



EMERSON ACADEMY
CHILD DEVELOPMENT CENTER

Registration Information Questionnaire

Date _____

Child's Name

(First) (Middle) (Last)

Date of Birth ____/____/____ Age (as of Sept. 1st) ____ Sex ____

Place of Birth _____ School District of Residence _____

Language/s Spoken in the Home

Does your child have siblings? Yes No

If yes, please list their name(s) and ages

Parent/Guardian 1

Name _____ Home Phone (_____) _____

Cell Phone (_____) _____ Email _____

Address _____
(Street) (City, State) (Zip)

Occupation _____ Business Phone _____

Marital Status (Circle One): Single Married Separated Divorced Partner

Parent/Guardian 2

Name _____ Home Phone (_____) _____

Cell Phone (_____) _____ Email _____

Address _____
(Street) _____ (City, State) _____ (Zip) _____

Occupation _____ Business Phone _____

Marital Status (Circle One): Single Married Separated Divorced Partner

Primary Caregiver (If other than parent)

Name _____ Home Phone (_____) _____

Cell Phone (_____) _____ Email _____

Address _____
(Street) _____ (City, State) _____ (Zip) _____

Occupation _____ Business Phone _____

Marital Status (Circle One): Single Married Separated Divorced Partner

Emergency Telephone Numbers

Name _____ Relationship _____

Phone _____ Cell Phone _____

Name _____ Relationship _____

Phone _____ Cell Phone _____

SOCIAL HISTORY

Does your child currently attend a childcare center? Yes No
If yes, where?

Does your child receive Early Childhood Intervention (ECI) services or Special Education through the school district? Yes No
If yes, where?

What are your child's most enjoyable activities?

What things frighten your child?

What do you do to comfort your child?

What is your child's sleeping/napping schedule? (you may want to continue on the back)

What is your child's schedule for snack and lunch?

What are your child's favorite activities and toys?

List the places your child frequently visits:

List the significant people in your child's life:

Is there anything that you would like for Emerson Academy staff to know about your background or beliefs that you believe will help us to understand your family better? If so, please list any information, special requirements or requests below:

DEVELOPMENTAL MILESTONES

When did your child first: (mark n/a if not yet reached)

Roll over _____ Sleep through the night _____ Say first word _____

Sit up Smile _____ Babble _____ Combine two words _____

Take first step _____ Crawl on hands and knees _____

Stand Alone _____ Toilet train; if not, please describe toileting behavior:

Comments / Concerns regarding developmental milestones:

MEDICAL INFORMATION

During pregnancy, did mother experience any unusual illnesses, conditions, or accidents? Yes No If yes, please describe:

Length of pregnancy _____ Complications during delivery? Yes No
If yes, please describe:

Birth Weight _____ lbs. _____ oz.

Did the baby have trouble breathing? Yes No
If yes, please describe:

Did the baby have feeding problems?

Was the baby on a respirator?

Did the baby have seizures?

Were there any other problems?

Check the illnesses the child has had, if any. Please indicate the child's age at the last occurrence, and whether or not the child was hospitalized:

Illness	Yes	No	Age	Hospitalization
Measles	___	___	___	___
Chicken Pox	___	___	___	___
Mumps	___	___	___	___
Strep Throat	___	___	___	___
Scarlet Fever	___	___	___	___
Tonsillitis	___	___	___	___
Ear Infections	___	___	___	___
Seizures	___	___	___	___
Meningitis	___	___	___	___

Were any of these illnesses followed by noticeable changes in the child's general behavior? Yes No

If yes, please describe :

Describe any surgeries the child has had: (Surgery Date, Hospital)

Does your child have allergies? Yes No

If yes, please list:

List medications that your child may take on a regular basis:

(Medication, Dosage, Reason taking)

Please list the names of your child's doctor(s) and their contact information:

Vision

Does your child have a vision problem? Yes No

If yes, please describe: _____

Date of most recent vision test: _____

Test results: _____

Place tested completed: _____

Hearing

Does your child have a hearing problem? Yes No

If yes, please describe: _____

Date of most recent hearing test: _____

Test results: _____

Place tested was completed: _____

Developmental Evaluation

Has your child been diagnosed with any developmental problems? Yes No

If yes, please describe:

Date of most recent developmental evaluation: _____

Evaluation results:

Place evaluation was completed: _____

Adaptive Equipment

Please indicate any adaptive equipment used by your child:

_____ Hearing aid _____ Splints _____ Wheelchair _____ Walker

_____ Glasses _____ Other (describe): _____

Therapy Services

List the therapy services (if any) your child has received:

Type of therapy: _____ Dates: _____

Therapist: _____ Location: _____

Your child's reaction to the therapy (positive and negative): _____

Type of therapy: _____ Dates: _____

Therapist: _____ Location: _____

Your child's reaction to the therapy (positive and negative): _____
