

1-DAY IMMUNIZATION FORM

Dear Parent or Guardian:

In order to provide a healthy and safe environment for the children in the 1-Day program, please indicate below the dates of your child's immunizations.

Child's Name _____

Polio _____

DPT/Td _____

MMR

HIB Meningitis

Hepatitis B _____

Varicella (Required at 15 months by licensing as of July 1, 2019) _____

(parent's signature) (date)

CHILD INFORMATION SHEET

Please complete this form in detail and bring it with you to your **first day of class during EASE-IN week, which is Monday, August 26th from 12:30-2:30**. The more information you can give us, the more help it is to our teachers.

Child's Name _____ Birth Date _____

Name by which child is called _____ Birth Place _____

Parents' Name _____ Phone _____

Address _____

Occupation of parents _____

Names and ages of other children in family

Other adults in the house besides parents (give relationship of child to each)

Does your child have the opportunity to play with other children outside the family?

Favorite play materials _____

Favorite pastimes _____

Types of family outings your child enjoys _____

Family pets (kinds and names) _____

Special problems: Fears _____

Foods _____

Health _____

Allergy to Food or Materials _____

Previous Serious Injuries or Illnesses _____

Any other information that will help the teacher better understand your child (please use reverse side)

Date _____ Parent's Signature _____