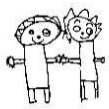
For Office Use Only
Date of Enrollment: _____ Date of Exit: _____



Trinity Children's Center
Enrollment Form

Child's Name: _____ Gender: _____

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

Attending: ▢ Full-Time (M-F, 8am-4:30pm) OR ▢ Part-Time (list days) _____(8am-4:30pm)

******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 the 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 the 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

Others Living in the Home:

Name:	Relationship:	DOB/Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____

Does your child have medical diagnosis or allergies? _____

▢ ** ***TCC OFFICE NEEDS A COPY OF CURRENT IMMUNIZATION PRIOR TO FIRST DAY OF ENROLLMENT (You can have this faxed directly to Trinity at 802-656-5015)***

▢ ***** 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, PRIOR TO FIRST DAY OF ENROLLMENT (You can have this faxed directly to Trinity at 802-656-5015)***

Child's Dentist:

Dentist's Name: _____

Dental Office Name: _____ Phone Number: _____

Date of Last Dental Exam: _____

Health Insurance Information:

Name of Policy Holder: _____

Name of Insurance Carrier: _____

Policy #: _____

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 name, contact number, relationship to child.

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

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

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

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

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: _____

Cell Phone #: _____ Home Phone #: _____

Work Phone #: _____ Place of Employment : _____

Emergency Contact #2:

Name: _____ Relationship to Child: _____

Cell Phone #: _____ Home Phone #: _____

Work Phone #: _____ Place of Employment : _____

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 Name Date

_____

Parent/Guardian Signature

Family Survey

Child's Name: _____

What does your child prefer to be called? _____

Languages spoken in the home: _____

1) **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?):**

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

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

4) **What is a typical day like for you (work, classes, etc…)?**

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

6) **What holidays/traditions do you celebrate as a family?**

7) **Is there anything in particular that feels tricky or challenging for you or your child right now?**

8) **What do you most enjoy doing with your child?**

9) **What are your goals for your child while attending TCC?**

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

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

12) **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…)?**

EATING/MEALTIMES

Is your child on any special diet? ▢ No ▢ Yes

If yes, please describe _____

_____

Does your child have any food allergies? ▢ No ▢ Yes

If yes, please describe:_____

_____

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

_____

Please share some of your child's favorite foods: _____

_____

SLEEPING

What time does your child typically go to bed in the evening: _____

What time does your child typically wake up in the morning: _____

Does your child nap? ▢ No ▢ Yes ▢ Sometimes

If No, when did your child stop napping?: _____

If Yes or Sometimes, please describe (i.e. nap schedule, what time of day, how long): _____

_____

Does your child sleep with a special blanket, toy, "stuffy", or pacifier? ▢ No ▢ Yes

If yes, please describe:_____

_____

TOILETING

Does your child wear a diaper or pull up? ▢ No ▢ Yes ▢ Sometimes

If sometimes, please describe when your child wears a diaper/pull and when they do not:

_____

Does your child use a potty/toilet? ▢ No ▢ Yes ▢ Sometimes

If Yes or Sometimes, how does our child let you know that they need to use the toilet? _____

_____

Any other information you would like to share about using toileting? _____

_____

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/Speech
▢ Social/Emotional ▢ Gross Motor/Movement ▢ Fine Motor
▢ Other

Please Describe:

_____

_____

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

If yes, please provide the name of their case manager and district: _____

Does your child see a medical specialist? ▢ No ▢ Yes

If yes, please provide the name of the specialist: _____

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

If yes or maybe, please check off all areas that you have questions or concerns about:

▢ Hearing ▢ Vision ▢ Language/Speech
▢ Social/Emotional ▢ Gross Motor/Movement ▢ Fine Motor
▢ Other

Please Describe:

_____

_____