MOUNTAIN SHADOWS
EXCEPTIONAL KIDS

# CHILD IDENTIFICATION INFORMATION

Child's Name:______________________________ Birthdate:____________
Last First Nickname

Address:______________________________ City:__________ Zip:__________

Home Phone: ______________________________ ☐ Male ☐ Female

Mother's Name:______________________________ SS#:______________________

Employer:______________________________ Work Phone:______________________

Cell Phone: ______________________________ Email: ______________________

Father's Name:______________________________ SS#:______________________

Employer:______________________________ Work Phone:______________________

Cell Phone: ______________________________ Email: ______________________

Parents are: ☐ Married ☐ Separated ☐ Single ☐ Divorced ☐ Deceased (Father/Mother)

☐ Grandparents ☐ Foster Parent ☐ Other ____________

Names of persons not listed above that are authorized to take the child from the Center

*The child **will not** be released to anyone without written authorization from parent or guardian*

Name______________________ Relationship________________ Phone____________

Name______________________ Relationship________________ Phone____________

Name______________________ Relationship________________ Phone____________

Name______________________ Relationship________________ Phone____________

Mountain Shadows Exceptional Kids

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Child's Name: ______________________________________________ Room #:____________________
Last First Nickname

Allergies: __________________________________________________

Food Sensitivities: ___________________________________________

Medications: _______________________________________________

___________________________________________________________

Special Health Condition: ______________________________________

Child's Photo

_____________________________________________________________________________________

As the parent, or legal guardian, I herby give consent to Mountain Shadows Exceptional Kids, and their employees to provide all emergency medical or dental care prescribed by a duty licensed physician (M.D.) or dentist (D.D.S.) for my child. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent. This includes calling an Emergency Rescue vehicle and to arrange for emergency medical and surgical care, in case I am not immediately available. It is understood that a conscientious effort will be made to notify us (the parents) before such action will be taken. I also agree to accept responsibly for the cost of the above medical services not covered by school insurance.

Doctor's Name: __________________________________________________ Phone: _________________

Address: ____________________________________ City: ___________________ Zip: ______________

Medical Insurance Co: _______________________________ Policy #: _____________________________

Dentist Name: _____________________________________ Phone: ______________________________

Address: ____________________________________ City: ___________________ Zip: ______________

In case of illness or emergency, these additional persons are authorized to pick up the child.

Name______________________________ Relationship_____________________ Phone_______________

Name______________________________ Relationship_____________________ Phone_______________

This form **MUST** have two (2) signatures. If this child is in the custody of one parent, please indication.

Parent/Guardian Signature: ____________________________________________ Date: _______________

Parent/Guardian Signature: ____________________________________________ Date: _______________

Mountain Shadows Exceptional Kids

# EMERGENCY DISASTER RELEASE FORM

In the event of a community disaster (flood, earthquake, etc.) my child shall only be released from the school grounds to his/her parents, or the individual(s) listed here:

Name: ______________________________________________ Phone:__________________________
Last First Middle

Name: ______________________________________________ Phone:__________________________
Last First Middle

Name: ______________________________________________ Phone:__________________________
Last First Middle

This form **MUST** have two (2) signatures. If this child is in the custody of one parent, please indication.

Parent/Guardian Signature: ___________________________________________ Date: ______________

Parent/Guardian Signature: ___________________________________________ Date: ______________

Mountain Shadows Exceptional Kids

INFANT / TODDLER INDIVIDUAL NEEDS & SERVICE PLAN

Feeding: ☐ Breast Fed ☐ Bottle Fed ☐ Cup

Milk/Formula Brand: ___________________________

Time child drinks Breast/Bottle Milk

AM 6 7 8 9 10 11 12 1 2 3 4 5 6 PM

Average amount of ounces per feeding: __________

Time child drinks Juice or Water

AM 6 7 8 9 10 11 12 1 2 3 4 5 6 PM

Average amount of ounces per feeding: __________

Current Diet: ☐ Milk/Formula ☐ Baby Food

☐ Soft Table Food ☐ Most Table Food ☐ Cereal

☐ Egg ☐ Vegetables ☐ Meat

☐ Fruit ☐ Products ☐ Dairy

**Feeding Times:**

Breakfast:_______________ Lunch: ______________

Dinner: _________________Snacks:______________

**Amounts:**

Breakfast:_______________ Lunch: ______________

Dinner: _________________Snacks:______________

Child Able to Feed Self: ☐ Yes ☐ No

Child Able to use:

☐ Sipper ☐ Cup ☐ Spoon ☐Fork

Foods/Liquids Child likes: ______________________

Foods/Liquids Child dislikes: __________________

Food Allergies: _______________________________

**Schedule of Introduction**

Approximate age your child should be introduced to

Food: Puree____________ Semi Solid ___________

Chopped ___________ Finger Foods _____________

Utensils: Sipper Cup ____________ Cup _________

Spoon _______________ Fork __________________

Child uses: ☐ Diapers Cloth or Disposable

☐ Pull up/ Training Pants ☐ Potty Chair ☐ Toilet

Is child allergic to disposable diapers? ☐ Y ☐ N

Brand to use: _________________________________

Is Child Allergic to diaper wipes? ☐ Y ☐ N

Is Child Prone to Diaper Rash? ☐ Y ☐ N

Ointment to use _______________________________

**Schedule of Introduction**

Approximate age that you wish to start Toilet Training your child? ___________________________

Method used to assist in toilet training ___________

_______________________________________________

Sleeping Time child wakes up _____________

Time child goes to bed ____________

Does child sleep through the night?

☐ No ☐ Yes ☐ Occasionally

Times of Child's naps ________________________

Average length of each nap ____________________

Indications of Sleepiness _______________________

Child uses:

☐ Blanket ☐ Pacifier ☐ Toy (describe) __________

Does child need to be rocked to sleep? ☐ Y ☐ N

Does child cry him/herself to sleep? ☐ Y ☐ N

If so, for how long? __________________________

Child sleeps on ☐ Back ☐ Stomach ☐ Side

Any other helpful information on sleeping habits…

_______________________________________________

**General Information**

Child is able to…

☐ Hold head up ☐ Roll Over ☐ Sit up Alone

☐ Sit up w/ assistance ☐ Scoot ☐ Creep

☐ Crawl ☐ Pull self up ☐ Walk

Does child use pacifier other than sleeping times?

☐ Y ☐ N

Experiences and noises frightening to your child:

_______________________________________________

_______________________________________________

Best way to comfort your child _________________

_______________________________________________

Fears you may having learning your child at our Center _________________________________________

Parent's Signature ___________________________

Date: ______________

Mountain Shadows Exceptional Kids

CHILD'S FAMILY & SOCIAL HISTORY

**Family/ Home Environment**

Child has:

☐ Stepmother Name: ________________________

☐ Stepfather Name: __________________________

Siblings: *Names* ________________ *Ages*

____________________________________________

____________________________________________

____________________________________________

Name/Relationship of other adults besides parent(s) living in the home: ___________________________

____________________________________________

Child's favorite activities ______________________

____________________________________________

Child's favorite toy __________________________

Things child dislikes having done to him/her _____

____________________________________________

**Parent's Perspective**

Describe child's personality, behavior at home...…..

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Describe discipline used at home ________________

____________________________________________

____________________________________________

____________________________________________

Describe any fears your child may have and how you have dealt with them ______________________

____________________________________________

____________________________________________

What do you want most out of this Early Childhood experience? ________________________________

____________________________________________

Areas of development you want to see emphasized in your child _______________________________

____________________________________________

**Daily Routines**

Eating habits:

☐ Slow eater ☐ Selective eater ☐ Eats a variety

Favorite Foods _______________________________

Foods disliked _______________________________

Usual eating times:

Breakfast _______Lunch ________Dinner_______

Toileting:

Does child verbalize bathroom needs? ☐ Y ☐ N

Does your child need assistance? ☐ Y ☐ N

Describe ____________________________________

Words child uses for…

Bowel Movement _________ Urination_________

Are bowel movements regular? ☐ Y ☐ N

Child toilet trained at what age _________________

Does child have daytime accidents?

☐ Yes ☐ No ☐ Occasionally

Does child have nighttime accidents?

☐ Yes ☐ No ☐ Occasionally

**Social**

Has child had previous group play/care experiences

☐ Y ☐ N

How does child get along with parents? _________

____________________________________________

Siblings ____________________________________

Other Children _______________________________

Does child have difficulty separating from family?

☐ Yes ☐ No ☐ Occasionally

How do you handle separations? _______________

____________________________________________

What languages are spoken at home? ___________

Is there anything about your family's culture or religion you'd like to share? ___________________

____________________________________________

Does child have an outdoor play area at home?

☐ Y ☐ N

Any neighborhood playmates? ☐ Y ☐ N

Does child have difficulty sharing? ☐ Y ☐ N

Mountain Shadows Exceptional Kids

CHILD'S MEDICAL INFORMATION & DEVELOPMENTAL NEEDS

**Medical Information**

At Birth ☐ Normal ☐ Premature ☐ Complications Birth weight ___________________

Has your child had any surgery? ☐ Yes ☐ No Please explain: ____________________________________

________________________________________________________________________________

Past Illnesses: Please check illnesses that your child has had with approximate dates:

☐ Chicken Pox/Date ________________________ ☐ Rheumatic Fever/Date ______________________
☐ Whooping Cough/Date ____________________ ☐ Hay Fever/Date__________________________
☐ Asthma/Date ____________________________ ☐ Mumps/Date ____________________________
☐ Poliomyelitis/Date _______________________ ☐ Ten Day Measles/Date ______________________
☐ Diabetes/Date ___________________________ ☐ Other / Date ___________________________
☐ Three Day Measles/Date ___________________

What physical problems are present at this time? ☐ None If yes, please explain in the space provided.

☐ Respiratory: ______________________________________________________________
☐ Orthopedic: ______________________________________________________________
☐ Seizures: ________________________________________________________________
☐ Visual: __________________________________________________________________
☐ Hearing: _________________________________________________________________
☐ Heart: ___________________________________________________________________

Allergies: _____________________________________Food Allergies: _________________________________

Food Restrictions: ____________________________________________________________

Does child have frequent colds? ☐ Y ☐ N

**Developmental Needs**

Check and describe any special developmental needs your child has that we should be aware of or possibly attend to:

☐ Speech/Language: ____________________________________________________________
☐ Motor Development: ___________________________________________________________
☐ Self Help Skills: _____________________________________________________________
☐ Attention Span: ______________________________________________________________
☐ Emotional Development: _______________________________________________________
☐ Social Development: __________________________________________________________
☐ Behavioral Problems: _________________________________________________________
☐ Other:______________________________________________________________________

Is your child currently on, or in the process of being evaluated for, an IEP or an IFSP? ☐ Yes ☐ No

What diagnosis, if any, has your child received? ____________________________________________

Age your child…
Smiled_______ Sat up ________ Crawled _______Talked ______ Walked ________ Fed Self_______

Mountain Shadows Exceptional Kids

MEDIA RELEASE FORM

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By signing this form I give Mountain Shadows Exceptional Kids personnel permission to take photographs and / or video of my child. I understand that this media (photos/videos) may be used within the center (child record, classrooms), in center newsletters, in media advertising (printed, digital, website, or any other form), in art and crafts projects, and to make parent gifts.

Child's Name: ____________________________________________ Birthdate: ____________________
Last First Middle

☐ Yes, I give permission to MSEK to use media of my child in any way as described above.

Parent/Guardian Signature: __________________________________________ Date: _______________

Parent Name (printed) _____________________________________________

☐ No, I do not give permission to MSEK to use media of my child in any way as described above.

Parent/Guardian Signature: __________________________________________ Date: _______________

Parent Name (printed) _____________________________________________

☐ Other: I give my permission to MSEK to use media only on the following (please check):

- ☐ Within the facility (child records, class pictures, arts & crafts project) Initial____________
- ☐ Parent Gifts Initial____________
- ☐ Center Newsletters only Initial____________
- ☐ Media Advertising (printed media only, flyers, brochures, etc) Initial____________
- ☐ Media Advertising Digital (website, facebook,) Initial____________

Parent/Guardian Signature: __________________________________________ Date: _______________

Parent Name (printed) _____________________________________________

Mountain Shadows Exceptional Kids

MEDICATION AUTHORIZATION

Child's Name: ______________________________________________ Birthdate:__________________
Last First Nickname

Name of Medication: ____________________________________________________________________

Date(s) to administer: __________________________________________________________________

Dosage to be given: ___________________________ Time(s) to be administered: ___________________

Method of delivery (route): Topical Oral

Possible side effects that need to be reported: ________________________________________________

Reason for use (indication): _____________________________________________________________

Refrigerate Medication: ☐ Yes ☐ No

Physician's Name: ____________________________________ Phone Number: ___________________

Prescription Number: ___________________________________________________________________

Parent/Guardian Signature: ______________________________ Date: __________________________

**ALL MEDICATIONS MUST BE IN THE ORIGINAL LABELED BOTTLE AND NOT EXPIRED**

**For Office Use**

1. Is the consent form above completed? YES NO
2. Is the original label on the medication container? YES NO
3. Is the child's name on the medication container? YES NO
4. Is the date on the prescription current? YES NO
5. Is the medication name, dose, and frequency of administration on the label consistent with parental instructions given above? YES NO

Staff Signature:_________________

**Medication Administration Record**

| Date | Time | Dose | Staff Signature |
|---|---|---|---|
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