



Dream Makers Enrollment Packet

QUICK REFERENCE

Child's Full Name _____ DOB _____

Home Address _____ Parent 1 Name _____

_____ Parent 2 Name _____

Parent 1 Email _____ Parent 1 Cell _____

Parent 2 Email _____ Parent 2 Cell _____

IN CASE OF EMERGENCY

Name Phone Email

CALL FIRST _____

CALL SECOND _____

CALL THIRD _____

EMERGENCY CONTACTS

Please contact the following individuals if child's parents/guardians cannot be reached:

Name Address Phone Email

ALLERGIES: _____

Signature:

Date:

I authorize Dream Maker's Staff to make an emergency medical decision to seek help for my child. YES NO

My child may be transported by ambulance or vehicle to the following nearby hospital:

or to the following nearby urgent care facility (name/address):

CHILD'S INFORMATION

Child's Full Name _____ Nickname _____

Preferred Pronouns _____ M/F/Non-binary _____

Home Address _____ DOB _____

Language(s) Spoken at Home _____

PARENT/GUARDIAN 1

Name _____ Cell _____

Home Address _____ DOB _____

_____ Occupation _____

Employer & Address _____

Work Hours _____ Work Phone _____

BEST WAY TO REACH YOU: _____

PARENT/GUARDIAN 2

Name _____ Cell _____

Home Address _____ DOB _____

_____ Occupation _____

Employer & Address _____

Work Hours _____ Work Phone _____

BEST WAY TO REACH YOU: _____

Signature:

Date:

OTHER CHILDREN IN HOUSEHOLD

Child Name _____ Age _____

DOB _____ M/F/Non-binary _____

Child Name _____ Age _____

DOB _____ M/F/Non-binary _____

PLAY AND SOCIAL EXPERIENCE

Has your child participated in any group experiences? Please describe.

Where? _____ # of Children: _____

Was it enjoyable for your child? _____

Does your child prefer to play alone? _____

Is there anything your child is afraid of? _____

What are your child's favorite songs? _____

CHILD'S TEMPERAMENT

Describe your child's temperament: _____

How do you handle conflict between you and your child? _____

CHILD'S EATING HABITS

What foods does your child like? _____

What foods does your child dislike? _____

Is your child on a special diet? _____

Any foods your child does not eat for personal or religious reasons: _____

Signature:

Date:

MEDICAL/PHYSICIAN/INSURANCE

Child's Physician Name _____ Physician Phone _____

Physician Address _____

Hospital Preference, Address, and Phone _____

Medical Insurance Provider _____ ID # _____

Child's Dentist _____ Dentist Phone _____

Dentist Address _____

Dental Insurance _____ ID # _____

Chronic Medical Conditions _____

DEVELOPMENT IN EARLY CHILDHOOD

What age did your child walk? _____

What age did your child talk? _____

Is your child adopted? _____

If yes, is your child aware of their adoption status? _____

Is your child potty trained? _____

Child's terminology: _____

Describe any special toileting needs or health problems related to toileting:

Does your child need help/reminding about using the toilet? _____

Does your child nap? _____ At what time? _____

Signature:

Date:

PERMISSIONS

While your child is enrolled at Dream Makers, they will be involved in a number of special activities for which we need your permission. Please read the following information carefully. You are encouraged to ask questions about anything that is unclear to you. You have the option of withdrawing permission at any time.

I DO I DO NOT give permission for my child to go on walks with the teacher and class in the nearby neighborhood.

From time to time, photographs of children at Dream Makers will be taken for educational purposes and publicity. These pictures will be representative of the enriching experiences offered to your child.

I DO I DO NOT give permission for my child to be photographed for this purpose.

On a continuing basis, photographs will be taken of your child at play at Dream Makers. These photographs will be displayed IN OUR SCHOOL ONLY.

I DO I DO NOT give permission for my child to be photographed for this purpose.

We at Dream Makers ask that you apply sunscreen to your child at least 30 minutes before arriving at school each day. We will assist with applying sunscreen to bare surfaces including the face, tops of ears, and bare shoulders, arms, legs, and feet, 15-30 minutes before outdoor activities, should the need arise. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be promptly reported to the parent/guardian.

In the event that my child's sunscreen is not readily available, my child may use the sunscreen provided by the school. (Kids Rocky Mountain Sunscreen SPF 50 Fragrance-Free sunscreen provided by the school.)

I do not want my child to use any sunscreen other than the one they bring. (Label with child's name, give to teacher to keep at school.)

I do not want my child using any sunscreen and will send sun protective clothing.

None of the above. I will provide a doctor's note stating that sun protection is not required.

Signature:

Date:

ENROLLMENT DETAILS

How did you hear about Dream Makers? _____

Please circle the days/times you would like your child to attend Fall-Spring program:

Monday	Tuesday	Wednesday	Thursday	Friday
9:00am-1:00pm	9:00am - 1:00pm	9:00am-1:00pm	9:00am-1:00pm	9:00am-1:00pm
	1:00pm - 3:15pm	1:00pm -3:15pm	1:00pm - 3:15pm	

TRANSPORTATION DETAILS

I authorize the following people to pick up my child from school:

Name	Address	Phone
_____	_____	_____
_____	_____	_____

If someone other than myself or those listed will be picking my child up from school, I will send a note or phone Dream Makers.

Signature: _____ Date: _____

I have read and agree to all the policies of the Dream Makers Parent Handbook.

Signature: _____ Date: _____

Please attach proof of a medical examination your child has had within the past year, and an up to date immunization record.

Signature:

Date: