Little Stars
early learning center, LLC

CHILD ENROLLMENT FORM

This form enrolls your child at the Little Stars Early Learning Center. You will provide detailed information on this form that will allow Little Stars personnel to tailor their child care to your child's specific needs. Please be as accurate and complete as you can with the information you provide on this form.

Child Information

Last Name:	First Name:	Date of Birth (mm/dd/yyyy):		
Street Address:	City:	State:	Zip:	
Phone:	Start Date (mm/dd/yyyy):			
Days Attending X >>	Mon ☐	Tue ☐	Wed ☐	Thu ☐	Fri ☐
Days & Hours Attending Between (7 AM & 6 PM) From>>					
To>>					

Mother's Information

Last Name:	First Name:	Middle Name:	
Street Address:	City:	State:	Zip:
Home Phone:	Work phone (Not required if not working):	Mobile Phone:	
Phone Number where parent can be reached during program hours:	Place of Employment:		

Father's Information

Last Name:	First Name:	Middle Name:	
Street Address:	City:	State:	Zip:
Home Phone:	Work phone (Not required if not working):	Mobile Phone:	
Phone Number where parent can be reached during program hours:	Place of Employment:		

Marital Status of Parents

☐ Married	☐ Divorced Years: Months:	☐ Separated Years: Months:	☐ Single

Sibling Information

Last Name:	First Name:	Date of Birth (mm/dd/yyyy):
Last Name:	First Name:	Date of Birth (mm/dd/yyyy):
Last Name:	First Name:	Date of Birth (mm/dd/yyyy):
Last Name:	First Name:	Date of Birth (mm/dd/yyyy):

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Other Members of Household Information

Last Name:	First Name:	Age (Years):
Last Name:	First Name:	Age (Years):

Emergency Information

Pick-up and/or Drop-off Person #1	Last Name:	First Name:	Relationship to Child:	
Pick-up and/or Drop-off Person #2	Last Name:	First Name:	Relationship to Child:	
Authorized emergency pickup person #1:	Last Name:	First Name:	Relationship to Child:	
	Street Address:	City:	State:	Zip:
	Home Phone:	Work Phone (If working):	Cell Phone:	
Authorized emergency pickup person #2:	Last Name:	First Name:	Relationship to Child:	
	Street Address:	City:	State:	Zip:
	Home Phone:	Work Phone (If working):	Cell Phone:	
NOT authorized to pickup person #1:	Last Name:	First Name:	Non-Custodial Court Decision on File:: ☐ Yes ☐ No	
NOT authorized to pickup person #2:	Last Name:	First Name:	Non-Custodial Court Decision on File:: ☐ Yes ☐ No	

Note: A copy of the non-custodial court decision must be on file at Little Stars Early Learning Center, LLC in order for the program **NOT** to release a child to his/her non-custodial parent/relative.

Health Care Provider Information

Doctor:	Last Name:	First Name:	Telephone Number:	
	Street Address:	City:	State:	Zip:
Hospital / Clinic:	Hospital/Clinic Name:		Telephone Number:	
	Street Address:	City:	State:	Zip:
Dentist:	Last Name:	First Name:	Telephone Number:	
	Street Address:	City:	State:	Zip:

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Health History

Does your child have allergies?:	☐ Yes	
Does your child take any medications?:	☐ Yes	
Does your child have any disabilities?:	☐ Yes	
Has your child been seen by a medical specialist?:	☐ Yes	
Does your child have any contagious illness that could impact the children or staff?:	☐ Yes	☐ AIDS ☐ HIV ☐ Hepatitis A or B ☐ Malaria ☐ Other
Does your child have any other illnesses / diseases?	☐ Yes	
Does your child have any speech difficulties?:	☐ Yes	
Does your child have frequent colds, sore throat, or infections?:	☐ Yes	
Has your child ever been hospitalized?:	☐ Yes	
Has your child ever had any serious accidents or poisonings?:	☐ Yes	
Has your child been to the Dentist?:	☐ Yes	
Has your child had his/her vision checked?:	☐ Yes	
Has your child had his/her hearing checked?:	☐ Yes	
Check all of the following conditions at right that apply to your child:	☐ Convulsions or seizure	
	☐ Premature Birth	
	☐ Trouble breathing at birth	
	☐ Head injury	
	☐ Birth injury or defect	

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Feeding/Eating

Does your child have any food allergie ⁻	☐ Yes		
Does your child have any eating difficulties?:	☐ Yes		
Does your child refuse to eat any foods?:	☐ Yes		
Does your child eat with any of these? (Check all that apply):	☐ Spoon ☐ Fork ☐ Hands		
Does your child have any dietary restrictions?:	☐ Yes		
Does your child have any favorite foods?:	☐ Yes		
Is your child usually hungry at mealtimes?:	☐ Yes	Is your child hungry between meals?: ☐ Yes	

What time does your child normally eat? *Use HH:MM Time Format>>*	Breakfast	Lunch	Snack	Supper
	AM	AM	PM	PM

Does your child have a dietary preference? ☐ Yes	Vegetarian ☐	Vegan ☐	Other ☐	*List>>*

Describe your child's eating amounts (Enter 0 if not applicable):

Item▼ / Qty▶	Juice (Oz)	Food (Cups)	Milk/Formula
Breakfast			
Lunch			
Snack			

Infant

How is your child fed? (Check all that apply):	☐ Breast	☐ Bottle	Type of Bottle:	Type of Nipple:	Formula:
Does your child have to be burped?:	☐ Yes				

Toileting

Bowel movement & bathroom frequency and appearance:		*Bowel Movements/Day:*	*Appearance of stool:*	*Bathroom Visits/Day:*
Infant / Toddler	Does your child have diaper rash often?: ☐ Yes			
Toddler / Preschool	Is your child toilet trained?: ☐ Yes			
	What was the difficulty of potty training your child?:	☐ Easy	☐ Difficult	
	Is your child able to indicate when he/she need to use the toilet?: ☐ Yes			

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Toileting (continued)

Toddler / Preschool	Does your child use a potty chair?: ☐ Yes	
	What words does your child use for urination or bowel movement?:	
	Is your child afraid of the bathroom?: ☐ Yes	
	Does your child have toileting accidents?: ☐ Yes	

Sleeping

Describe your child's sleep schedule:	Night Time: From: ☐ PM To: ☐ AM	Morning Nap From: ☐ AM To: ☐ AM	Afternoon Nap From: ☐ PM To: ☐ PM
Does your child have a pacifier, blanket or special toy for sleeping?: ☐ Yes			
Do you have a specific way of helping your child go to sleep?: ☐ Yes			
Does your child cry when falling asleep?: ☐ Yes			
Describe your child's mood when awakening:			

Social Involvement

Describe your child's natural nature:	☐ Friendly ☐ Aggressive ☐ Shy ☐ Withdrawn ☐ Other
Will your child know anyone at Little Stars?: ☐ Yes	
What age group does your child prefer to play with? (Check all that apply):	☐ Infant ☐ Toddler ☐ Preschool ☐ School-Age ☐ Adult
Identify the words that best describe your child (Check all that apply):	☐ Anxious ☐ Confident ☐ Cooperative ☐ Fearful ☐ Follower ☐ Friendly ☐ Insecure ☐ Leader ☐ Loving ☐ Responsible ☐ Self-Reliant ☐ Shy
Describe how your child reacts and adjusts to babysitters, new people, or new situations?:	
Describe how your child reacts and adjusts to new people and places?:	
Describe how your child handles sharing:	Likes to share ☐ Does not share ☐
Has your child had experience playing with other children?: ☐ Yes	
Describe your child shows his/her feelings:	

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Social Involvement (continued)

Describe what makes your child angry or upset:	
Fears & Anxieties>> Describe any fears or anxieties that your child has and what behavior guidance methods work best with you child *Best working behavior guidance methods>>*	
Describe how behavior guidance is handled at home:	
Does your child have any behavior concerns?: ☐ Yes	
Describe how you handle or prevent these concerns:	
Hours your child spends each day doing these activities:	Playing Alone (Excluding TV):_____Hrs/Day Playing Outside:_____Hrs/Day
Does your child have things / situations they need extra help with: ☐ Yes	
Identify the things your child can do by himself/herself: *List>>*	☐ Dressing ☐ Drinking ☐ Feeding ☐ Ties Shoes ☐ Toileting ☐ Washing Hands ☒ Other

Developmental History

What language is spoken in your home?:	
What language(s) do you or your child speak?	
Does your child have a favorite toy?: ☐ Yes	
Does your child have a favorite Activity?: ☐ Yes	
Identify the things your child has experience with (Check all that apply):	☐ Blocks ☐ Clay ☐ Easel Painting ☐ Finger Painting ☐ Glue ☐ Scissors ☐ Water Play
Identify the things your child likes:	Being read to? ☐ Yes ☐ No Climbing ☐ Yes ☐ No Listen to music? ☐ Yes ☐ No Tri-cycling or bicycling ☐ Yes ☐ No Playing outdoors ☐ Yes ☐ No
Has your child been in a group child care setting previously?:	☐ Yes ☐ No
Check the activities that your toddler / pre-school child can perform and enter the earliest month performed.	☐ Sit: ☐ Crawl: ☐ Walk: ☐ Talk:
What do you do to comfort your child?:	

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Special Interests

What interests or fascinates your child?	
What activities does your child prefer most often?: Indoors►	
Outdoors►	
Specify any special abilities that your child may have:	
Is your child allowed to be around animals? (If No explain):	☐ Yes ☐ No
Do you own an animal?: ☐ Yes	
Is your child able to participate in Holiday activities held at the center? (If No specify excluded holidays):	☐ Yes ☐ No
Identify any cultural practices or holidays that you would like us to know about:	
Identify any special benefits or learning experiences that you wish for your child to have during his/her experience with us:	
Please note any additional information about your child that will help staff know how to better care for him/her:	

Signatures

Mother Signature:	*Date (mm/dd/yyyy)*
Father Signature:	*Date (mm/dd/yyyy)*
Little Stars Director Signature:	*Date (mm/dd/yyyy)*
Little Stars Treasurer Signature:	*Date (mm/dd/yyyy)*

When you are finished click the "SUBMIT" button to the right. You will be notified of errors requiring correction. You can save the form and finish it later. When the form has passed all checks it will be locked from further changes. You will be able to save it to your computer and print copies for signature/submission and records.

SUBMIT

INFORMATION BELOW FILLED IN BY LITTLE STARS

Date First Week Tuition(s) received:		Issued Sign-In Code:	
Date Health Care Summary(s) received:		Fingerprint Scan-In Date (If applicable):	
Date Immunization Form(s) received:		Name of LSELC Approver:	