

**2024-2025 School Year  
Enrollment Form  
Early Education Center**



Today's Date: \_\_\_\_\_ Year \_\_\_\_\_ Child's Date of Birth \_\_\_\_\_

**Part 1**  
All information in part 1 of this form will be considered confidential and used only by the center for purposes required by licensing.

NAME OF CHILD: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Enrollment: \_\_\_\_\_ Sex:  Male  Female  Non-Binary

**GENERAL INFORMATION**

Home Address \_\_\_\_\_  
street city state zip

Home Phone \_\_\_\_\_

E-mail \_\_\_\_\_  
\*Please list all email addresses you would like on the listserve

PARENT'S/GUARDIAN'S NAME: \_\_\_\_\_ Social Security # \_\_\_\_\_ Dragon ID # \_\_\_\_\_

Occupation \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

PARENT'S/GUARDIAN'S NAME: \_\_\_\_\_ Social Security # \_\_\_\_\_ Dragon ID # \_\_\_\_\_

Occupation \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

The State of Minnesota requires that you list **two** people who will assume contact in an emergency and are authorized to take child from care if you cannot be reached:

1. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
(put actual address please)

2. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
(put actual address please)

Your child will be released only to your care unless we are given authorization to release her/him to someone else. List anyone else to whom you may be giving this authorization. For security, we need to have a photo of that person for our files.

1. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

(If we don't have a photo, written permission and photo I.D. must accompany the person on the day they pick up your child. In addition, please give your child's teacher a call if possible.)

**NOTE**

All children must have a physical exam and a record of current immunizations signed by a physician before they can be admitted to this program. These Health Forms must be completed again when the child becomes three years old and also when they enter Kindergarten.

## Part 2

### FAMILY DATA

Type of family unit:  two parent family  single parent family  guardian  foster care

Is your child adopted?  Yes  No If yes, at what age? \_\_\_\_\_ Has s/he been told?  Yes  No

Names and ages of others in the home: (Including siblings, relatives, others)

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Is any language other than English spoken in the home?  Yes  No If yes, please list \_\_\_\_\_

Does your child enjoy any special stories or music from your family's culture? \_\_\_\_\_

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Does your family celebrate holiday/birthdays? \_\_\_\_\_

List any holidays your family celebrates: Please be specific \_\_\_\_\_

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How do family members show affection for one another? \_\_\_\_\_

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Do you have pets in your home?  Yes  No If yes, please list \_\_\_\_\_

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Type of dwelling:  house  apartment  duplex  trailer

What access to outdoor play does your child have? \_\_\_\_\_

How often does your child play outdoors? \_\_\_\_\_

Type of transportation used by the family: \_\_\_\_\_

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### DEVELOPMENTAL HISTORY – Please complete with current information for your child

Was this pregnancy and delivery normal and without complications? \_\_\_\_\_

Explain, if not \_\_\_\_\_

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Was this child full term?  Yes  No Premature?  Yes  No (# of weeks \_\_\_\_\_)

Age when child: said first words \_\_\_\_\_ crawled \_\_\_\_\_ walked \_\_\_\_\_

Comment on your child's language development \_\_\_\_\_

Is your child toilet trained?  Yes  No Does s/he have any difficulties with toileting? \_\_\_\_\_

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What time does s/he usually go to bed at night? \_\_\_\_\_ awake? \_\_\_\_\_

Are you comfortable with these hours? \_\_\_\_\_

Does your child feed himself/herself? \_\_\_\_\_

Does your child have any food allergies?  Yes  No If so, please list: \_\_\_\_\_

Does s/he have any special dislikes? \_\_\_\_\_

Preferences? \_\_\_\_\_

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Are there any foods that your child cannot have for health, religious, or cultural reasons? \_\_\_\_\_

Do you have any concerns about your child's eating habits? \_\_\_\_\_

Does your child have any unusual eating or sleeping problems, language difficulties, or intense fears? \_\_\_\_\_

**MEDICAL TREATMENT:**

The MSUM Early Education Center has my permission to provide and/or obtain emergency medical and dental treatment by the child's physician/dentist or an alternate, if I cannot be reached. If you have no local physician or dentist or your child has not seen one yet, please write "no preference" in the blank or list your personal dentist. If no dentist is listed the default dentist of Dr. Erik Skatvold, DDS will be used. Moorhead Dental Associates's phone number is: 218-236-5466.

Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
(child's full name )

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Parent's Signature \*if 2: parent/family both must sign)

\_\_\_\_\_  
(date)

**PERMISSIONS:**

The MSUM Early Education Center has my permission to use Wet Wipes, etc. on my child when diapering or if my child has an accident with toileting. (Please let your child's teacher know of any allergies to this type of product.)

\_\_\_\_\_  
(child's full name )

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Parent's Signature \*if 2: parent/family both must sign) (date)

The MSUM Early Education Center has my permission to use insect repellent and/or sunscreen on my child. (Please let your child's teacher know of any allergies to this type of product.)

\_\_\_\_\_  
(child's full name )

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Parent's Signature \*if 2: parent/family both must sign) (date)

The MSUM Early Education Center has my permission to use photos of my child in ads, brochures, or on website, blog and Facebook page for promotional purposes.

\_\_\_\_\_  
(child's full name )

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Parent's Signature \*if 2: parent/family both must sign) (date)

I understand that information in Part 2 will be available to the classroom teacher, student teacher, or other professionals who work to meet the needs of my child. However, this information is still considered confidential and will not be used in any other context.

\_\_\_\_\_  
(child's full name )

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Parent's Signature \*if 2: parent/family both must sign) (date)

The MSUM Early Education Center has my permission to use lotion on my child when s/he has chapped hands or face. (Please let your child's teacher know of any allergies to this type of product.)

\_\_\_\_\_  
(child's full name )

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Parent's Signature \*if 2: parent/family both must sign) (date)

As a parent of a child at the Early Education Center, I understand that my child's name may be displayed in places where other families, students of MSUM, and/or University faculty and staff may see it. These places may include, but are not limited to: sign-in sheets, bathroom charts, classroom attendance sheets, hallway cubbies, bathroom cubbies, art/writing cubbies, and artwork.

\_\_\_\_\_  
(child's full name )

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Parent's Signature \*if 2: parent/family both must sign) (date)

## HEALTH INFORMATION

Name of child's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Approximately how often is your child seen by this physician? \_\_\_\_\_

Are all immunizations up to date?  Yes  No If not, explain: \_\_\_\_\_

Has your child had chicken pox?  Yes  No

List any allergies, injuries, prolonged illnesses, or any limiting conditions your child may have: \_\_\_\_\_

\_\_\_\_\_

Does your child experience any of the following:  seizures  ear infections  strep infection  impetigo

sudden high temperatures  diarrhea  constipation  upset stomach  other \_\_\_\_\_

Have you noted any signs of hearing or sight loss? \_\_\_\_\_

If your child is older than 2 1/2 years, has s/he has a recent dental exam? \_\_\_\_\_

If so, name of dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last examination: \_\_\_\_\_

## BEHAVIORAL BACKGROUND

What is your child's favorite activity and/or toys? \_\_\_\_\_

Does s/he have regular playmates?  Yes  No Ages? \_\_\_\_\_

Does s/he have any unusual problems when interacting with other children? Describe: \_\_\_\_\_

\_\_\_\_\_

Would you judge your child to be  extremely active  somewhat active  quiet  very passive  shy

Does your child have any fears such as dogs or loud noises? \_\_\_\_\_

Does your child have nightmares? \_\_\_\_\_

Does your child have persistent habits or mannerisms such as thumb sucking, nail biting, etc. ? Describe: \_\_\_\_\_

If you do not ignore these mannerisms, how do you deal with this behavior? \_\_\_\_\_

List any special skills or interests your child may have: \_\_\_\_\_

What means of discipline is most effective with your child? \_\_\_\_\_

How does your child comfort himself/herself? \_\_\_\_\_

What do you want the center to provide for you and your child? \_\_\_\_\_

Is your child on an IEP or IFSP?  Yes  No If yes, please provide center with a copy.

We value the fact that parents are a child's first and foremost teacher. Therefore, we have developed a Family Activity Board to promote parental involvement in the MSUM Early Education Center. Please indicate your interest in becoming involved in the board:

Yes, please contact me  No, I am not interested at this time.

**Thanks for helping us understand your child better.**

**If you feel there is other important information that we should know about your child,  
please contact the teacher or the director.**