Playcare, Inc.
1416 W Gore Blvd., Ste. 5
Lawton, OK 73501
580-355-0814
The Best Start is a Smart Start!

Smart Start #

Name of Child _____ Nickname _____

Birthdate _____ Sex: M F SS# _____

Parent/Guardian Information

Mother/Guardian Name _____ SS# _____

Address _____

Employer _____ Rank _____

HM Phone _____ WK Phone _____ CELL Phone _____

Father/Guardian Name _____ SS# _____

Address _____

Employer _____ Rank _____

HM Phone _____ WK Phone _____ CELL Phone _____

Email Address _____ MES Phone _____

Emergency Contact Information

1.) Name _____ Relation to child _____

HM Phone _____ WK Phone _____ CELL Phone _____

Authorized to pick up child: YES NO

2.) Name _____ Relation to child _____

HM Phone _____ WK Phone _____ CELL Phone _____

Authorized to pick up child: YES NO

3.) Name _____ Relation to child _____

HM Phone _____ WK Phone _____ CELL Phone _____

Authorized to pick up child: YES NO

I authorize Playcare, Inc. to share daily reports, illness reports, incident reports and medical information about the child with the above listed people.

Signature _____ Print Name _____ Date _____

Personal Information

School Child Attends _____ Grade _____

Child's Usual Physician or Hospital _____ Phone _____

Child's Usual Dentist _____ Phone _____

Conditions which could be important in an emergency:

Severe Asthma Diabetes Seizures, Convulsions

Heart Condition Sickle Cell Anemia Allergies

Other

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, injuries during the past 12 months, any medication prescribed for long-term continuous use, developmental issues and any other information which staff need to know in order to properly care for your child.

_____

_____

_____

Does your child need any special accommodations in order to take part in our programs? If so, what?

_____

_____

What other child care center has your child attended? Why did you leave?

_____

_____

Household Information

Family Members	Birth date	Lives w/child Yes or No	Family Members Health Problems
Mother			
Father			
Brothers & Sisters			
1.			
2.			
3.			
4.			
Other(Specify Relationship)			
1.			
2.			
3.			

CHILD'S NAME_____ SEX_____ BIRTHDATE_____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?			
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?			
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5. WHAT WAS CHILD'S BIRTH WEIGHT?			_____LBS. _____OZ.
6. WAS ANYTHING WRONG WITH THE CHILD AT BIRTH?			
7. WAS ANYTHING WRONG WITH THE CHILD IN THE NURSERY?			
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9. IS MOTHER PREGNANT NOW?			

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)*?			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			

HEALTH PROBLEMS	YES	NO	EXPLAIN (Use additional sheets if needed)
13. DOES CHILD HAVE FREQUENT ___SORE THROAT; ___COUGH; ___URINARY INFECTIONS OR TROUBLE URINATING; ___STOMACH PAIN, VOMITING, DIARRHEA?			
14. DOES CHILD HAVE DIFFICULTY SEEING? *(squint, cross eyes, look closely at books?)*	*		
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?			
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear?)*	*		*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?			*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO?_____
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	*		*If "yes" ask:* WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Medicine register form must be signed daily to* administer *any medication).*			WHAT MEDICINE? _____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT THE CENTER?_____ HOW OFTEN? _____
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			PHYSICIAN NAME_____ DENTIST NAME _____
21. HAS CHILD HAD: ___BOILS; ___CHICKENPOX; ___ECZEMA; ___GERMAN MEASLES; ___MEASLES; ___MUMPS; ___SCARLET FEVER; ___WHOOPING COUGH?			
22. HAS CHILD HAD: ___HIVES; ___POLIO?	*		
23. HAS CHILD HAD: ___ASTHMA; ___BLEEDING TENDENCIES; ___DIABETES; ___EPILEPSY; ___HEART/BLOOD VESSEL DISEASE; ___LIVER DISEASE; ___RHEUMATIC FEVER; ___SICKLE CELL ANEMIA?	*		
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS? *(Rash, itching, swelling, difficulty breathing, sneezing)?* a. WHEN EATING ANY FOODS?_____ b. WHEN TAKING ANY MEDICATION?_____ c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.?_____	*		
25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN:
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE HOW: WHEN:

HEALTH HISTORY (continued)

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____NO, _____YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE?) _____NO, _____YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET?

31. DOES YOUR CHILD NEEP HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

33. HOW DOES YOUR CHILD ACT WITH FEW CHILDREN HIS/HER OWN AGE?

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? _____NO, _____YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM/HER TO WORRY OR TO BE AFRAID?

36. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

37. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? _____NO, _____YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

_____

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

38. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

39. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

40. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE?

Dental History

1.IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride* Topical Fluoride Application? No___Unknown___Yes___ Fluoride Water No___Unknown___Yes___ Fluoride Supplement diet? No___Unknown___Yes___ (tablets_____, liquid_____)	2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAT THE PARENT KNOWS ABOUT?
3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST. Dentist's name_____ 4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE. Physician's name_____ 5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION. Type_____	6. Does the child brush or have teeth brushed daily at home?_____ 7. How often? _____

Developmental History

Children learn to do things at different ages. We need to know what each child already can do or is learning to do easily and where they might need help so that we can fit our program to meet each child's need. Please complete the following chart to assist our staff in developing a program for your child.

	Earlier	When Expected	Later	Age
1. sit up without help				
2. crawl				
3. walk				
4. talk				
5. feed and dress self				
6. use the bathroom by self				
7. respond to directions				
8. Play with toys				
9. use crayons				
10. understand what is said to him/her				

Immunization Record

	1	2	3	4	5
DTaP					
IPV					
PREVNAR					X
MMR			X	X	X
HIB					
TB TINE/PPD					
HEP.B				X	X
HEP. A			X	X	X
VARICELLA		X	X	X	X

Revised: 1/15/2014

Infants under One Year

I would like my infant who is under 3 months to be swaddled with the light weight swaddling blanket I provide until my child turns 4 months _____yes _____no

My infant is able to turn over from back to stomach _____yes _____no

Permissions and Releases

I agree to keep my child's immunization records up to date and supply the center with current records of these immunizations.

I authorize Playcare, Inc. to administer medication to my child. I understand that I must sign the medication in daily on the medication form. The medication form will be signed by the person administering the medication and records will be available for 90 days.

If a medical emergency occurs I will be called but if I cannot be reached, I hereby authorize the person in charge at Playcare, Inc. to transport my child to the nearest medical facility and notify my family physician. I also give my consent for the program to share my children's health information with the emergency medical professionals and other necessary service providers who would respond.

I hereby give permission for Playcare, Inc. to transport my child for field trips and learning experiences away from the center provided that I am notified in advance.

I hereby give consent for the release of photographs to the local media taken of my child while participating in the programs sponsored by Playcare, Inc.

If I inform the center that my child has allergies to certain foods or conditions, I give permission for the center to post this information about my child in a prominent position in the classroom so that all adults in the room are easily made aware of the situation.

_____Parent/Guardian Signature