



Rhode Island Department of Human Services

Licensed Child Care: Child Information Form

Child Information			
Child's Full Name:			
Date of Birth (MM/DD/YYYY):		Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Language:			
Secondary Language:			
Primary Address			
Number and Street:			
City/Town:		State:	Zip:
School Information (<i>School age, developmental preschool, early intervention, services, etc.</i>)			
School/Program Name:	Montessori Centre of Barrington	Phone:	(401) 245 - 4754
Number and Street:	303 Sowams Road		
City/Town:	Barrington	State:	RI
		Zip:	02806

Parent/Guardian 1 Information			
Parent/Guardian Full Name:			
Parent/Guardian Role:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Mother <input type="checkbox"/> Step Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____		
Contact Information			
Primary Phone:	() -	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home	
Secondary Phone:	() -	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home	
Email:			
Home Address			<input type="checkbox"/> Same as Child
Number and Street:			
City/Town:		State:	Zip:
Employer Information			
Employer Name:			
Address:			
City/Town:		State:	Zip:
Typical Schedule			

Child Information Form

Child's Name: _____

Parent/Guardian 1 Information							
Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours:							

Parent/Guardian 2 Information							
Parent/Guardian Full Name: _____							
Parent/Guardian Role:		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step Mother <input type="checkbox"/> Step Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____					
Contact Information							
Primary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home				
Secondary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home				
Email: _____							
Home Address							<input type="checkbox"/> Same as Child
Number and Street: _____							
City/Town: _____			State: _____		Zip: _____		
Employer Information							
Employer Name: _____							
Address: _____							
City/Town: _____			State: _____		Zip: _____		
Typical Schedule							
Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours:							

Additional Members of Child's Household	
Full Name: _____	Relationship: _____
Full Name: _____	Relationship: _____
Full Name: _____	Relationship: _____
Full Name: _____	Relationship: _____
Full Name: _____	Relationship: _____

Child Information Form

Child's Name: _____

Additional Child Information			
<i>It is recommended that this form is copied and provided to the child's direct teacher/provider.</i>			
Social-Emotional			
Child's Habits:			
Child's Fears:			
Favorite Toys/ Activities:			
Child's Interests:			
How do you comfort your child?			
How do you guide your child's behavior?			
Bathroom Habits			
Is your child potty trained?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Almost/Starting	Does your child tell you when they have to use the bathroom? If so, how?	
Is your child prone to diaper rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What do you use to treat diaper rash?	<input type="checkbox"/> Lotion <input type="checkbox"/> Oil <input type="checkbox"/> Powder <input type="checkbox"/> Other:
Sleeping Habits			
Is your child sleep in a crib?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typical nap/time and/or nap habits:	
Health			
Special physical conditions and/or disabilities:	<input type="checkbox"/> Yes: If yes, please explain: <input type="checkbox"/> No		
Regular medications:	<input type="checkbox"/> Yes: If yes, please explain: <input type="checkbox"/> No		
Allergies:	<input type="checkbox"/> Yes* - If yes, please complete the Allergy Information Sheet <input type="checkbox"/> No		

Child Information Form

Child's Name: _____

Child Care Schedule							
Day:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Arrive:	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
Depart:	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM

Parental Access Restrictions

If there are temporary or permanent restrictions on a person's access to their child, please read and complete this section thoroughly. Please note: If the restricted person(s) are a child's biological parent(s), in order to abide by the permissions stated below, programs MUST have received a copy of any/all court documentations regarding restraining orders, physical/legal custody, joint custody, etc. Without court documentation, programs/providers are unable to withhold a child from their biological parent.

Restricted Person's Name:							Relation to Child:	
The above stated person has permission to see the child on the following days:								
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		

Restricted Person's Name:							Relation to Child:	
The above stated person has permission to see the child on the following days:								
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		

Restricted Person's Name:							Relation to Child:	
The above stated person has permission to see the child on the following days:								
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		

Acknowledgment

By signing this form, I acknowledge that the information contained in this document is true and accurate. I understand that it is my responsibility to update the program/provider in the event of any changes or updates to the information in this form.

 Parent/Guardian Name (Print)

 Relation to Child

 Parent/Guardian Signature

 Date