Hugs Child Development Center
4812 Franklin
Boise, ID 83705
363-9111

Start Date: _____

Pin #_____

Child Information Record

Child's Full Name: _____ Birthday: _____
Child's Full Name: _____ Birthday: _____
Child's Full Name: _____ Birthday: _____
Child's Full Name: _____ Birthday: _____

Mother/Guardian: _____ Social Security #: _____
Address: _____ Home Phone: _____
City_____ State_____ Zip_____
Employer: _____ Work Phone: _____

Cell Phone/Pager: _____ Email:_____

Father/Guardian: _____ Social Security #: _____
Address: _____ Home Phone: _____
Employer: _____ Work Phone: _____

Cell Phone/Pager: _____ Email:_____

Please list all children in order of birth living in household:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Is anyone legally restricted from contact with child? If so please list and attach court documentation: _____

Please list 2 people we may contact in case of emergency in the event you are unavailable:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

How did you hear about us? _____

Documents Needed to start:

- Drivers License
- Immunization Records
- Medical Insurance Card

Medical History

Has your child had any serious illnesses, operations, or accidents?

Name:_____ Date:_____

Incident:_____

Name:_____ Date:_____

Incident:_____

_____

Has your child had or currently have any of the following?

	Child's Name	Date	Comments
Diabetes			
Urinary Problems			
Bowel Problems			
Chicken Pox			
Measles			
Mumps			
Whooping Cough			
Epilepsy			
Asthma			
Emotional Problems			
Chronic Ear Infections			
Other			

Does your child have any allergies?

Child's Name	Allergic To	Reaction	What Hugs is to do
.			
.			
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.			
.			
.			
.			

Medical Information and Release

Child's Doctor: _____ Phone: _____

Doctor's address: _____

Hospital Preference: St. Alphonsus St. Lukes(Boise)

Insurance Co.: _____ Policy #: _____

Name of Insured: _____ Insured SSN: _____

I, _____ verify that the medical information listed is complete and accurate. I authorize Hug's Child Development Center to secure emergency medical and/or surgical treatment for my child. I understand all efforts will be made to notify me or the emergency contacts in case of emergency.

Parent Signature: _____ Date: _____

Information about my child

What is the primary language used in the home? _____

Secondary language? _____

List your child's favorite toys and/or activities:

Indoor	Outdoor
_____	_____
_____	_____
_____	_____

List your child's favorite and least favorite foods:

Likes	Dislikes
_____	_____
_____	_____
_____	_____

Please list any fears your child has: _____
_____

Is your child potty trained? Yes No

What word does your child use:
For urine: _____ For bowel movements: _____
Has your child been in child care before? Yes No

Reason for leaving: _____
_____

Has either parent been divorced? _____

Is either parent deceased? _____

Is there a custody arrangement? _____

Is there any changes in your child's life recently that has affected his/her behavior?_____
_____

Attendance and Tuition

Days of Care needed	Monday	Tuesday	Wednesday	Thursday	Friday
Time of Care needed					

Tuition per Week:
Child: _____ Tuition: $_____
Child: _____ Tuition: $_____
Child: _____ Tuition: $_____
Child: _____ Tuition: $_____

Total Tuition Due $_____

Family receives Assistance? Yes No

Tuition will be due in full by 6:00 on Friday prior to week of service. If payment is not received in full by that date a penalty of $5.00 will be charged each additional day it is late up to three days. If payment is not received by the fourth day (Wednesday), services will be suspended. To regain your child's enrollment at Hugs Child Development Center, the full amount owed including late fees plus a $20.00 reinstatement fee must be paid prior to their return, provided space available.

Release Form

The following people are authorized to pick up: _____ (Child's Name)

1. Name: _____ Parent Signature: _____

2. Name: _____ Parent Signature: _____

3. Name: _____ Parent Signature: _____

4. Name: _____ Parent Signature: _____

Contract for Care

I have been given a copy of the Hugs Child Development Center Parent Handbook. I have read the Handbook and am aware and agree to the terms and conditions of enrollment. I understand I am responsible for updating this information record as necessary. IE: Phone numbers, emergency contacts, persons authorized to pick up my child(ren), etc. I have given Hugs Child Development Center copies of my child's immunization record, a copy of insurance/medical card, and a copy of any divorce decree and or custody arrangement.

Parent Signature: _____ Date: _____

Statement of Responsibility: I further understand and agree that in operating this child care facility and caring for my child(ren), Hugs Child Development Center, LLC shall be responsible for acting in a reasonable manner and in compliance with the legal requirements of the State of Idaho ("Standard of Care"). However, I also understand that Hugs Child Development Center is not a guarantor of my child's safety and that the risk of accidents or injury to my child cannot be completely eliminated even when Hugs Child Development Center has satisfied the Standard of Care. I accept this risk and agree that Hugs Child Development Center will only be liable for accident or injury to my child that results from their failure to meet the Standard of Care, and that I will not sue and will indemnify Hugs Child Development Center against a liability for accident or injury to my child occurring under all other circumstances.

Agreed to: _____ by _____
Date Parent/Guardian Signature

Parent/Guardian's Name: (print) _____

FOR THE TEACHER

CHILD'S FULL NAME_____

NAME CHILD GOES BY_____

HAS YOUR CHILD BEEN IN CHILD CARE BEFORE? Y N

IF YES WHERE?_____

WHAT I NEED MY TEACHER TO KNOW ABOUT ME

I AM _____ YEARS OLD.

MY BIRTHDAY IS_____.

MY ADDRESS IS_____.

MY PHONE NUMBER IS_____.

MOM AND DAD'S NAME'S ARE_____ _____.

I HAVE_____BROTHER'S & _____ SISTERS.

MY FAVORITE COLOR IS_____.

THE THING THAT I AM AFRAID OF THE MOST IS _____.

I HAVE _____PETS, THEY ARE THIS KIND OF ANIMAL AND THEIR NAMES ARE,_____
_____

_____ _____

I AM ALLERGIC TO _____

I HAVE THE FOLLOWING SPECIAL HEALTH
PROBLEMS_____