



# NOAH'S CORNER CHILDCARE LLC

**Office Use Only:**

Date Received: \_\_\_\_\_ Child's Initials: \_\_\_\_\_ Childs age: \_\_\_\_\_ Registration Fee: \_\_\_\_\_

**CHILD INFORMATION:**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male Female (circle one)

Anticipated start date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Child lives with: \_\_\_\_\_

-----

**PRIMARY HOURS OF CARE:**

**(Please list your child's anticipated schedule below)**

**Full-time:** (3-4 days/week, up to 12 hours a day)

**Part-time:** (1-2 days/week, up to 12 hours a day)

**(Our hours of operation are 8:00 pm-8:00 am Monday-Thursday)**

	Drop off	Pick up	Additional Notes:
<b>Monday</b>			
<b>Tuesday</b>			
<b>Wednesday</b>			
<b>Thursday</b>			

Signature of Parent or Guardian: \_\_\_\_\_

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



# NOAH'S CORNER CHILDCARE LLC

## PARENT/GUARDIAN INFORMATION: #1

Parent/Guardian First/LastName: \_\_\_\_\_  
Home address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_  
Home number: \_\_\_\_\_  
Work number: \_\_\_\_\_  
Cell Number: \_\_\_\_\_  
Which number is best: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Place of employment: \_\_\_\_\_  
Work address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION: #2

Parent/Guardian First/LastName: \_\_\_\_\_  
Home address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_  
Home number: \_\_\_\_\_  
Work number: \_\_\_\_\_  
Cell Number: \_\_\_\_\_  
Which number is best: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Place of employment: \_\_\_\_\_  
Work address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_



# NOAH'S CORNER CHILDCARE LLC

## EMERGENCY CONTACT:

List persons who are authorized to pick up your child: (He/She will need to present his/her driver's license at the time of pickup)

**Persons are permitted to remove the child from the childcare home on behalf of the parent.\*\*\***

### (Person 1)

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Home of number: \_\_\_\_\_

Cell number: \_\_\_\_\_

Which number is best: \_\_\_\_\_

### (Person 2)

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Home of number: \_\_\_\_\_

Cell number: \_\_\_\_\_

Which number is best: \_\_\_\_\_

The people will be called in case of an emergency if parents cannot be reached. Is that okay? Yes or No (circle one)

**Please ensure the information is current and accurate.\*\*\***

### Child's Emergency Medical Care Provider:

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Child's Physician:

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Child's Dentist:

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_



# NOAH'S CORNER CHILDCARE LLC

## DEVELOPMENT HISTORY AND BACKGROUND INFORMATION

Regulations for licensed child care programs require this information to be on file to address the needs of children while in care

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### HEALTH

Any known complications at birth: \_\_\_\_\_

Serious illnesses and/or hospitalizations: \_\_\_\_\_

Special physical conditions, disabilities: \_\_\_\_\_

**ALLERGIES: i.e. asthma, hay fever, insect bites, medicine, food reactions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EATING HABITS: Special characteristics or difficulties:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*If the infant is on a special formula, describe its preparation in detail**

**Favorite foods:** \_\_\_\_\_

**Foods refused:** \_\_\_\_\_

**Is your child fed (please check one or more) Lap \_\_\_\_\_ High chair \_\_\_\_\_**

**\* Does your child eat with: (please check one or more)**

Spoon \_\_\_\_\_ Fork \_\_\_\_\_ Hands \_\_\_\_\_

Immunization/Record/Forms: [Microsoft Word - DRAFT ec\\_har Revised September 2018 \(ct.gov\)](#)