For Office Use Only
Date of Enrollment: _____
Date of Exit: _____

Trinity Children's Center
Enrollment Form

Child's Name: _____ Gender: _____

Date of Birth: _____ Date of Adoption (if applicable): _____

******If there is a custody and/or visitation agreement in place for your child, this legal document MUST be submitted to TCC at time of enrollment or at the time of the legal mandate. If agreement changes occur over the course of enrollment, TCC must also be notified by legal document.***

Parent or Guardian #1:

Name: _____ Pronouns (optional) _____

What does your child call you? _____ Does child reside with this person? _____

Address: _____

Cell Phone: _____ Home Phone: _____

Place of Employment/Job Title: _____ Work Phone: _____

E-Mail Address: _____

Home Language: _____ Other Languages Spoken in the Home: _____

Interpreter Preferences: ☐ None ☐ Daily Communication (calls/updates/announcements)

☐ Meetings/Conferences/Presentations ☐ Written Messages

Parent or Guardian #2:

Name: _____ Pronouns (optional): _____

What does your child call you? _____ Does child reside with this person? _____

Address: _____

Cell Phone: _____ Home Phone: _____

Place of Employment/Job Title: _____ Work Phone: _____

E-Mail Address: _____

Home Language: _____ Other Languages Spoken in the Home: _____

Interpreter Preferences: ☐ None ☐ Daily Communication (calls/updates/announcements)

☐ Meetings/Conferences/Presentations ☐ Written Messages

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Others Living in the Home:

Name: Age: Relationship:

_____
_____
_____
_____

Ethnicity of Child:

☐ Pacific Islander ☐Black ☐Hispanic ☐White ☐Asian
☐ Native American ☐Native American ☐Multi-Racial ☐Other _____

Child's Physician:

Physician's Name: _____

Doctor Office Name: _____ Phone Number: _____

Date of Last Physical Exam: _____

☐ ***** TCC OFFICE NEEDS A COPY OF CURRENT IMMUNIZATION PRIOR TO FIRST DAY OF ENROLLMENT***

☐ ***** TCC NEEDS DOCUMENTATION OF YOUR CHILD'S WELL CARE EXAM, TO INCLUDE ANY INFORMATION REGARDING ANY HEALTH CONDITIONS OR MEDICATIONS THAT MAY IMPACT THE CARE WE PROVIDE***

Child's Dentist:

Dentist's Name: _____

Dental Office Name: _____ Phone Number: _____

Date of Last Dental Exam: _____

Health Insurance Information:

Name of insured: _____

Name of Insurance Carrier: _____

Policy #: _____

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Authorized to Pick My Child Up from Trinity Children's Center:

**Please list below anyone that is authorized to pick up your child from Trinity Children's Center. Upon our first time meeting these people, we will need to see a photo I.D. that matches the name below. We will not release your child to anyone other than the people listed on this form without your written permission. Please list names, relationship to your child, and their personal phone number.

1) Name: _____ Relationship to Child: _____
   Phone Number: _____

2) Name: _____ Relationship to Child: _____
   Phone Number: _____

3) Name: _____ Relationship to Child: _____
   Phone Number: _____

4) Name: _____ Relationship to Child: _____
   Phone Number: _____

Emergency Contacts

**In case of emergency, if the parent(s) or guardian(s) cannot be reached, please list at least two other people who are authorized to pick up your child. These individuals are also authorized by the family to have access to health information about the child. The emergency contacts must be located within a 30 minute radius of the Preschool and have access to transportation.

Emergency Contact #1:

Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____
Place of Employment: _____ Work Phone: _____

Emergency Contact #2:

Name: _____ Relationship to Child: _____
Home Phone: _____ Cell Phone: _____
Place of Employment: _____ Work Phone: _____

In case of emergency, if the above-named persons cannot be contacted and the situation calls for immediate medical/dental care, I hereby authorize the staff of Trinity Children's Center to seek medical care for my child from my child's primary care physician or dentist, as specified below.

_____ _____

Parent/Guardian Signature **Date**

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Family Survey

Child's Name: _____

Does your child have a nickname? _____

Primary Language spoken in the home: _____

Please describe your child's history and experience with child care (i.e. home with family member, home provider, licensed center program, part-time or full-time schedule?):

What family support do you have in the area, if any, and who are the important people in your child's life?

What kind of transportation will you be using to bring your child to school?

What is a typical day like for you (work, classes, etc...)?

What information, if any, might be helpful for us to support and/or celebrate your family's cultural beliefs and practices at school?

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What holidays/traditions do you celebrate as a family?

Are you having any frustrations/concerns with your child?

What do you most enjoy doing with your child?

What are your goals for your child while attending TCC?

What are your expectations of both administration and your child's teachers here at TCC?

Is there anything else regarding your family or child that you would like to share with us?

Do you (as the guardian) have any special interests or talents that you would like to share with us here at Trinity (playing an instrument, crafts, baking, gardening, etc...)?

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Eating

Is your child on any special diet? _____ If yes, please describe _____

_____

Does your child have any food allergies? _____ If yes, please describe_____

_____

Please describe your child's typical daily snack/meal schedule: _____

_____

_____

Sleeping

Does your child nap? _____ How many times per day? _____ How long? _____

Does your child sleep with a special blanket, toy, "stuffy", or pacifier? _____ If yes, please describe

_____

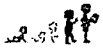
Toileting

Does your child use a potty/toilet? _____

How does our child let you know that it's time "to go?" _____

Does your child need regular reminders to use the bathroom? _____

Development



Does your child have any special developmental needs and/or diagnosed medical conditions?

☐ No ☐ Yes

If yes, please check off all areas that apply:

☐ Hearing ☐ Vision ☐ Language ☐ Social/Emotional
☐ Gross Motor/Movement ☐ Fine Motor ☐ Other

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Please Describe:

_____

Is your child on an IEP (Individualized Education Plan)? ☐ No ☐ Yes

Does your child see a medical specialist? ☐ No ☐ Yes (If yes, name of specialist: _____)

Do you have any concerns about your child's development that have not been evaluated or diagnosed?
☐ No ☐ Yes

If yes, please check off all that apply:

☐ Hearing ☐ Vision ☐ Language ☐ Social/Emotional
☐ Gross Motor/Movement ☐ Fine Motor ☐ Other

Please Describe:

_____