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DROP-IN CARE PROGRAM REGISTRATION FORM

This form is to be completed ONLY by families NOT native to THIS BB Drop-In Care Location

***** When bringing your child, please make sure to bring a FULLY PACKED BAG with all NEEDED supplies – please make sure to label ALL items. Items such as, but not limited to: diapers, wipes, meals, snacks, changes of clothes, soothing and attachment items, etc. If your Drop-In Care Location is different from your regularly attended BungalowBranch location, the providers/teachers at your Drop-In Care Location cannot administer any prescription and non-prescription medications. Please schedule to administer medications before and after your child's stay with us. *****

***** Please arrive at least 15 minutes early to your Drop-In Care Location to complete the following paperwork if you don't complete before hand. Thank you and we hope our Drop-In Care Program offers quality and convenience to you and your family. *****

Today's Date: _____

Child's Name: _____ **D.O.B.:** _____ ☐ **M** ☐ **F**

BB Location Hosting Drop-In Care Program: _____ Branch

Please briefly explain your reasoning for using our Drop-In Care Program: _____

_____

Mother or Guardian #1 Information ☐ **Primary Contact Person**

Name: _____ Phone: _____
Address:
_____
(Street) *(City)* *(State)* *(Zip)*

Employer: _____ Work Phone: _____ Work Email: _____

Cell / Other Phone: _____ Personal Email: _____

Father's or Guardian #2 Information ☐ **Primary Contact Person**

Name: _____ Phone: _____
Address:
_____
(Street) *(City)* *(State)* *(Zip)*

Employer: _____ Work Phone: _____ Work Email: _____

Cell / Other Phone: _____ Personal Email: _____

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Emergency Contact #1

Relationship: _____

Name: _____ Phone: _____
Address:
_____
(Street) *(City)* *(State)* *(Zip)*

Employer: _____ Work Phone: _____ Work Email: _____

Cell / Other Phone: _____ Personal Email: _____

Emergency Contact #2

Relationship: _____

Name: _____ Phone: _____
Address:
_____
(Street) *(City)* *(State)* *(Zip)*

Employer: _____ Work Phone: _____ Work Email: _____

Cell / Other Phone: _____ Personal Email: _____

Other
Relationship: _____

Name: _____ Phone: _____
Address:
_____
(Street) *(City)* *(State)* *(Zip)*

Employer: _____ Work Phone: _____ Work Email: _____

Cell / Other Phone: _____ Personal Email: _____

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BASIC NEEDS INFORMATION

*****FOOD*****

Is your child bottle-fed? □ Yes □ No

Is your child breast-fed? □ Yes □ No

- *If Yes:*

  Did you bring a supply of breast milk? □ Yes □ No

Do you supplement with formula? □ Yes □ No

- *If Yes:*

  Did you bring formula? □ Yes □ No

If bottle-fed, what is your child's bottle feeding schedule?

TYPE	AMOUNT	TIMES
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____
• _____	• _____	• _____

What position does your child like to be in while bottle-feeding? _____

_____

What position does your child like to be in while being burped? _____

_____

Has your child been introduced to solid food yet? □ Yes □ No

- *If Yes*, what type? □ baby food □ table food
- *If Yes*, did you bring the food your child eats? □ Yes □ No
- *If Yes*, what is your child's feeding schedule?

SOLIDS	TYPE	CONSISTENCY	AMOUNT	TIMES
• _____	• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____	• _____
• _____	• _____	• _____	• _____	• _____

Does your child have any food sensitivities? □ Yes □ No

- *If Yes*, please identify: _____

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******SLEEP******

Describe your child's sleep routine (include naps & lengths of naps):

_____

_____

Does your child usually cry when going to sleep? □ Yes □ No

- *If Yes*, for how long? _____

Where does your child normally sleep? _____

What position does your child sleep in? _____

If your child sleeps on his/her stomach, and is **12 months or under, YOU MUST PROVIDE A WRITTEN STATEMENT BY YOUR PEDIATRIAN STATING YOUR CHILD CAN SLEEP ON HIS/HER STOMACH.**

******SOCIAL/EMOTIONAL DEVELOPMENT******

Does your child have any physical, mental, developmental disabilities? If so, please explain:

_____

Describe your child's temperament: (i.e. colic, likes to cuddle)

_____

_____

What signs does your child give of being hungry, tired or over-stimulated? (i.e. pulls at ears, rubs eyes)

_____

Does your child separate easily from you? □ Yes □ No

Comments: _____

Is your child afraid of anything? □ Yes □ No

Comments: _____

Circle the personality traits which describe your child:

Shy	**Independent**	**Outgoing**	**Talkative**
Friendly	**Assertive**	**Happy**	**Dependent**
Impulsive	**Quiet**	**Stubborn**	**Attentive**
Emotional	**Other:**		

Does your child have a favorite toy, blanket or soother? □ Yes □ No

Please identify: _____

Did you bring this today? □ Yes □ No

Does your child enjoy spending time with other children? □ Yes □ No

Comments: _____

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What activities does your child enjoy? _____

_____

How do you discipline your child? _____

_____

Are there any age-appropriate activities that you restrict your child from participating in? _____

_____

Please provide any other information relating to your child that would be helpful in understanding and caring for your child:

_____

_____

******DIAPERING******

Is your child in diapers? □ Yes □ No

Comments: _____

What size diapers does your child use? _____

Did you bring diapers? □ Yes □ No ******POTTY TRAINING******

Is your child potty trained? □ Yes □ No

Comments: _____

- *If yes*, does your child require assistance with using the potty? □ Yes □ No

Comments: _____

******MEDICAL INFO******

Doctor's Name: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Is your child up to date on shots? ☐ **YES** ☐ **NO** Date of last checkup: _____

In the event that I cannot be reached to make arrangements for emergency medical or dental care for my child, I **GRANT** permission for: **THIS INDEPENDENT BUNGALOWBRANCH LOCATION** to take my child to the nearest hospital, medical, or dental facility for treatment for any accident or illness as deemed necessary by the provider. I accept full liability for all treatment and ambulance expenses.

PLEASE INITIAL: _____

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******CHILD PICK-UP AUTHORIZATION******

The following individuals have my permission to pickup my child from **THIS INDEPENDENT BUNGALOWBRANCH LOCATION.** ***Authorized members, whom my child care provider does not know or remember, must provide ID. DO NOT FORGET TO INCLUDE PARENT/GUARDIANS' NAMES – WE WILL NOT ASSUME THE ABOVE LISTED PARENT/GUARDIANS AND/OR EMERGENCY CONTACTS HAVE AUTHORIZATIONS.***

Name: _____ Relationship: _____

Address: _____

Phone: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____

Special Remarks or Concerns: _____

Signature(s):

Parent / Guardian Signature Printed Name

Relationship Date

BB Staff *Printed Name* ***Signature*** ***Date***