child had any surgery? Yes ( ) No ( ) If yes, please explain: _____

_____

_____

MEDICATIONS: List **ALL** medications that your child takes daily or when needed. A consent form is **REQUIRED** for **ALL** medication taken at school, including over the counter medications. **THE CONSENT MUST BE SIGNED BY BOTH HEALTH CARE PROVIDER AND PARENT.** A new consent is needed each school year. Forms are available in the health office.

Medication Name	**Purpose**	**Dose**	**How often taken?**

HEALTH INSURANCE:

____ My child has health insurance:
____Medical Assistance____ Minnesota Care
____Assured Care ____Other: _____

____ My child has no health insurance

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care? Yes No

Name of doctor or clinic Location and Phone

_____

_____

Hospital preference: _____

This health information may be shared with Close To My Heart staff as needed. If you do not want this health information shared, please contact 651-307-1492.

I authorize the child care provider/staff to obtain the following services for this child if necessary: Public Health Nurse, Physician and or Ambulance in the event of an emergency. (Ambulance fees and/or health care costs are the responsibility of the parent/guardian)

Parent/Guardian signature_____ Phone _____

Print Parent/Guardian name_____ Date _____
(print name) (month-day-year)

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Consent for Non-Prescription Medications

Child's Name: _____

I hereby give Close To My Heart/The Salvation Army permission to apply any of the external preparations that are checked in accordance with the directions for use on the appropriate container:

_____ Soap
_____ Baby Wipes
_____ Baby Lotion
_____ Baby Powder
_____ Baby Oil
_____ Non-prescription ointments (Desitin, Vaseline, etc.)
_____ Teething Gel
_____ Sunscreen
_____ Insect Repellant
_____ Other, please specify: _____

Child's Physician Signature: _____ Date: _____

Child's Parent/Guardian Signature: _____ Date: _____

Date	Medicine Administered	Amount Given	Time Given	Initials

Close To My Heart
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Infant Social Resume

Child's Name: _____

Family

Names of brothers and sisters | Birth Date

_____ _____
_____ _____
_____ _____
_____ _____

Names of others living in the home | Relationship to child

_____ _____
_____ _____
_____ _____

What language is spoken in your home: _____?

Does your child have any pets? ____ Yes ____ No If yes, what are they: _____

FOOD

Describe your child's appetite: _____
_____

What foods does your child like? _____
_____

What foods does your child dislike? _____
_____

Does your child feed himself/herself? ____Yes ____No

Does your child have any food sensitivities or allergies? ____Yes ____No
If yes, please identify: _____
_____

What time does your child eat: Breakfast_____ Lunch_____ Supper_____?

Self Care

Is your child in diapers? _____Yes _____No Comment: _____

Has training begun? _____Yes _____No Comment: _____

Is your child trained? _____Yes _____No Comment: _____

Health History -Infants/Toddlers

Please circle Y for yes, N for no for each question listed.

A. Health

Y N 1.Does your child seem well most of the time?

Y N 2. Is your child taking any medications now (including aspirin, laxatives, vitamins, etc.)?

If YES, What?

_____

How often?

_____

Y N 3. In a year has your child had as many as three ear infections?

Y N 4. Are you concerned with your child's hearing?

Y N 5. In a year, does your child have more than three colds or sore throat infections with fever?

Y N 6. Are you concerned about your child's eyes or vision?

Y N 7. Has your child been seen by a medical specialist?

If YES, Who?

_____

For What?

_____

Y N 8. Does your child have any disabilities?

Y N 9. Other illness/diseases?

Y N 10. Has your child been hospitalized within the past year?

Y N 11. Has your child had any serious accidents or poisonings?

Y N 12. Does your child chew unusual things, such as pencils, chalk, crib, window ledges, paint chips, plaster, or hair?

Has your child had any of the following:

Y N Premature birth

Y N Birth injury or defect

Y N Trouble breathing at birth

Y N Convulsions/seizures

Y N Allergies: (please circle) Eczema Hives Drug/food intolerance Hay Fever Wheezing Asthma Insect stings Other:

B. Developmental History

14. How do you comfort your child?

_____

15. What are your child's favorite toys?

_____

What are your child's favorite activities?

_____

Infant Developmental History

Child's name _____ DOB _____

Parent's names _____

Sleeping

- Fill in typical sleeping patterns

Nighttime: From _____ to _____

A.M. Nap: From _____ to _____

P.M. Nap: From _____ to _____

- Preferred sleeping position:

___ Back (This is the recommended position. Your baby's doctor must give written orders if we are to use another position.)

___ Side

___ Stomach

Feeding

- Baby drinks:

___ Breast milk

___ Whole milk

___ Formula, (Type: _____)

___ Other: _____

- Baby uses:

___ Bottle

___ Sippy cup

- Baby prefers bottles:

___ Warm

___ Room temperature

___ Cool

- Baby is fed every _____ hours
- Baby's typical feeding times and amounts (include foods and liquids):

Breakfast _____

Lunch _____

Snacks _____

- Check snack/breakfast items that we may serve your child at the center:

___ None apply

___ Crackers (Examples: graham, saltine, cheese, etc.)

___ Cheerios

___ Cookies (Examples: vanilla wafers, animal crackers, etc.)

___ Nutrigrain bar

___ Cheese

___ Yogurt

___ Fruit (Examples: diced peaches, diced pears, etc.)

___ Pancakes, waffles, French toast, etc.

___ Other foods your baby enjoys _____

_____

- List any dietary restrictions: _____

Health

- Is your baby generally healthy? _____
- Describe any health concerns:

_____

- Let us know about any on-going medications your child is taking:

_____

Infant Objectives

Physical Development:

1. Allowing rest times: by individual sleeping (sleeping infants are allowed to sleep)
2. Movement: by encouraging crawling, and walking
3. Balance and sitting: using swings, chairs and infant seats, encouraging rolling over & allowing infant "tummy time"

Intellectual Development

1. Language: by talking to the child, singing and reading books.
2. Cognitive: showing cause and effect. Playing peak a a boo
3. Creativity: by stimulating the environment through sounds, music textures, and books

Emotional Development

1. Love: caressing, holding during feeding, changing and play
2. Security: by responding to needs, having reliable caregivers

Social Development

1. Behavioral Skills: separating children during disagreements and over activity.

A. Our goals and objectives for Infants:

1. Physical Development:

Gross Motor:

a. Control of arms and legs
b. Moving from place to place by rolling, creeping, crawling, walking.
c. Climbing on objects such as a slide, etc.
d. Pulling self up
e. Kicking and throwing balls or other objects

Fine Motor:

a. Is able to grasp objects with thumb and forefinger
b. Is able to hold objects and manipulate them well
c. Is able to put objects in container
d. Is able to scribble with crayon
e. Is able to feed self and drink from a cup

2. Cognitive Development:

a. Can pick up and manipulate objects
b. Remembers familiar things
c. Can use several senses at once
d. Can solve simple manipulative problems
e. Explores new approaches to problems
f. Imitates people and/or noises
g. Begins to use language

C. Assessments:

Parents are informed of their child's progress in the areas of physical, cognitive, social and emotional development, through written developmental observations, and teachers are available for conferences.

D. Infant Daily Schedule (approximate):

7:00- 8:00 Staff greet Children and parents, receive Information from parents, interact with babies. Infants may select activities, such as manipulative toys, large muscle toys, etc. Breakfast (satisfy nutritional needs, Encourage feeding skills)

8:00-9:00 Breakfast (satisfy nutritional needs, encourage feeding Skills)

9:00-11:00 Free play (stimulate cognitive, physical, social and **Emotional development) and naps as needed**

11:00-12:00 Lunchtime

12:00-3:00 Snack

3:30-6:00 Free play, naps as needed, departure

Note: This is merely a general description of our day. Infants will be Changed, fed and allowed to nap throughout the day according to their individual needs. Special activities, such as walks, outside play finger painting, coloring, play dough, dancing and singing to music, etc., are offered daily as time allows.

E. List of activities and equipment/materials:

- Quiet: Books, quiet music, stroller rides, song singing, story telling, mobiles to look at
- Active: Large muscle toys, trucks/car for riding, large blocks, climbing stairs, climber/slide, musical instruments for dancing, balls of varying size, and sensory experiences such as water play.
- Teacher Directed: Group activities, dancing to music, using musical Instruments, wagon/stroller rides, gym/outdoor play, coloring, finger- painting and play dough and art activities.
  Child Initiated: Manipulative, looking at books, playing with blocks, Playing with blocks, stuffed blocks, stuffed toys, climbing on the climber and slide, playing with trucks and cars

***Activities and equipment are rotated to provide for a variety of learning Experiences. Toys are washed daily and mouthed toys are washed in between use.**