



# Registration Form

The program will serve children between six weeks through 5 years of age (Pre-K). We will be open from 7:30 a.m. to 5:00 p.m. Enrollment packets must be completed annually; forms included in enrollment packet are Registration Form, Agreement Form, Parent Permission Form, and Household Income Statement Form. Additional forms that need to be completed by your child's physician before their start date are Health Care Summary and Child Care Immunization Form (a signature required on the reverse side). You may also attach copy of child's immunization history.

<b>Child's Name:</b> _____			<b>Birthdate:</b> _____			<b>or Due Date:</b> _____			<input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>Program Enrollment:</b> Full Day, <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri									Hours in care: Start Time: _____ End Time: _____		
<input type="checkbox"/> Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschool						<b>Summer Care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> P.M. snack											
<b>Others in household, including parents: Name</b>			<b>Relationship to Child</b>			<b>Age (siblings only)</b>					
_____			_____			_____			_____		
_____			_____			_____			_____		
_____			_____			_____			_____		
_____			_____			_____			_____		

<b>Current Employment of Parents:</b> Please include: <b>Employer</b>				<b>Work Address</b>	<b>Work Schedule</b>	<b>Work Phone</b>
<b>Parent:</b> _____						
<b>Parent:</b> _____						

I would like my child to start attending the Early Childhood Development Center on: \_\_\_\_\_

A registration fee of \$20 is billed the first month of enrollment. Upon my child's enrollment, I recognize that I am responsible for adherence to all policies as outlined in the Statement of Policies/Parent handbook.

*\*Child admission is based on the following prioritized factors: licensing capacity; consistency of scheduling; University students, faculty, staff; date application received, and currently enrolled families.*

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

*\*This should be the information you would like your child's account setup under.*

Address: \_\_\_\_\_ City & Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ (Billing)

If you want, separate email for parent communication; email address: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Childcare tuition is subject to change the beginning of each year (September 1). Childcare tuition is billed as a flat monthly rate.\* You will not receive a credit for sick days, vacations days, holidays, staff development days, season breaks, and emergency closure dates, as these are all considered part of the enrollment schedule.  
\*Preschoolers who will be kindergartners in the next school program year will have a pro-rate in May (who are not enrolled in the ECDC summer program) or August (who are enrolled in the summer program, ends the day before ECDC Professional Staff Development Days-TBD).  
\*Any new child to the program, who starts the first day of the new fall program year, will have a pro-rate.

Office Use -Date Received: \_\_\_\_\_

**HEALTH INFORMATION**

Name of child’s physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Date of last examination: \_\_\_\_\_

Approximately, how often does this physician see your child? \_\_\_\_\_

Are all immunizations up to date?  Yes  No If not, explain: \_\_\_\_\_

Has your child had chicken pox?  Yes or  No

List any allergies, injuries, prolonged illnesses, or any limiting conditions your child may have: \_\_\_\_\_  
\_\_\_\_\_

Does your child experience any of the following:  seizures  ear infections  strep infection  sudden high temperatures

Impetigo  diarrhea  constipation  upset stomach  other \_\_\_\_\_

Have you noted any signs of hearing or sight loss? \_\_\_\_\_

If your child is older than 3 years, has s/he has a recent dental exam? \_\_\_\_\_

If so, name of dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Child’s Interests/Activities/Special Needs or Behaviors**

What is your child’s favorite activity and/or toys? \_\_\_\_\_

Does s/he have regular playmates?  Yes  No Ages? \_\_\_\_\_

Would you judge your child to be  extremely active  somewhat active  quiet  very passive  shy

Napping (yes or no, sometimes, on a schedule)? \_\_\_\_\_

Eating (picky eater, eats everything, on a schedule)? \_\_\_\_\_

Elimination or toileting behaviors (constipation, shows interest in using the toilet)? \_\_\_\_\_

Communication (6 weeks-36 months) \_\_\_\_\_

How does your child comfort himself/herself? \_\_\_\_\_

Are there any special circumstances in the family that we may need to know (e.g. adoption, illness, & legal custody arrangements)?  
\_\_\_\_\_

**Please describe** your child as you see him or her? \_\_\_\_\_

**Please tell us** what you hope to gain for your child and yourself from our early childhood program? \_\_\_\_\_  
\_\_\_\_\_

**Return form to:**  
Early Childhood Development Center  
2900 University Ave  
Crookston, MN 56716

**Or Email:**  
Tu Lynn  
somme032@crk.umn.edu