Tennessee Department of Human Services

Child's Application

Full Name of Child	Date of Admission	Child's DOB	Name Child Goes By
	/ /	/ /	

Is the child related to the primary caregiver?	Yes ☐ No ☐	Relationship:	
Child's School Name (if applicable)	Address N/A		Phone - -

Are the child's immunization records housed at the above school?		Yes ☒ No ☐
If no, list the school where they are housed (Name)	Address	Phone - -

Name of Agency: Munford Methodist Preschool				
57 S Tipton St.	Munford	TN	38058	901-837-9130
Street Address	City	State	ZIP	Phone

Parents/Custodial Parents:

Mother's Name:					
Street Address (Home)		City		State	ZIP
Home Phone	Cell Phone	Employment:			
Work Street Address	City	State	ZIP	Work Phone - -	Work Hours

Father's Name:					
Street Address (Home)		City		State	ZIP
Home Phone	Cell Phone	Employment:			
Work Street Address	City	State	ZIP	Work Phone - -	Work Hours

Transportation Plan:

Please list any other adults to whom your child may be released or are authorized to provide transportation for your child:

Will the child be transported by the agency? ☐ No ☐ Yes If yes, check all that apply: ☐ to school ☐ from school ☐ to home ☐ from home ☐ field trips only - with prior written permission for each off-site activity

Emergency Contact Information:

1. Name of person, other than the child care provider, authorized to act for parent in an emergency:				
				- -
Home Address	City	State	ZIP	Phone
Place & Street Address of Employment/School	City	State	ZIP	
	- -	- -		
Work Hours	Work Phone	Alternate Phone (Cell, Home, Etc.)		

2. Name of person, other than the child care provider, authorized to act for parent in an emergency:				
				- -
Home Address	City	State	ZIP	Phone
Place & Street Address of Employment/School	City	State	ZIP	
	- -	- -		
Work Hours	Work Phone	Alternate Phone (Cell, Home, Etc.)		

3. Name of person, other than the child care provider, authorized to act for parent in an emergency:				
				- -
Home Address	City	State	ZIP	Phone
Place & Street Address of Employment/School	City	State	ZIP	
	- -	- -		
Work Hours	Work Phone	Alternate Phone (Cell, Home, Etc.)		

Physician Contact Information

	- -		
Name of Physician	Phone Number		
Street Address	City	State	ZIP

Background Information:

Other Children in the Family	Date of Birth	School
	/ /	
	/ /	
	/ /	
	/ /	

Experiences with Others:

What are some of the ways the child plays at home?
Does he/she play with children from other families? ☐ Yes ☐ No How?
Does he/she react when he/she does not get his/her own way? ☐ Yes ☐ No

Is the entire family together for any time during the day? ☐ Yes ☐ No

Eating Habits:

At what time does the child eat:	Breakfast:	Lunch:	Dinner:

Between Meal Snacks:	Does the Child feed his/herself? ☐ Yes ☐ No
What is the child's general attitude toward eating?	
If the child refuses to eat, how is this handled and by whom?	
Food Favorites:	
Food Dislikes:	
Food Allergies:	

If the child is an infant, use a separate sheet for information about the formula, bottle schedule, etc.

Sleep Habits:

Has own room: ☐ Yes ☐ No	Shares Room With ☐ Other Children ☐ Parents
At night sleeps from: to	Average Hours of sleep per night:
Naps from: to	Average Hours of naps:
Attitude toward going to bed:	
If there is difficulty, how is this handled?	
Habits associated with going to bed?	

Is bed wetting an issue? ☐ Yes ☐ No	At nap time:	At night:
If yes, how is the situation handled?		

Toilet Habits:

Time at which child is taken to the bathroom?
Can the child take themselves? ☐ Yes ☐ No Time of bowel movement? Regular?
Constipated? ☐ Yes ☐ No
Does the child tell you when he/she needs to go and does he/she go willingly? ☐ Yes ☐ No
Can he/she manage his/her clothes at the toilet? ☐ Yes ☐ No
What words does he/she use for: Urinating: Bowel Movement:

Speech and Physical Growth:

The child talks: ☐ Well ☐ Fairly Well ☐ Not Very Well ☐ Not at All
Does anyone read to the child? ☐ Yes ☐ No How regularly? At what age did the child creep?
Crawl? ☐ Yes ☐ No Walk? ☐ Yes ☐ No
Which of the following words would you use to describe the child (check all that apply): ☐ active ☐ quiet ☐ thin ☐ average weight ☐ heavy ☐ tall ☐ average height ☐ short ☐ friendly ☐ unfriendly
Is there any other information you think we should have about the child?

Ongoing Medical Care:

Does the child have any medical diagnosis that requires ongoing care? ☐ Yes ☐ No
If yes, explain what type of care is administered at home and by whom?
Are you requesting that this care be provided at the facility? ☐ Yes ☐ No If yes, describe the care required:

(Request a doctor's statement for any specified requests for care at the facility).

Parent Declarations:

I received a summary of the licensing requirements. ☐
I do hereby authorize emergency medical care for my child (a limited power of attorney may be required for military dependents). ☐
I visited the facility prior to enrolling my child. ☐ Pre-enrollment Visit Date: / /
I received a copy of the child care facility's policy statement or handbook, and payment contract, and I have signed their copy, verifying by receipt my understanding and agreement of their content. ☐
I authorize the agency to transport my child as specified in the transportation plan section (see page 1). ☐

Signature of Parent(s)/Guardian(s) _____ Date _____

Date of Child's Withdrawal	/ /	Reason for Withdrawal	

This form/information shall be maintained for one year after date of disenrollment.
Information on this form shall be updated annually or as needed to ensure the protection of the child.

Date of last update with parent's initials:

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	/ /		/ /