Aubie Daubie Daycare, LLC
Child Intake Form

Date_____

Childs Information
Childs Name_____
Nickname (if applicable)_____
Date of birth_____

Parents/Primary Guardian/Family Information
Mother Name_____
Phone_____
Email_____
Address_____

Father Name_____
Phone_____
Email_____
Address_____

Other Primary Caregiver Name_____
Specify Role_____
Phone_____
Email_____
Address_____

Sibling(s) Names_____

Approved Pick up List (please give names, addresses, and phone numbers for alternative people allowed to pick up your child. They will be asked for ID upon pick up.)

1. _____

2. _____
3. _____
4. _____
5. _____
6. _____

Emergency Contacts

1. Mother

Name_____

Phone Number_____

2. Father

Name_____

Phone Number_____

3. 1st Emergency contact

Name_____

Phone Number_____

4. 2nd Emergency Contact

Name_____

Phone Number_____

Health Information

1. Doctors Name, Address, and Telephone Number

   _____

2. Does your child have any special health requirements?

   _____

3. Does your child have any known allergies (food, animals, plasters, medication, etc)? What does a reaction look like for these allergies?

   _____

   _____

4. Does your child have any special dietary requirements?

   _____

5. Please attach vaccination record to this document.

Other Information

1. Languages used at home: _____
2. Ethic origins: _____
3. Holidays celebrated at home: _____
4. Details of any other settings or childcare attended:

   _____

5. Details of any other agencies or professionals working with your child and their role:
   _____
   _____
6. Any other details or information it may be useful for us to know? *E.g. What your child likes, what their fears may be, any special words they use, what comforters they may need and when.*
   _____
   _____

Consent Information

Please initial the following statements allowing consent for these activities

___ Transportation via bus or van to parks, schools, and other outings within the Thorntown/Lebanon area
___Holding personal information (paper and computer based)
___Photography to be used for in house materials
___ Photography to be used for publicity material, including www.aubiedaubiedaycare.com (child's names will NOT be used on any website or in any publicity)
___ Administration of first aid and emergency medical treatment
___ Use of Childs own provided sun cream or a name brand supplied by Aubie Daubie Daycare

Parents signature_____

Please check the box on child's enrollment type:

- ❑ Part-Time Care
  - ❑ Monday
  - ❑ Tuesday
  - ❑ Wednesday
  - ❑ Thursday
  - ❑ Friday

  *please note that the days you sign up for, you will be required to pay regardless of attendance that day.

- ❑ Full-Time Care

- ❑ Before and After School Care

Discount applied (please talk to Aubrey Hunt, aubiedaubiedaycare@gmail.com for more information on valid discounts): _____
Supervisor signature_____

Please attach the following items to this form:

1. Birth Certificate

2. Vaccination Records
3. Physical signed by doctor (see attached forms)
4. Signed Parent Handbook including Discipline Form
5. Fees

   These can be submitted on your child's first week of care through Brightwheel Payments

   a. Enrollment Deposit (Brightwheel payments are accepted)
   b. Holding Fee (if applicable)
   c. Registration Fee ($35 if not enrolling in auto pay, Brightwheel payments are accepted) (this is waived for all current Fellowship Friends and Aubie Daubie Daycare families)

I have filled this form out completely and attached the required documents….

Mother
Printed Name_____
Signature_____

Father
Printed Name_____
Signature_____

Other legal guardian (if applicable)
Printed Name_____
Signature_____

Preschool Child Physical Exam Form

(All areas MUST be completed) Head Start will accept any documentation as long as it contains this information

Child's Name	Date of Birth:
Preschool Classroom site:	Gender: ☐ Male ☐ Female

Date of physical exam: _____

Height: _____inches Weight: _____lbs_____oz BMI: _____ Blood pressure: _____

Allergies? _____

Sensory Screening:

Vision: Right eye: _____ Left eye: _____

Hearing: Right ear: _____ Left ear: _____

Date/results of most recent hemoglobin: _____

Date/results of most recent lead test: _____

___ Not needed – low risk

Physical Exam:

	Normal for age?	Comments:
HEENT		
Teeth		
Heart		
Lungs		
Stomach/Abdomen		
Genitilia		
Skin		
Extremities, Joints, Muscles, Spine		
Neurological		
Posture, Gait, Coordination		

Abnormal findings/diagnosis:

- _____ Treatment Plan/Follow up: _____
- _____ Treatment Plan/Follow up: _____
- _____ Treatment Plan/Follow up: _____

☐ The child may participate in developmentally appropriate child care/preschool with NO health restrictions.

☐ The child may participate in developmentally appropriate child care/preschool with the following restrictions:

_____

Health Care Provider Name (please print): _____ Business Phone: _____

Address: _____

Health Care Provider Signature: _____ Date: _____

Return form to NICAO-Head Start, 1190 Briarstone Drive, Suite 1, Mason City IA 50401 or fax to 641-494-1894

Revised 11/14/14 Approved by HPC; Revised 1/7/15

HEALTH CARE PROGRAM FOR CHILD CARE
HEALTH RECORD - CHILD

State Form 49969 (R5 / 7-19)

FAMILY AND SOCIAL SERVICES ADMINISTRATION - MS02
402 W. Washington St., Room W362
Indianapolis, IN 46204

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)		
Child lives with (*relationship*)	Name	Telephone number ( )

MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date *(month, day, year)***		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION

Date of exam (*month, day, year*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			or Chicken Pox Disease	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEP A		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner / physician assistant completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner / physician assistant	

ADDITIONAL NOTES AND INSTRUCTIONS