Little Sprouts Child Information Form

Child's Name: _____ Application Date: _____/_____/_____

Primary Language:_____ Date of Birth: _____/_____/_____

Child's Address:_____
Street City/Town Zip Code

Hours Child Will Attend Center

		Hours		Hours
Monday	Full Day	to	Half Day	to
Tuesday	Full Day	to	Half Day	to
Wednesday	Full Day	to	Half Day	to
Thursday	Full Day	to	Half Day	to
Friday	Full Day	to	Half Day	to

Family Information

Parental Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Custodial & Legal Guardian is: ☐ Both Mother & Father ☐ Mother ☐ Father ☐ Other_____

Child Resides With: ☐ Both Mother & Father ☐ Mother ☐ Father ☐ Other_____

Current Living Arrangement: (Check One)

☐ Family Home ☐ Foster Home ☐ Adoptive Home ☐ Extended Family Home

Parent/Guardian Information

Name:_____ Name:_____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Email Address: _____ Email Address:_____

Cell Phone: _____ Cell Phone: _____

Parent/Guardian Business Information

Company Name: _____ Company Name: _____

Occupation: _____ Occupation: _____

Address: _____ Address: _____

_____ _____

Business Phone: _____ Business Phone: _____

Medical Information

Eye Color:_____ Hair Color:_____ Height:_____ Weight:_____ Race:_____ Gender: M / F

Identified Allergies:_____

Identifying Marks: _____

Child's Insurance Information:

Child's Health Insurance Provider: _____

Name of Insured: _____

Policy Number: _____

Physician/Dentist Information:

Name of Physician/Clinic: _____ Phone: _____

Physician Address: _____
Street City/Town Zip Code

Name of Dentist/Clinic: _____ Phone: _____

Dentist Address: _____
Street City/Town Zip Code

Nebraska State Department of Health and Human Services requires that every child's immunization history be on file (**a current record must be on file at all times).** This record must be provided **prior to the first day of care**. Please attach a copy of your child's up-to-date immunization history. A written statement must be provided in the event you choose not to immunize your child and reasons for your decision.

☐ Immunization Records Attached ☐ Verified by Director

Parent/Guardian Signature: _____Date: _____/_____/_____

FOR CENTER USE: Date of Admission: _____ Age of Admission: _____

Date Enrollment Fee Rec'd: _____ Director's Initials:_____