

KinderArt

Inspiring Confident Enthusiastic Learners!

Infant and Toddler Application

Child's Name: _____ Birthdate: _____

Address: _____ Sex: _____

_____ Telephone: _____

Days Desired M T W Th F

Early Care? Y/N

Mother's Name: _____ Occupation: _____

Address & Alternative Phone #: _____

Email Address: _____

Father's Name: _____ Occupation: _____

Address & Alternative Phone #: _____

Email Address: _____

Marital Status of Parents: _____

Custody-Visiting Arrangements: _____

List Siblings and their Ages:

Other Members of the Household:

Is there anyone else who will be picking up your child? Yes No

If yes, names _____

Has your child ever been in childcare before? Yes No

What type? _____

Was it a positive experience? _____

How would you describe your child's temperament? (easy going, hard to please,
demanding, aggressive, etc.) _____

What are some of your child's favorite activities? _____

Are there any food restrictions? Yes No

If yes, please explain: _____

Does your child have any known allergies? Yes No

If so, please explain: _____

Are you concerned that your child may be prone to any type of allergies?

Yes No

If yes, please explain: _____

Does your child have any medical conditions which KinderArt should be made
aware of? Yes No

If yes, please explain: _____

Does your child have any diagnosed speech, hearing or visual problems?

Yes No

If yes, please explain: _____

Do you have any concerns about any aspect of your child's development?

Yes No

If yes, please explain: _____

Does your child have:

Frequent colds?	Yes	No
Earaches?	Yes	No
Stomachaches?	Yes	No
Sore Throats?	Yes	No
Fevers?	Yes	No
Constipation?	Yes	No
Convulsions?	Yes	No
Diarrhea?	Yes	No
Fainting Spells?	Yes	No
Skin Rash?	Yes	No
Stomach Upsets?	Yes	No
Urinary Problems?	Yes	No
Asthma?	Yes	No
Diabetes?	Yes	No
Heart Disease?	Yes	No
Hepatitis?	Yes	No

Are there any special medical, physical or emotional needs or restrictions that

KinderArt should be aware of? _____

Age your child began to: Sit _____ Crawl _____ Walk _____

Talk _____ Any difficulties with speech? Yes No

If yes, please explain: _____

Does your child eat with a spoon? _____ fork? _____ hands? _____
(check all that apply)

Are there any sibling? Please name them and specify ages and gender.

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Name _____ age _____ gender _____

Has your child had experience playing with other children? Yes No

If yes, where? _____

Have you read KinderArt's policies and procedures? Yes No

Do you have any specific concerns? Yes No

If yes, what? _____

How did you hear about KinderArt? _____

Pricing:

Sweet Peas		Ducklings/Little Lambs		Ducklings/Little Lambs	
Frequency	Weekly Fee	Half Day	Monthly	Full Day	Monthly
1 Day	\$60.00				
2 Days	\$120.00	T, Th	\$284.50	T, Th	\$375.90
3 Days	\$180.00	M, W, F	\$421.50	M, W, F	\$558.30
4 Days	\$240.00	M-F	\$688.60	M-F	\$923.10

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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Infant/Toddler Deposit Record

Child's Name: _____ Date of Birth: _____

Address: _____

Mother's Name: _____ Father's Name: _____

(H) _____ (H) _____

(W) _____ (W) _____

(OTHER) _____ (OTHER) _____

- Application
- Immunization Form
- Emergency Information Sheet
- Copy of Birth Certificate

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(for office use only)

Class: _____

Days Enrolled: M T W Th F Half Full

Deposit Amount: _____

Date: _____

Check Number: _____

Balance: _____

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Child's Name: _____ Date of Birth: _____

Person to be notified in case of emergency:

Mother: _____ Home: _____
Work: _____ Other: _____
Father: _____ Home: _____
Work: _____ Other: _____

Name: _____ Relationship: _____
Telephone: _____ Other: _____
Name: _____ Relationship: _____
Telephone: _____ Other: _____

Persons authorized to pick up your child:

Mother: _____ Father: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I authorize KinderArt to seek medical attention for my child, _____

Special Considerations: _____
Allergies: _____
Physician: _____ Telephone: _____
Address: _____
Emergency Hospital Preference: _____

Date: _____ Parent Signature: _____

School Name & Address:



Health Care Provider Name and Address:

**STATE OF RHODE ISLAND
SCHOOL PHYSICAL FORM**

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State	Zip Code
			Home Phone	

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS					
Please enter dates in MM/DD/YYYY format					
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella	<input type="checkbox"/> Student has history of varicella disease				
Tetanus-Diphtheria-Pertussis TdaP/Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption: Medical Religious

Hep B DTaP PCV Polio Hib MMR Varicella Td/Tdap Rotavirus Hep A Mening HPV

PHYSICAL EXAMINATION

Date of PE ____/____/____ Height _____ Weight _____ BP _____

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No Yes DIABETES: No Yes OTHER: _____

Significant Systems Findings: _____

ALLERGIES: No Yes (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No Yes

Treatment Plan: _____

MEDICATION (REQUIRED AT SCHOOL): No Yes (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

RESTRICTIONS: Can participate in physical education: Fully With limitation _____

Can participate in sports: Fully With limitation _____

LEAD SCREENING (Required for children < 6 years of age only)
Student is in compliance with lead screening requirements:
Yes No

SCOLIOSIS SCREENING
Yes No

VISION SCREENING (Children entering Kindergarten)
 Passed screening
 Screened and referred for comprehensive exam
 Referred for comprehensive exam, but not screened
Screening Date: _____ Comprehensive Exam Date: _____

TUBERCULOSIS (If required by school district)
Date of TB test: _____

HEALTH CARE PROVIDER SIGNATURE: _____

DATE: _____

PRINT NAME: _____